

Research Registry for Neonatal Lupus (*RRNL*)

Enrollment Questionnaire

**National Institute for Arthritis, Musculoskeletal, and
Skin Diseases**

and

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New York, NY 10016
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Research Registry for Neonatal Lupus

Information about the person filling out the questionnaire

Today's date:								
<p>What is your relationship to the child with Neonatal Lupus?:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;"><input type="checkbox"/> Mother</td> <td style="width: 50%;"><input type="checkbox"/> Sibling</td> </tr> <tr> <td><input type="checkbox"/> Father</td> <td><input type="checkbox"/> Self</td> </tr> <tr> <td><input type="checkbox"/> Grandparent</td> <td><input type="checkbox"/> Uncle or Aunt</td> </tr> <tr> <td colspan="2"><input type="checkbox"/> Other, please describe:</td> </tr> </table>	<input type="checkbox"/> Mother	<input type="checkbox"/> Sibling	<input type="checkbox"/> Father	<input type="checkbox"/> Self	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Uncle or Aunt	<input type="checkbox"/> Other, please describe:	
<input type="checkbox"/> Mother	<input type="checkbox"/> Sibling							
<input type="checkbox"/> Father	<input type="checkbox"/> Self							
<input type="checkbox"/> Grandparent	<input type="checkbox"/> Uncle or Aunt							
<input type="checkbox"/> Other, please describe:								
Please give your name, address and telephone number if you are NOT the child's mother:								

Information about the Neonatal Lupus Child's Mother

Mother's name:	Date of Birth:		
Address:			
City:	State:	Zip:	
Home phone:	Mobile phone:	Work phone:	E-mail address:
<p><i>(For all studies involving human subjects, Federal regulations (OMB Directive No. 15) require that we maintain, collect and present data on ethnicity and race for reporting the inclusion of women and minorities as subjects in research.</i></p>			
<p><u>Ethnic Categories:</u></p> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown (individuals not reporting ethnicity)		<p><u>Racial Categories:</u></p> <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> More than one Race <input type="checkbox"/> Unknown or Not Reported <input type="checkbox"/> Decline	

Medical History of the Neonatal Lupus Child's Mother

Have you had daily, persistent, troublesome dry eyes for more than 3 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No														
Do your eyes often feel gritty or sandy?	<input type="checkbox"/> Yes <input type="checkbox"/> No														
Do you use tear substitutes more than 3 times a day?	<input type="checkbox"/> Yes <input type="checkbox"/> No														
Have you had a daily feeling of dry mouth for more than 3 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No														
As an adult, have you had frequent or long-lasting mumps-like swelling on the side of your face? (Do not include childhood mumps)	<input type="checkbox"/> Yes <input type="checkbox"/> No														
Do you often drink liquids to help you swallow dry foods?	<input type="checkbox"/> Yes <input type="checkbox"/> No														
Have exposed parts of your body (including your face) ever broken out in a rash when you went out in the sun?	<input type="checkbox"/> Yes <input type="checkbox"/> No														
Within the last 5 years, have you had mouth ulcers (check all that apply): <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <input type="checkbox"/> on the inside of your cheeks? <input type="checkbox"/> on your gums? <input type="checkbox"/> No mouth ulcers </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <input type="checkbox"/> on your tongue? <input type="checkbox"/> on the roof of your mouth? </div>															
Do your fingertips change colors (for example, become white, blue, and then red) when exposed to the cold?	<input type="checkbox"/> Yes <input type="checkbox"/> No														
Have you ever been told by a doctor that you had fluid around your heart (pericarditis)?	<input type="checkbox"/> Yes When? _____ <input type="checkbox"/> No														
Have you ever been told by a doctor that you had fluid around your lung (pleuritis)?	<input type="checkbox"/> Yes When? _____ <input type="checkbox"/> No														
Have you ever experienced joint pain not as a result of injury? If yes, answer the following:	<input type="checkbox"/> Yes <input type="checkbox"/> No														
<table style="width: 100%; border: none;"> <thead> <tr> <th style="text-align: left; border: none;">Which joints?</th> <th style="text-align: left; border: none;">Date last happened</th> </tr> </thead> <tbody> <tr> <td style="border: none;"><input type="checkbox"/> Hands/wrist</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Elbow</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Shoulder</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Hips</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Knee</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Ankle</td> <td style="border: none;">_____</td> </tr> </tbody> </table>		Which joints?	Date last happened	<input type="checkbox"/> Hands/wrist	_____	<input type="checkbox"/> Elbow	_____	<input type="checkbox"/> Shoulder	_____	<input type="checkbox"/> Hips	_____	<input type="checkbox"/> Knee	_____	<input type="checkbox"/> Ankle	_____
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<input type="checkbox"/> Hands/wrist	_____														
<input type="checkbox"/> Elbow	_____														
<input type="checkbox"/> Shoulder	_____														
<input type="checkbox"/> Hips	_____														
<input type="checkbox"/> Knee	_____														
<input type="checkbox"/> Ankle	_____														

Medical History of the Neonatal Lupus Child's Mother (continued)

Have any of your joints swelled not as a result of injury? If yes, answer the following:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Which joints? Date last happened <input type="checkbox"/> Hands/wrist _____ <input type="checkbox"/> Elbow _____ <input type="checkbox"/> Shoulder _____ <input type="checkbox"/> Hips _____ <input type="checkbox"/> Knee _____ <input type="checkbox"/> Ankle _____	
Have any of your joints ever been red or felt hot not as a result of injury? If yes, answer the following:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Which joints? Date last happened <input type="checkbox"/> Hands/wrist _____ <input type="checkbox"/> Elbow _____ <input type="checkbox"/> Shoulder _____ <input type="checkbox"/> Hips _____ <input type="checkbox"/> Knee _____ <input type="checkbox"/> Ankle _____	
Has a doctor ever told you that you had protein in your urine?	<input type="checkbox"/> Yes When? _____ <input type="checkbox"/> No
Have you ever had a seizure?	<input type="checkbox"/> Yes When? _____ <input type="checkbox"/> No
Have you ever had a stroke?	<input type="checkbox"/> Yes When? _____ <input type="checkbox"/> No
Has a doctor ever told you that you had a low white blood count?	<input type="checkbox"/> Yes When? _____ <input type="checkbox"/> No
Has a doctor ever told you that you had a low platelet count?	<input type="checkbox"/> Yes When? _____ <input type="checkbox"/> No
Have you ever had a lip biopsy done?	<input type="checkbox"/> Yes When? _____ <input type="checkbox"/> No
Has a doctor ever told you that you have Sjögren's Syndrome?	<input type="checkbox"/> Yes When? _____ <input type="checkbox"/> No
Has a doctor ever told you that you have Systemic Lupus Erythematosus?	<input type="checkbox"/> Yes When? _____ <input type="checkbox"/> No

Medical History of the Neonatal Lupus Child's Mother (continued)

Have you had a DEXA Scan for the evaluation of osteoporosis (bone thinning)?	<input type="checkbox"/> Yes When? _____ <input type="checkbox"/> No
Have you been diagnosed with osteoporosis?	<input type="checkbox"/> Yes When? _____ <input type="checkbox"/> No

Has a doctor ever told you that you have Rheumatoid Arthritis?	<input type="checkbox"/> Yes When? _____ <input type="checkbox"/> No
Please list any medical conditions for which you see a physician.	
What medications (if any) are you currently taking? Please specify dosage, if known.	
What is your blood type?	

Questions about the Mother's Relatives

Does anyone in your family have Sjögren's Syndrome?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does anyone in your family have Systemic Lupus Erythematosus?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has anyone else in your family had a baby with Neonatal Lupus? <input type="checkbox"/> if No, please go to the next page <input type="checkbox"/> if Yes, please answer the following questions: How are you related to that baby's mother? <i>That baby's mother is my...</i> <input type="checkbox"/> Sister <input type="checkbox"/> Aunt <input type="checkbox"/> Daughter <input type="checkbox"/> Cousin <input type="checkbox"/> Parent <input type="checkbox"/> Other, please specify: _____	
What problem did that baby have? (Check all that apply) <i>That baby had...</i> <input type="checkbox"/> Heart block <input type="checkbox"/> Liver problems <input type="checkbox"/> Low blood count <input type="checkbox"/> Skin rash <input type="checkbox"/> Don't know	

Information about Mother's Current Physician

Information about the Neonatal Lupus Child's Pediatrician

Name:		Specialty:
Address:		
City:	State:	Zip:
Phone number:	Fax number:	E-mail address:

Questions about the Mother's Pregnancy History

How many times have you been pregnant? <i>(Include all deliveries, miscarriages, and terminated pregnancies)</i>	
How many pregnancies have lasted for at least 4 months?	
How many babies were born alive?	
How many of your children are currently living?	
Did all of your child have the same biological father?	<input type="checkbox"/> Yes, all my children have the same biological father <input type="checkbox"/> No, at least one child has a biological father different from the rest

Please read this:

The next pages are sheets for obtaining information about each pregnancy that lasted longer than 4 months. There are two pages for each pregnancy.

Please complete the sheets for each pregnancy, even those in which the baby died. There are enough forms for six different pregnancies.

If you had more than six pregnancies which lasted longer than six months, please mark the box below and someone from the Neonatal Lupus Registry Project will call you for information about the additional pregnancies.

- Check here if you had MORE than six different pregnancies which have lasted more than four months.**

- Check here if you had FEWER than six different pregnancies which have lasted more than four months.**

When you're done with the Pregnancy Information Sheets, please go to the last page of the questionnaire.

Information Sheet About Your FIRST Pregnancy lasting more than four months

Please complete the following questions about the first pregnancy you had.

Were you sick with any illnesses during the pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did you take any medications during the pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No																
<table style="width: 100%; border: none;"> <tr> <td style="width: 30%;">Illness</td> <td style="width: 70%;">During what month?</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> </table>	Illness	During what month?	_____	_____	_____	_____	_____	_____	<table style="width: 100%; border: none;"> <tr> <td style="width: 30%;">Medication</td> <td style="width: 70%;">During what month?</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> </table>	Medication	During what month?	_____	_____	_____	_____	_____	_____
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_____	_____																
_____	_____																
Medication	During what month?																
_____	_____																
_____	_____																
_____	_____																

If this pregnancy lasted more than four months, please complete the following questions:

Delivery date or the date the pregnancy ended: _____ How did the pregnancy end? <input type="checkbox"/> Normal delivery <input type="checkbox"/> Premature delivery (20 - 37 weeks gestation) <input type="checkbox"/> Miscarriage <input type="checkbox"/> Induced abortion How many weeks/days pregnant were you when the pregnancy ended? _____	How many babies were there? <input type="checkbox"/> One <input type="checkbox"/> Twins <input type="checkbox"/> Triplets <input type="checkbox"/> More than three <div style="display: inline-block; vertical-align: middle; margin-left: 10px;">] -If you had twins or triplets (or more), were the babies: <input type="checkbox"/> Identical <input type="checkbox"/> Fraternal </div> Delivery method: <input type="checkbox"/> Vaginal <input type="checkbox"/> Cesarean
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<p><i>Delivering Obstetrician</i></p> Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____	<p><i>Hospital</i></p> Hospital delivered: _____ City: _____ State: _____
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Information Sheet About Your FIRST Pregnancy lasting more than four months

Complete the following for each baby in the pregnancy. Answer the questions in the 'First baby' column if there was one baby. If you had twins, answer the questions for the columns 'first baby' and 'Twin' for each baby, respectively. If you had triplets, complete all three columns.

	First Baby	Twin	Triplet
Baby's name			
Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Delivery outcome	<input type="checkbox"/> Live <input type="checkbox"/> Stillborn Weight: _____ lbs _____ oz Length: _____ inches	<input type="checkbox"/> Live <input type="checkbox"/> Stillborn Weight: _____ lbs _____ oz Length: _____ inches	<input type="checkbox"/> Live <input type="checkbox"/> Stillborn Weight: _____ lbs _____ oz Length: _____ inches
Did the baby have any of the following problems? (Check all that apply)	<input type="checkbox"/> Heart block: Diagnosed: <input type="checkbox"/> During pregnancy - At how many weeks gestation? _____ wks <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> Low blood count: Diagnosed: <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> Liver problems: Diagnosed: <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> Skin rash: Diagnosed: <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> None of the above	<input type="checkbox"/> Heart block: Diagnosed: <input type="checkbox"/> During pregnancy - At how many weeks gestation? _____ wks <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> Low blood count: Diagnosed: <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> Liver problems: Diagnosed: <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> Skin rash: Diagnosed: <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> None of the above	<input type="checkbox"/> Heart block: Diagnosed: <input type="checkbox"/> During pregnancy - At how many weeks gestation? _____ wks <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> Low blood count: Diagnosed: <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> Liver problems: Diagnosed: <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> Skin rash: Diagnosed: <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> None of the above
If the child had heart block, was a pacemaker implanted?	<input type="checkbox"/> Yes - Date: _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes - Date: _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes - Date: _____ <input type="checkbox"/> No
If the baby was born alive, is the child still living?	<input type="checkbox"/> Yes - Child still alive <input type="checkbox"/> No - Date child died: _____ Autopsy done? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes - Child still alive <input type="checkbox"/> No - Date child died: _____ Autopsy done? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes - Child still alive <input type="checkbox"/> No - Date child died: _____ Autopsy done? <input type="checkbox"/> Yes <input type="checkbox"/> No
If the baby was born alive, was the baby breast fed?	<input type="checkbox"/> Yes - Child was breast fed for _____ wks <input type="checkbox"/> No - Child was not breast fed	<input type="checkbox"/> Yes - Child was breast fed for _____ wks <input type="checkbox"/> No - Child was not breast fed	<input type="checkbox"/> Yes - Child was breast fed for _____ wks <input type="checkbox"/> No - Child was not breast fed
Child's Blood Type:			

Information Sheet About Your SECOND Pregnancy lasting more than four months

Please complete the following questions about the second pregnancy you had.

Were you sick with any illnesses during the pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No <table style="width:100%; border: none;"> <tr> <td style="width:30%; border: none;">Illness</td> <td style="width:70%; border: none;">During what month?</td> </tr> <tr> <td style="border: none;">_____</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;">_____</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;">_____</td> <td style="border: none;">_____</td> </tr> </table>	Illness	During what month?	_____	_____	_____	_____	_____	_____	Did you take any medications during the pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No <table style="width:100%; border: none;"> <tr> <td style="width:30%; border: none;">Medication</td> <td style="width:70%; border: none;">During what month?</td> </tr> <tr> <td style="border: none;">_____</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;">_____</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;">_____</td> <td style="border: none;">_____</td> </tr> </table>	Medication	During what month?	_____	_____	_____	_____	_____	_____
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_____	_____																
Medication	During what month?																
_____	_____																
_____	_____																
_____	_____																

If this pregnancy lasted more than four months, please complete the following questions:

Delivery date or the date the pregnancy ended: _____ How did the pregnancy end? <input type="checkbox"/> Normal delivery <input type="checkbox"/> Premature delivery (20 - 37 weeks gestation) <input type="checkbox"/> Miscarriage <input type="checkbox"/> Induced abortion How many weeks/days pregnant were you when the pregnancy ended? _____	How many babies were there? <input type="checkbox"/> One <input type="checkbox"/> Twins <input type="checkbox"/> Triplets <input type="checkbox"/> More than three <table style="margin-left: 20px; border: none;"> <tr> <td style="font-size: 2em;">}</td> <td>-If you had twins or triplets (or more), were the babies:</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Identical <input type="checkbox"/> Fraternal</td> </tr> </table> Delivery method: <input type="checkbox"/> Vaginal <input type="checkbox"/> Cesarean	}	-If you had twins or triplets (or more), were the babies:		<input type="checkbox"/> Identical <input type="checkbox"/> Fraternal
}	-If you had twins or triplets (or more), were the babies:				
	<input type="checkbox"/> Identical <input type="checkbox"/> Fraternal				

<p><i>Delivering Obstetrician</i></p> Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____	<p><i>Hospital</i></p> Hospital delivered: _____ City: _____ State: _____
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Information Sheet About Your SECOND Pregnancy lasting more than four months

Complete the following for each baby in the pregnancy. Answer the questions in the 'First baby' column if there was one baby. If you had twins, answer the questions for the columns 'first baby' and 'Twin' for each baby, respectively. If you had triplets, complete all three columns.

	First Baby	Twin	Triplet
Baby's name			
Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Delivery outcome	<input type="checkbox"/> Live <input type="checkbox"/> Stillborn	<input type="checkbox"/> Live <input type="checkbox"/> Stillborn	<input type="checkbox"/> Live <input type="checkbox"/> Stillborn
	Weight: _____ lbs _____ oz Length: _____ inches	Weight: _____ lbs _____ oz Length: _____ inches	Weight: _____ lbs _____ oz Length: _____ inches
Did the baby have any of the following problems? (Check all that apply)	<input type="checkbox"/> Heart block: Diagnosed: <input type="checkbox"/> During pregnancy - At how many weeks gestation? _____ wks <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> Low blood count: Diagnosed: <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> Liver problems: Diagnosed: <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> Skin rash: Diagnosed: <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> None of the above	<input type="checkbox"/> Heart block: Diagnosed: <input type="checkbox"/> During pregnancy - At how many weeks gestation? _____ wks <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> Low blood count: Diagnosed: <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> Liver problems: Diagnosed: <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> Skin rash: Diagnosed: <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> None of the above	<input type="checkbox"/> Heart block: Diagnosed: <input type="checkbox"/> During pregnancy - At how many weeks gestation? _____ wks <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> Low blood count: Diagnosed: <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> Liver problems: Diagnosed: <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> Skin rash: Diagnosed: <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> None of the above
If the child had heart block, was a pacemaker implanted?	<input type="checkbox"/> Yes - Date: _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes - Date: _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes - Date: _____ <input type="checkbox"/> No
If the baby was born alive, is the child still living?	<input type="checkbox"/> Yes - Child still alive <input type="checkbox"/> No - Date child died: _____ Autopsy done? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes - Child still alive <input type="checkbox"/> No - Date child died: _____ Autopsy done? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes - Child still alive <input type="checkbox"/> No - Date child died: _____ Autopsy done? <input type="checkbox"/> Yes <input type="checkbox"/> No
If the baby was born alive, was the baby breast fed?	<input type="checkbox"/> Yes - Child was breast fed for _____ wks <input type="checkbox"/> No - Child was not breast fed	<input type="checkbox"/> Yes - Child was breast fed for _____ wks <input type="checkbox"/> No - Child was not breast fed	<input type="checkbox"/> Yes - Child was breast fed for _____ wks <input type="checkbox"/> No - Child was not breast fed
Child's Blood Type:			

Information Sheet About Your THIRD Pregnancy lasting more than four months

Please complete the following questions about the third pregnancy you had.

Were you sick with any illnesses during the pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No <table style="width:100%; border: none;"> <tr> <td style="width:50%; border: none;">Illness _____</td> <td style="width:50%; border: none;">During what month? _____</td> </tr> <tr> <td style="border: none;">_____</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;">_____</td> <td style="border: none;">_____</td> </tr> </table>	Illness _____	During what month? _____	_____	_____	_____	_____	Did you take any medications during the pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No <table style="width:100%; border: none;"> <tr> <td style="width:50%; border: none;">Medication _____</td> <td style="width:50%; border: none;">During what month? _____</td> </tr> <tr> <td style="border: none;">_____</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;">_____</td> <td style="border: none;">_____</td> </tr> </table>	Medication _____	During what month? _____	_____	_____	_____	_____
Illness _____	During what month? _____												
_____	_____												
_____	_____												
Medication _____	During what month? _____												
_____	_____												
_____	_____												

If this pregnancy lasted more than four months, please complete the following questions:

Delivery date or the date the pregnancy ended: _____ How did the pregnancy end? <input type="checkbox"/> Normal delivery <input type="checkbox"/> Premature delivery (20 - 37 weeks gestation) <input type="checkbox"/> Miscarriage <input type="checkbox"/> Induced abortion How many weeks/days pregnant were you when the pregnancy ended? _____	How many babies were there? <input type="checkbox"/> One <input type="checkbox"/> Twins <input type="checkbox"/> Triplets <input type="checkbox"/> More than three -If you had twins or triplets (or more), were the babies: <input type="checkbox"/> Identical <input type="checkbox"/> Fraternal Delivery method: <input type="checkbox"/> Vaginal <input type="checkbox"/> Cesarean
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<i>Delivering Obstetrician</i> Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____	<i>Hospital</i> Hospital delivered: _____ City: _____ State: _____
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Information Sheet About Your THIRD Pregnancy lasting more than four months

Complete the following for each baby in the pregnancy. Answer the questions in the 'First baby' column if there was one baby. If you had twins, answer the questions for the columns 'first baby' and 'Twin' for each baby, respectively. If you had triplets, complete all three columns.

	First Baby	Twin	Triplet
Baby's name			
Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Delivery outcome	<input type="checkbox"/> Live <input type="checkbox"/> Stillborn	<input type="checkbox"/> Live <input type="checkbox"/> Stillborn	<input type="checkbox"/> Live <input type="checkbox"/> Stillborn
	Weight: _____ lbs _____ oz Length: _____ inches	Weight: _____ lbs _____ oz Length: _____ inches	Weight: _____ lbs _____ oz Length: _____ inches
Did the baby have any of the following problems? (Check all that apply)	<input type="checkbox"/> Heart block: Diagnosed: <input type="checkbox"/> During pregnancy - At how many weeks gestation? _____ wks <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> Low blood count: Diagnosed: <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> Liver problems: Diagnosed: <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> Skin rash: Diagnosed: <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> None of the above	<input type="checkbox"/> Heart block: Diagnosed: <input type="checkbox"/> During pregnancy - At how many weeks gestation? _____ wks <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> Low blood count: Diagnosed: <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> Liver problems: Diagnosed: <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> Skin rash: Diagnosed: <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> None of the above	<input type="checkbox"/> Heart block: Diagnosed: <input type="checkbox"/> During pregnancy - At how many weeks gestation? _____ wks <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> Low blood count: Diagnosed: <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> Liver problems: Diagnosed: <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> Skin rash: Diagnosed: <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> None of the above
If the child had heart block, was a pacemaker implanted?	<input type="checkbox"/> Yes - Date: _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes - Date: _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes - Date: _____ <input type="checkbox"/> No
If the baby was born alive, is the child still living?	<input type="checkbox"/> Yes - Child still alive <input type="checkbox"/> No - Date child died: _____ Autopsy done? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes - Child still alive <input type="checkbox"/> No - Date child died: _____ Autopsy done? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes - Child still alive <input type="checkbox"/> No - Date child died: _____ Autopsy done? <input type="checkbox"/> Yes <input type="checkbox"/> No
If the baby was born alive, was the baby breast fed?	<input type="checkbox"/> Yes - Child was breast fed for _____ wks <input type="checkbox"/> No - Child was not breast fed	<input type="checkbox"/> Yes - Child was breast fed for _____ wks <input type="checkbox"/> No - Child was not breast fed	<input type="checkbox"/> Yes - Child was breast fed for _____ wks <input type="checkbox"/> No - Child was not breast fed
Child's Blood Type:			

Information Sheet About Your FOURTH Pregnancy lasting more than four months

Please complete the following questions about the fourth pregnancy you had.

Were you sick with any illnesses during the pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No Illness _____ During what month? _____ _____ _____	Did you take any medications during the pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No Medication _____ During what month? _____ _____ _____
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If this pregnancy lasted more than four months, please complete the following questions:

Delivery date or the date the pregnancy ended: _____ How did the pregnancy end? <input type="checkbox"/> Normal delivery <input type="checkbox"/> Premature delivery (20 - 37 weeks gestation) <input type="checkbox"/> Miscarriage <input type="checkbox"/> Induced abortion How many weeks/days pregnant were you when the pregnancy ended? _____	How many babies were there? <input type="checkbox"/> One <input type="checkbox"/> Twins <input type="checkbox"/> Triplets <input type="checkbox"/> More than three -If you had twins or triplets (or more), were the babies: <input type="checkbox"/> Identical <input type="checkbox"/> Fraternal Delivery method: <input type="checkbox"/> Vaginal <input type="checkbox"/> Cesarean
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<p><i>Delivering Obstetrician</i></p> Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____	<p><i>Hospital</i></p> Hospital delivered: _____ City: _____ State: _____
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Information Sheet About Your FOURTH Pregnancy lasting more than four months

Complete the following for each baby in the pregnancy. Answer the questions in the 'First baby' column if there was one baby. If you had twins, answer the questions for the columns 'first baby' and 'Twin' for each baby, respectively. If you had triplets, complete all three columns.

	First Baby	Twin	Triplet
Baby's name			
Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Delivery outcome	<input type="checkbox"/> Live <input type="checkbox"/> Stillborn	<input type="checkbox"/> Live <input type="checkbox"/> Stillborn	<input type="checkbox"/> Live <input type="checkbox"/> Stillborn
	Weight: _____ lbs _____ oz Length: _____ inches	Weight: _____ lbs _____ oz Length: _____ inches	Weight: _____ lbs _____ oz Length: _____ inches
Did the baby have any of the following problems? (Check all that apply)	<input type="checkbox"/> Heart block: Diagnosed: <input type="checkbox"/> During pregnancy - At how many weeks gestation? _____ wks <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> Low blood count: Diagnosed: <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> Liver problems: Diagnosed: <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> Skin rash: Diagnosed: <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> None of the above	<input type="checkbox"/> Heart block: Diagnosed: <input type="checkbox"/> During pregnancy - At how many weeks gestation? _____ wks <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> Low blood count: Diagnosed: <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> Liver problems: Diagnosed: <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> Skin rash: Diagnosed: <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> None of the above	<input type="checkbox"/> Heart block: Diagnosed: <input type="checkbox"/> During pregnancy - At how many weeks gestation? _____ wks <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> Low blood count: Diagnosed: <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> Liver problems: Diagnosed: <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> Skin rash: Diagnosed: <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> None of the above
If the child had heart block, was a pacemaker implanted?	<input type="checkbox"/> Yes - Date: _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes - Date: _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes - Date: _____ <input type="checkbox"/> No
If the baby was born alive, is the child still living?	<input type="checkbox"/> Yes - Child still alive <input type="checkbox"/> No - Date child died: _____ Autopsy done? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes - Child still alive <input type="checkbox"/> No - Date child died: _____ Autopsy done? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes - Child still alive <input type="checkbox"/> No - Date child died: _____ Autopsy done? <input type="checkbox"/> Yes <input type="checkbox"/> No
If the baby was born alive, was the baby breast fed?	<input type="checkbox"/> Yes - Child was breast fed for _____ wks <input type="checkbox"/> No - Child was not breast fed	<input type="checkbox"/> Yes - Child was breast fed for _____ wks <input type="checkbox"/> No - Child was not breast fed	<input type="checkbox"/> Yes - Child was breast fed for _____ wks <input type="checkbox"/> No - Child was not breast fed
Child's Blood Type:			

Information Sheet About Your FIFTH Pregnancy lasting more than four months

Please complete the following questions about the fifth pregnancy you had.

Were you sick with any illnesses during the pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No <table style="width:100%; border:none;"> <tr> <td style="width:30%;">Illness</td> <td style="width:70%;">During what month?</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> </table>	Illness	During what month?	_____	_____	_____	_____	_____	_____	Did you take any medications during the pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No <table style="width:100%; border:none;"> <tr> <td style="width:30%;">Medication</td> <td style="width:70%;">During what month?</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> </table>	Medication	During what month?	_____	_____	_____	_____	_____	_____
Illness	During what month?																
_____	_____																
_____	_____																
_____	_____																
Medication	During what month?																
_____	_____																
_____	_____																
_____	_____																

If this pregnancy lasted more than four months, please complete the following questions:

Delivery date or the date the pregnancy ended: _____ How did the pregnancy end? <input type="checkbox"/> Normal delivery <input type="checkbox"/> Premature delivery (20 - 37 weeks gestation) <input type="checkbox"/> Miscarriage <input type="checkbox"/> Induced abortion How many weeks/days pregnant were you when the pregnancy ended? _____	How many babies were there? <input type="checkbox"/> One <input type="checkbox"/> Twins <input type="checkbox"/> Triplets <input type="checkbox"/> More than three } -If you had twins or triplets (or more), were the babies: <input type="checkbox"/> Identical <input type="checkbox"/> Fraternal Delivery method: <input type="checkbox"/> Vaginal <input type="checkbox"/> Cesarean
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<p><i>Delivering Obstetrician</i></p> Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____	<p><i>Hospital</i></p> Hospital delivered: _____ City: _____ State: _____
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Information Sheet About Your FIFTH Pregnancy lasting more than four months

Complete the following for each baby in the pregnancy. Answer the questions in the 'First baby' column if there was one baby. If you had twins, answer the questions for the columns 'first baby' and 'Twin' for each baby, respectively. If you had triplets, complete all three columns.

	First Baby	Twin	Triplet
Baby's name			
Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Delivery outcome	<input type="checkbox"/> Live <input type="checkbox"/> Stillborn	<input type="checkbox"/> Live <input type="checkbox"/> Stillborn	<input type="checkbox"/> Live <input type="checkbox"/> Stillborn
	Weight: _____ lbs _____ oz Length: _____ inches	Weight: _____ lbs _____ oz Length: _____ inches	Weight: _____ lbs _____ oz Length: _____ inches
Did the baby have any of the following problems? (Check all that apply)	<input type="checkbox"/> Heart block: Diagnosed: <input type="checkbox"/> During pregnancy - At how many weeks gestation? _____ wks <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> Low blood count: Diagnosed: <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> Liver problems: Diagnosed: <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> Skin rash: Diagnosed: <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> None of the above	<input type="checkbox"/> Heart block: Diagnosed: <input type="checkbox"/> During pregnancy - At how many weeks gestation? _____ wks <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> Low blood count: Diagnosed: <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> Liver problems: Diagnosed: <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> Skin rash: Diagnosed: <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> None of the above	<input type="checkbox"/> Heart block: Diagnosed: <input type="checkbox"/> During pregnancy - At how many weeks gestation? _____ wks <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> Low blood count: Diagnosed: <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> Liver problems: Diagnosed: <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> Skin rash: Diagnosed: <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> None of the above
If the child had heart block, was a pacemaker implanted?	<input type="checkbox"/> Yes - Date: _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes - Date: _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes - Date: _____ <input type="checkbox"/> No
If the baby was born alive, is the child still living?	<input type="checkbox"/> Yes - Child still alive <input type="checkbox"/> No - Date child died: _____ Autopsy done? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes - Child still alive <input type="checkbox"/> No - Date child died: _____ Autopsy done? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes - Child still alive <input type="checkbox"/> No - Date child died: _____ Autopsy done? <input type="checkbox"/> Yes <input type="checkbox"/> No
If the baby was born alive, was the baby breast fed?	<input type="checkbox"/> Yes - Child was breast fed for _____ wks <input type="checkbox"/> No - Child was not breast fed	<input type="checkbox"/> Yes - Child was breast fed for _____ wks <input type="checkbox"/> No - Child was not breast fed	<input type="checkbox"/> Yes - Child was breast fed for _____ wks <input type="checkbox"/> No - Child was not breast fed
Child's Blood Type:			

Information Sheet About Your SIXTH Pregnancy lasting more than four months

Please complete the following questions about the sixth pregnancy you had.

Were you sick with any illnesses during the pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No <table style="width:100%; border: none;"> <tr> <td style="width:30%; border: none;">Illness</td> <td style="width:70%; border: none;">During what month?</td> </tr> <tr> <td style="border: none;">_____</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;">_____</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;">_____</td> <td style="border: none;">_____</td> </tr> </table>	Illness	During what month?	_____	_____	_____	_____	_____	_____	Did you take any medications during the pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No <table style="width:100%; border: none;"> <tr> <td style="width:30%; border: none;">Medication</td> <td style="width:70%; border: none;">During what month?</td> </tr> <tr> <td style="border: none;">_____</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;">_____</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;">_____</td> <td style="border: none;">_____</td> </tr> </table>	Medication	During what month?	_____	_____	_____	_____	_____	_____
Illness	During what month?																
_____	_____																
_____	_____																
_____	_____																
Medication	During what month?																
_____	_____																
_____	_____																
_____	_____																

If this pregnancy lasted more than four months, please complete the following questions:

Delivery date or the date the pregnancy ended: _____ How did the pregnancy end? <input type="checkbox"/> Normal delivery <input type="checkbox"/> Premature delivery (20 - 37 weeks gestation) <input type="checkbox"/> Miscarriage <input type="checkbox"/> Induced abortion How many weeks/days pregnant were you when the pregnancy ended? _____	How many babies were there? <input type="checkbox"/> One <input type="checkbox"/> Twins <input type="checkbox"/> Triplets <input type="checkbox"/> More than three <table style="margin-left: 20px; border: none;"> <tr> <td style="font-size: 2em;">}</td> <td>-If you had twins or triplets (or more), were the babies:</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Identical <input type="checkbox"/> Fraternal</td> </tr> </table> Delivery method: <input type="checkbox"/> Vaginal <input type="checkbox"/> Cesarean	}	-If you had twins or triplets (or more), were the babies:		<input type="checkbox"/> Identical <input type="checkbox"/> Fraternal
}	-If you had twins or triplets (or more), were the babies:				
	<input type="checkbox"/> Identical <input type="checkbox"/> Fraternal				

<p><i>Delivering Obstetrician</i></p> Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____	<p><i>Hospital</i></p> Hospital delivered: _____ City: _____ State: _____
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Information Sheet About Your SIXTH Pregnancy lasting more than four months

Complete the following for each baby in the pregnancy. Answer the questions in the 'First baby' column if there was one baby. If you had twins, answer the questions for the columns 'first baby' and 'Twin' for each baby, respectively. If you had triplets, complete all three columns.

	First Baby	Twin	Triplet
Baby's name			
Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Delivery outcome	<input type="checkbox"/> Live <input type="checkbox"/> Stillborn	<input type="checkbox"/> Live <input type="checkbox"/> Stillborn	<input type="checkbox"/> Live <input type="checkbox"/> Stillborn
	Weight: _____ lbs _____ oz Length: _____ inches	Weight: _____ lbs _____ oz Length: _____ inches	Weight: _____ lbs _____ oz Length: _____ inches
Did the baby have any of the following problems? (Check all that apply)	<input type="checkbox"/> Heart block: Diagnosed: <input type="checkbox"/> During pregnancy - At how many weeks gestation? _____ wks <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> Low blood count: Diagnosed: <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> Liver problems: Diagnosed: <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> Skin rash: Diagnosed: <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> None of the above	<input type="checkbox"/> Heart block: Diagnosed: <input type="checkbox"/> During pregnancy - At how many weeks gestation? _____ wks <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> Low blood count: Diagnosed: <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> Liver problems: Diagnosed: <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> Skin rash: Diagnosed: <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> None of the above	<input type="checkbox"/> Heart block: Diagnosed: <input type="checkbox"/> During pregnancy - At how many weeks gestation? _____ wks <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> Low blood count: Diagnosed: <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> Liver problems: Diagnosed: <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> Skin rash: Diagnosed: <input type="checkbox"/> At birth <input type="checkbox"/> After birth - At how many weeks after birth? _____ wks <input type="checkbox"/> None of the above
If the child had heart block, was a pacemaker implanted?	<input type="checkbox"/> Yes - Date: _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes - Date: _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes - Date: _____ <input type="checkbox"/> No
If the baby was born alive, is the child still living?	<input type="checkbox"/> Yes - Child still alive <input type="checkbox"/> No - Date child died: _____ Autopsy done? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes - Child still alive <input type="checkbox"/> No - Date child died: _____ Autopsy done? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes - Child still alive <input type="checkbox"/> No - Date child died: _____ Autopsy done? <input type="checkbox"/> Yes <input type="checkbox"/> No
If the baby was born alive, was the baby breast fed?	<input type="checkbox"/> Yes - Child was breast fed for _____ wks <input type="checkbox"/> No - Child was not breast fed	<input type="checkbox"/> Yes - Child was breast fed for _____ wks <input type="checkbox"/> No - Child was not breast fed	<input type="checkbox"/> Yes - Child was breast fed for _____ wks <input type="checkbox"/> No - Child was not breast fed
Child's Blood Type:			

This is the end of the questionnaire. THANK YOU for your participation.

Please use this room to add any additional comments
(Feel free to use the back of this page or enclose additional sheets):

Thank You