Registry ID _____ State/Territory ID _____ Reset Form

U.S. Zika Pregnancy Registry and Birth Defects Surveillance — Integrated Maternal Health History Form

These data are considered confidential and will be stored in a secure database at the Centers for Disease Control and Prevention and the Virginia Department of Health.

Healthcare Provider: Please return completed form to the local health department by secure fax _____ or encrypted email (password protected) _____.

MHH.1. State/Territory ID: _____	**MHH.2. Maternal Age at Diagnosis:** _____	**MHH.3. State/Territory reporting:** Select State **MHH.4. County reporting:** _____

MHH.5. Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

MHH.6. Race *(check all that apply)*:
☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African-American ☐ Unknown/Not Specified
☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Other, specify_____

MHH.7. Indication for maternal Zika virus testing: ☐ Exposure history only, no known fetal abnormalities
☐ Exposure history and fetal abnormalities
☐ No known exposure (*skip to MHH.38*)

Maternal Zika Virus History

MHH.8. Date of Zika virus symptom onset: _____ **OR** **MHH.9.** ☐ Asymptomatic

MHH.10. If symptomatic, gestational age at onset: _____(weeks)_____(days)

MHH.11. If gestational age or date not known, trimester of symptom onset _____ (1^{st}, 2^{nd}, 3^{rd})

MHH.12. Symptoms of mother's Zika virus disease: *(check all that apply)*

☐ Fever *(if measured)* _____°F or _____°C ☐ Arthralgia ☐ Conjunctivitis ☐ Rash

☐ Other clinical presentation_____

MHH.13. If rash, check all that apply ☐ Maculopapular ☐ Petechial ☐ Purpuric ☐ Pruritic

Describe rash distribution_____

MHH.14. Hospitalized for Zika virus disease ☐ No ☐ Yes ☐ Unknown

MHH.15. Maternal Death ☐ No ☐ Yes ☐ Unknown **MHH.16. If yes, cause of death**_____
MHH.17. If yes, date of death _____

MHH.18. What was the suspected mode of Zika virus transmission?
☐ Human-mosquito-human (vector) ☐ Sexual ☐ Other, please specify_____ ☐ Unknown

MHH.19. Did the woman spend time in any areas <u>outside</u> the US states or US territories where there was active Zika virus transmission during the periconceptional period or during pregnancy?
(http://www.cdc.gov/zika/geo/active-countries.html)

☐ No ☐ Yes ☐ Unknown (*If 'no' or 'unknown', skip to MHH 27)*

MHH.20. *If yes*, please characterize the type of travel:

☐ Incoming travel (one way travel to US states <u>from</u> an area with active Zika virus transmission)
☐ Incoming travel (one way travel to US territories <u>from</u> an area with active Zika virus transmission)
☐ Outgoing and incoming travel (roundtrip <u>from</u> US states <u>to</u> an area with active Zika virus transmission)
☐ Outgoing and incoming travel (roundtrip <u>from</u> US territories <u>to</u> an area with active Zika virus transmission)

Registry ID _____ **State/Territory ID** _____

U.S. Zika Pregnancy Registry and Birth Defects Surveillance — Integrated Maternal Health History Form

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If incoming or outgoing travel, please list location and dates of travel:

MHH.21. Country of exposure (1) _____	**MHH.22.** Start Date _____ End Date _____ ☐ Start date is same as LMP
MHH.23. Country of exposure (2) _____	**MHH.24.** Start Date _____ End Date _____ ☐ Start date is same as LMP
MHH.25. Country of exposure (3) _____	**MHH.26.** Start Date _____ End Date _____ ☐ Start date is same as LMP

MHH.27. Was the Zika virus exposure within the 50 states, DC, or territories? ☐ No ☐ Yes ☐ Unknown

***If yes,* separately list each state or territory where Zika virus exposure occurred, and dates of possible exposure:**

MHH.28. State or territory 1 _____	**MHH.29.** Start Date _____ ☐ Start date is same as LMP	End Date _____ ☐ Still at location
MHH.30. State or territory 2 _____	**MHH.31.** Start Date _____ ☐ Start date is same as LMP	End Date _____ ☐ Still at location
MHH.32. State or territory 3 _____	**MHH.33.** Start Date _____ ☐ Start date is same as LMP	End Date _____ ☐ Still at location

MHH.34. If suspected mode of transmission is sexual, was the pregnant woman's sexual partner(s):
☐ Male ☐ Female *Please check all that apply*

MHH.35. Did any sexual partner(s) have an illness that included fever, rash, joint pain, or pink eye during or within 2 weeks of spending any time in an area with active Zika virus transmission?
☐ No ☐ Yes ☐ Unknown

MHH.36. If yes, was there unprotected sexual contact while partner(s) had this illness?
☐ No ☐ Yes ☐ Unknown

MHH.37. Did partner have a test that demonstrated laboratory evidence of Zika virus infection? ☐ No ☐ Yes ☐ Unknown

Maternal Health History *(Underlying maternal illness)*

MHH.38. Diabetes ☐ No ☐ Yes ☐ Unknown
MHH.39. Maternal Phenylketonuria (PKU) ☐ No ☐ Yes ☐ Unknown
MHH.40. Hypothyroidism ☐ No ☐ Yes ☐ Unknown
MHH.41. High Blood Pressure or Hypertension ☐ No ☐ Yes ☐ Unknown
MHH.42. Other underlying illness(es): ☐ No ☐ Yes ☐ Unknown
MHH.43. If yes, specify: _____

Pregnancy Information

MHH.44. Last menstrual period (LMP): _____	**MHH.45. Estimated delivery date (EDD):** _____

MHH.46. Estimated delivery date based on (*check all that apply*):
☐ LMP ☐ 1st trimester ultrasound ☐ 2nd trimester ultrasound ☐ 3rd trimester ultrasound
☐ Other, specify _____

Registry ID _____ **State/Territory ID** _____

U.S. Zika Pregnancy Registry and Birth Defects Surveillance — Integrated Maternal Health History Form

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OB History:	**MHH.47.** # pregnancies (including current pregnancy) _____	**MHH.48.** # living children _____
	MHH.49. # miscarriages _____	**MHH.50.** # elective terminations _____

MHH.51. Prior fetus/infant with microcephaly: ☐ No ☐ Yes ☐ Unknown
MHH.52. If yes, cause genetic?: ☐ No ☐ Yes ☐ Unknown

MHH.53. Gestation: ☐ Single ☐ Twins ☐ Triplets+

Substance use during this pregnancy:	**MHH.54.** Alcohol use:	☐ No ☐ Yes ☐ Unknown
	MHH.55. Cocaine use:	☐ No ☐ Yes ☐ Unknown
	MHH.56. Smoking:	☐ No ☐ Yes ☐ Unknown

Complications during current pregnancy

MHH.57.	Toxoplasmosis infection:	☐ No ☐ Yes ☐ Unknown
MHH.58.	Cytomegalovirus infection:	☐ No ☐ Yes ☐ Unknown
MHH.59.	Herpes Simplex infection:	☐ No ☐ Yes ☐ Unknown
MHH.60.	Rubella infection:	☐ No ☐ Yes ☐ Unknown
MHH.61.	Lymphocytic choriomeningitis virus infection:	☐ No ☐ Yes ☐ Unknown
MHH.62.	Syphilis infection:	☐ No ☐ Yes ☐ Unknown

MHH.63. If yes for infection testing during current pregnancy, please describe results:

MHH.64.	Fetal genetic abnormality:	☐ No ☐ Yes, describe _____ ☐ Unknown
MHH.65.	Gestational diabetes:	☐ No ☐ Yes ☐ Unknown
MHH.66.	Pregnancy-related hypertension:	☐ No ☐ Yes ☐ Unknown
MHH.67.	Intrauterine death of a twin:	☐ No ☐ Yes ☐ Unknown
MHH.68.	Other: ☐ No ☐ Yes ☐ Unknown **MHH.69.** If yes, please specify _____	

MHH.70. Medications during pregnancy: ☐ No ☐ Yes ☐ Unknown
MHH.71. If yes, specify (*please specify type and see guide for further instructions):*

Pregnancy Losses: *Please also complete pertinent sections of neonatal assessment form*

MHH.72. Did this pregnancy end in miscarriage (<20 weeks of gestation)?
☐ No ☐ Yes ☐ Unknown **MHH.73.** Date: _____ OR gestational age_____ weeks
MHH.74. Please describe any abnormalities noted _____

MHH.75. Did this pregnancy end in stillbirth (intrauterine fetal demise) (≥20 weeks of gestation)?
☐ No ☐ Yes ☐ Unknown **MHH.76.** Date: _____ OR gestational age_____ weeks
MHH.77. Please describe any abnormalities noted_____

MHH.78. Was this pregnancy terminated?
☐ No ☐ Yes ☐ Unknown **MHH.79.** Date: _____ OR gestational age _____ weeks
MHH.80. Please describe any abnormalities noted_____

Maternal Prenatal Imaging and Diagnostics

MHH.81.	**MHH.84. Overall fetal ultrasound results:** ☐ Normal ☐ Abnormal

Registry ID _____ State/Territory ID _____

U.S. Zika Pregnancy Registry and Birth Defects Surveillance — Integrated Maternal Health History Form

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<table>
<tr><td rowspan="15">Date(s) of ultrasound(s):

_____
☐ MHH.82.
Check if date approximated

MHH.83. If date not known,
Gestational age
_____ _____
(weeks) (days)</td><td colspan="4">MHH.85. ☐ Reported by patient/healthcare provider ☐ Ultrasound report</td></tr>
<tr><td colspan="4">MHH.86. Head circumference (HC) _____cm
MHH.87. ☐ Normal ☐ Abnormal (by physician report)</td></tr>
<tr><td colspan="4">MHH.88. Biparietal diameter (BPD) _____cm
MHH.89. Femur length (FL) _____cm
MHH.90. Abdominal circumference (AC) _____cm</td></tr>
<tr><td colspan="4">MHH.91. ☐ Symmetric intrauterine growth restriction (IUGR)
☐ Asymmetric IUGR (HC%>AC% or HC%>FL%)</td></tr>
<tr><td>MHH.92. Microcephaly</td><td>☐ No ☐ Yes</td><td>MHH.93. Intracranial calcifications</td><td>☐ No ☐ Yes</td></tr>
<tr><td>MHH.94. Cerebral /cortical atrophy</td><td>☐ No ☐ Yes</td><td>MHH.95. Abnormal cortical gyral patterns (e.g., polymicrogyria, lissencephaly, pachygyria, schizencephaly, gray matter heterotopia)</td><td>☐ No ☐ Yes</td></tr>
<tr><td>MHH.96. Corpus callosum abnormalities</td><td>☐ No ☐ Yes</td><td>MHH.97. Cerebellar abnormalities</td><td>☐ No ☐ Yes</td></tr>
<tr><td>MHH.98. Porencephaly</td><td>☐ No ☐ Yes</td><td>MHH.99. Hydranencephaly</td><td>☐ No ☐ Yes</td></tr>
<tr><td>MHH.100. Moderate or severe ventriculomegaly / hydrocephaly</td><td>☐ No ☐ Yes</td><td>MHH.101. Fetal brain disruption sequence (collapsed skull, overlapping sutures, prominent occipital bone, scalp rugae)</td><td>☐ No ☐ Yes</td></tr>
<tr><td>MHH.102. Other major brain abnormalities</td><td>☐ No ☐ Yes</td><td>MHH.103. Anencephaly / acrania</td><td>☐ No ☐ Yes</td></tr>
<tr><td>MHH.104. Encephalocele</td><td>☐ No ☐ Yes</td><td>MHH.105. Spina bifida</td><td>☐ No ☐ Yes</td></tr>
<tr><td>MHH.106. Holoprosencephaly / arhinencephaly</td><td>☐ No ☐ Yes</td><td>MHH.107. Structural eye abnormalities / dysplasia</td><td>☐ No ☐ Yes</td></tr>
<tr><td>MHH.108. Arthrogryposis</td><td>☐ No ☐ Yes</td><td>MHH.109. Clubfoot</td><td>☐ No ☐ Yes</td></tr>
<tr><td>MHH.110. Hydrops</td><td>☐ No ☐ Yes</td><td>MHH.111. Ascites</td><td>☐ No ☐ Yes</td></tr>
<tr><td>MHH.112. Other</td><td colspan="3">☐ No ☐ Yes If yes, describe:</td></tr>
<tr><td colspan="5">MHH.113. Description of abnormal ultrasound findings:</td></tr>
<tr><td rowspan="6">MHH.114. Date(s) of Ultrasound(s):

_____
☐ MHH.115.
check if date approximated</td><td colspan="4">MHH.117. Overall fetal ultrasound results: ☐ Normal ☐ Abnormal</td></tr>
<tr><td colspan="4">MHH.118. ☐ Reported by patient/healthcare provider ☐ Ultrasound report</td></tr>
<tr><td colspan="4">MHH.119. Head circumference (HC) _____cm
MHH.120. ☐ Normal ☐ Abnormal (by physician report)</td></tr>
<tr><td colspan="4">MHH.121. Biparietal diameter (BPD) _____cm
MHH.122. Femur length (FL) _____cm
MHH.123. Abdominal circumference (AC) _____cm</td></tr>
</table>

Registry ID _____ State/Territory ID _____

U.S. Zika Pregnancy Registry and Birth Defects Surveillance — Integrated Maternal Health History Form

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MHH.116. *if date not known,* gestational age _____ _____ (weeks) (days)	**MHH.124.** ☐ Symmetric IUGR ☐ Asymmetric IUGR (HC%>AC% or HC%>FL%)			
	MHH.125. Microcephaly	☐ No ☐ Yes	**MHH.126.** Intracranial calcifications	☐ No ☐ Yes
	MHH.127. Cerebral / cortical atrophy	☐ No ☐ Yes	**MHH.128.** Abnormal cortical gyral patterns (e.g., polymicrogyria, lissencephaly, pachygyria, schizencephaly, gray matter heterotopia)	☐ No ☐ Yes
	MHH.129. Corpus callosum abnormalities	☐ No ☐ Yes	**MHH.130.** Cerebellar abnormalities	☐ No ☐ Yes
	MHH.131. Porencephaly	☐ No ☐ Yes	**MHH.132.** Hydranencephaly	☐ No ☐ Yes
	MHH.133. Moderate or severe ventriculomegaly / hydrocephaly	☐ No ☐ Yes	**MHH.134.** Fetal brain disruption sequence (collapsed skull, overlapping sutures, prominent occipital bone, scalp rugae)	☐ No ☐ Yes
	MHH.135. Other major brain abnormalities	☐ No ☐ Yes	**MHH.136.** Anencephaly / acrania	☐ No ☐ Yes
	MHH.137. Encephalocele	☐ No ☐ Yes	**MHH.138.** Spina bifida	☐ No ☐ Yes
	MHH.139. Holoprosencephaly / arhinencephaly	☐ No ☐ Yes	**MHH.140.** Structural eye abnormalities / dysplasia	☐ No ☐ Yes
	MHH.141. Arthrogryposis	☐ No ☐ Yes	**MHH.142.** Clubfoot	☐ No ☐ Yes
	MHH.143. Hydrops	☐ No ☐ Yes	**MHH.144.** Ascites	☐ No ☐ Yes
	MHH.145. Other	☐ No ☐ Yes If yes, describe:		
MHH.146. Description of abnormal ultrasound findings:				
MHH.147. Date(s) of Ultrasound(s): _____ ☐ **MHH.148.** *check if date approximated* **MHH.149.** *if date not known,* gestational age _____ _____ (weeks) (days)	**MHH.150. Overall fetal ultrasound results:** ☐ Normal ☐ Abnormal			
	MHH.151. ☐ Reported by patient/healthcare provider ☐ Ultrasound report			
	MHH.152. Head circumference (HC)_____cm **MHH.153.** ☐ Normal ☐ Abnormal (*by physician report*)			
	MHH.154. Biparietal diameter (BPD) _____cm **MHH.155.** Femur length (FL) _____cm **MHH.156.**Abdominal circumference (AC) _____cm			
	MHH.157. ☐ Symmetric IUGR ☐ Asymmetric IUGR (HC%>AC% or HC%>FL%)			
	MHH.158. Microcephaly	☐ No ☐ Yes	**MHH.159.** Intracranial calcifications	☐ No ☐ Yes
	MHH.160. Cerebral / cortical atrophy	☐ No ☐ Yes	**MHH.161.** Abnormal cortical gyral patterns (e.g., polymicrogyria, lissencephaly, pachygyria, schizencephaly, gray matter heterotopia)	☐ No ☐ Yes
	MHH.162. Corpus callosum	☐ No ☐ Yes	**MHH.163.** Cerebellar	☐ No ☐ Yes

Registry ID _____ State/Territory ID _____

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	abnormalities		abnormalities	
	MHH.164. Porencephaly	☐ No ☐ Yes	**MHH.165.** Hydranencephaly	☐ No ☐ Yes
	MHH.166. Moderate or severe ventriculomegaly / hydrocephaly	☐ No ☐ Yes	**MHH.167.** Fetal brain disruption sequence (collapsed skull, overlapping sutures, prominent occipital bone, scalp rugae)	☐ No ☐ Yes
	MHH.168. Other major brain abnormalities	☐ No ☐ Yes	**MHH.169.** Anencephaly / Acrania	☐ No ☐ Yes
	MHH.170. Encephalocele	☐ No ☐ Yes	**MHH.171.** Spina bifida	☐ No ☐ Yes
	MHH.172. Holoprosencephaly / arhinencephaly	☐ No ☐ Yes	**MHH.173.** Structural eye abnormalities / dysplasia	☐ No ☐ Yes
	MHH.174. Arthrogryposis	☐ No ☐ Yes	**MHH.175.** Clubfoot	☐ No ☐ Yes
	MHH.176. Hydrops	☐ No ☐ Yes	**MHH.177.** Ascites	☐ No ☐ Yes
	MHH.178. Other	☐ No ☐ Yes If yes, describe:		

MHH.179. Description of abnormal ultrasound findings:

****For additional ultrasounds, please request a supplementary imaging form****

MHH.180. Fetal MRI performed: ☐ No ☐ Yes (If yes, please answer questions below)

MHH.181. Date(s) of MRI(s): _____ ☐ **MHH.182.** *check if date is approximated*	**MHH.184. Overall fetal MRI results:** ☐ Normal ☐ Abnormal			
	MHH.185. ☐ Reported by patient/healthcare provider ☐ MRI report			
	MHH.186. Head circumference (HC) ___cm **MHH.187.** ☐ Normal ☐ Abnormal (*by physician report*)			
	MHH.188. Biparietal diameter (BPD) _____cm **MHH.189.** Femur length (FL) _____cm **MHH.190.** Abdominal circumference (AC) _____cm			
	MHH.191. ☐ Symmetric IUGR ☐ Asymmetric IUGR (HC%>AC% or HC%>FL%)			
MHH.183. *if date not known,* gestational age _____ _____ (weeks) (days)	**MHH.192.** Microcephaly	☐ No ☐ Yes	**MHH.193.** Intracranial calcifications	☐ No ☐ Yes
	MHH.194. Cerebral / cortical atrophy	☐ No ☐ Yes	**MHH.195.** Abnormal cortical gyral patterns (e.g., polymicrogyria, lissencephaly, pachygyria, schizencephaly, gray matter heterotopia)	☐ No ☐ Yes
	MHH.196. Corpus callosum abnormalities	☐ No ☐ Yes	**MHH.197.** Cerebellar abnormalities	☐ No ☐ Yes
	MHH.198. Porencephaly	☐ No ☐ Yes	**MHH.199.** Hydranencephaly	☐ No ☐ Yes
	MHH.200. Moderate or severe ventriculomegaly / hydrocephaly	☐ No ☐ Yes	**MHH.201.** Fetal brain disruption sequence (collapsed skull, overlapping sutures, prominent occipital bone, scalp rugae)	☐ No ☐ Yes

Registry ID _____ **State/Territory ID _____**

U.S. Zika Pregnancy Registry and Birth Defects Surveillance — Integrated Maternal Health History Form

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	MHH.202. Other major brain abnormalities	☐ No ☐ Yes	**MHH.203.** Anencephaly / acrania	☐ No ☐ Yes
	MHH.204. Encephalocele	☐ No ☐ Yes	**MHH.205.** Spina bifida	☐ No ☐ Yes
	MHH.206. Holoprosencephaly / arhinencephaly	☐ No ☐ Yes	**MHH.207.** Structural eye abnormalities / dysplasia	☐ No ☐ Yes
	MHH.208. Arthrogryposis	☐ No ☐ Yes	**MHH.209.** Clubfoot	☐ No ☐ Yes
	MHH.210. Hydrops	☐ No ☐ Yes	**MHH.211.** Ascites	☐ No ☐ Yes
	MHH.212. Other	☐ No ☐ Yes If yes, describe:		

MHH.213. Description of abnormal MRI findings:

MHH.214. Amniocentesis performed: ☐ No ☐ Yes

If Zika virus testing performed on amniotic fluid, please enter in Laboratory Results Form.

If cytogenetic testing performed on amniotic fluid, please enter below.

Prenatal (Fetal) Cytogenetic Testing

MHH.215. Prenatal (fetal) cytogenetic testing performed: ☐ No ☐ Yes (If yes, please answer questions below)

MHH.216. Cytogenetic Tests	**MHH.217. Date of test:**	**MHH.219. Specimen type:**	**MHH.220. Test Result**
Karyotype FISH CGH microarray Cell-free DNA Other, specify _____	_____ **MHH.218. Gestational Age:** _____(weeks)_____ (days) or **Trimester:** ☐1st ☐2nd ☐3rd	☐ Amniocentesis ☐ Chorionic Villus Sampling (CVS) ☐ Maternal Serum ☐ Other, specify _____	☐ Normal ☐ Abnormal ☐ Unknown

MHH.221. Description of abnormal cytogenetic testing findings:

Prenatal (Fetal) Cytogenetic Testing

MHH.222. Prenatal (fetal) cytogenetic testing performed: ☐ No ☐ Yes (If yes, please answer questions below)

MHH.223. Cytogenetic Tests	**MHH.224. Date of test**	**MHH.226. Specimen type:**	**MHH.227. Test Result**
Karyotype FISH CGH microarray Cell-free DNA Other, specify _____	_____ **MHH.225. Gestational Age:** _____(weeks)_____ (days) or **Trimester:** ☐1st ☐2nd ☐3rd	☐ Amniocentesis ☐ Chorionic Villus Sampling (CVS) ☐ Maternal Serum ☐ Other, specify _____	☐ Normal ☐ Abnormal ☐ Unknown

Registry ID _____ State/Territory ID _____

U.S. Zika Pregnancy Registry and Birth Defects Surveillance — Integrated Maternal Health History Form

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MHH.228. Description of abnormal cytogenetic testing findings:

Health Department Information

MHH.229. Name of person completing form: _____

MHH.230. Phone: _____ MHH.231. Email: _____

MHH.232. Date form completed _____

Internal use only

Date entered_____ ***Data Entry POC Initials: _____***	***Data Entry Notes*:**