MEDICAL MONITORING PROGRAM CODE: _____

FEMALE REPRODUCTIVE HISTORY

IN ORDER TO HAVE COMPLETE INFORMATION FOR THIS MEDICAL MONITORING PROGRAM, WE NEED TO KNOW ABOUT YOUR REPRODUCTIVE HEALTH AND ABOUT ANY PREGNANCIES YOU MAY HAVE HAD IN THE PAST.

WHAT IS YOUR DATE OF BIRTH ____ / ____ / 19 ____
MONTH DAY YEAR

TODAY'S DATE ____ / ____ / 19 ____
MONTH DAY YEAR

1. Has there ever been a time period of one year or more when you were trying to be come pregnant, but were unsuccessful?

1. |_| Yes 0. |_| No -----> GO TO QUESTION 2 ON THIS PAGE

A. IF YES, please give the approximate dates for this time period. (If more than one such period of time, check this box |_| and specify the last time)

From: ____ 19 ____ To: ____ 19 ____
MONTH YEAR MONTH YEAR

B. Has a cause or reason for the infertility problem been identified by a physician?

1. |_| Yes 0. |_| No

2. Is your partner employed in a job where he works with chemicals?

1. |_| Yes 0. |_| No 2. |_| NO PARTNER

3. Are you now pregnant?

1. |_| YES - IF YES, "What is your due date?" ____ / ____ / ____
MONTH DAY YEAR

2. |_| no

4. Altogether how many times have you been pregnant, including live births, stillbirths, miscarriages, abortions, tubal pregnancies, and a current pregnancy? (FOR EXAMPLE, 2 pregnancies = 0 2)

PREGNANCIES: ___ ___

IF YOU HAVE EVER BEEN PREGNANT AT ANY TIME AND THAT PREGNANCY HAS ENDED WITH A BIRTH, MISCARRIAGE, ABORTION, STILLBIRTH OR TUBAL PREGNANCY, GO TO THE NEXT PAGE TO COMPLETE THE PREGNANCY HISTORY CHART.

MEDICAL MONITORING PROGRAM CODE: _____

PREGNANCY HISTORY

PLEASE COMPLETE THIS PREGNANCY HISTORY CHART FOR ANY PREGNANCY THAT YOU HAVE EVER HAD, AND THAT IS NOW OVER.

INCLUDE ALL PAST PREGNANCIES, THOSE FROM EARLIER MARRIAGES, & UNWED PREGNANCIES COMPLETE ALL QUESTIONS FOR 1ST PREGNANCY BEFORE ANSWERING QUESTIONS ABOUT THE 2ND ONE, ETC.

1. The following information is about my first, second, etc. pregnancy	First Pregnancy	Second Pregnancy	Third Pregnancy	Fourth Pregnancy
2. Thinking about your first (2nd, etc.) pregnancy, did you have a:				
1. Single Birth	1. ☐	1. ☐	1. ☐	1. ☐
2. Multiple Birth	2. ☐	2. ☐	2. ☐	2. ☐
3. Tubal Pregnancy	3. ☐	3. ☐	3. ☐	3. ☐
4. Abortion (medical or personal)	4. ☐	4. ☐	4. ☐	4. ☐
5. Miscarriage	5. ☐	5. ☐	5. ☐	5. ☐
6. Stillbirth	6. ☐	6. ☐	6. ☐	6. ☐
3. When was this child born? OR (If you had a tubal pregnancy, abortion, miscarriage or stillbirth,) What was the date that the pregnancy ended?	__ __/__ __/19__ __ Month Day Year (Go to the	__ __/__ __/19__ __ Month Day Year instructions on	__ __/__ __/19__ __ Month Day Year the next page	__ __/__ __/19__ __ Month Day Year if you cannot remember the exact month.)
4. How many total weeks were you pregnant? (Count from the first day of your last menstrual period. Use the instructions on the next page to convert months to weeks.)	___ ___ WEEKS	___ ___ WEEKS	___ ___ WEEKS	___ ___ WEEKS

IF YOU HAD A SINGLE OR MULTIPLE LIVE BIRTH, OR A STILLBIRTH, PLEASE ANSWER QUESTIONS AT THE TOP OF PAGE 4.

IF YOU HAD A TUBAL PREGNANCY, ABORTION, OR MISCARRIAGE, PLEASE GO TO QUESTION 8 ON PAGE 4.

DATE CONVERSION

This page can be used to assist you in answering **Questions 3, 4 and 8** on the PREGNANCY HISTORY CHART.

QUESTION #3:

If you are not sure of the date that your pregnancy ended, the following guidelines will be helpful.

If you are unsure of the month that the pregnancy ended, but can remember the season, use the following:

"summer" insert "07" for month
"fall" insert "10" for month
"winter" insert "01" for month
"spring" insert "04" for month

If you have no idea of the month that the pregnancy ended, use "DK" for month.

If you can remember the month and year, but cannot remember the day, use "DK" for the day.

If you cannot remember the date at all, use "DK/DK/19DK" for month, day, and year.

QUESTIONS 4 AND 8:

We are asking you to answer these questions with the number of weeks of pregnancy. If you can remember months, but not weeks, use the following conversion chart. Remember to count from the first day of your last menstrual period.

1 month	04 weeks
2 months	09 weeks
3 months	13 weeks
4 months	18 weeks
5 months	22 weeks
6 months	27 weeks
7 months	31 weeks
8 months	36 weeks
9 months or full term -	40 weeks
Full term + 2 weeks late -	42 weeks

MEDICAL MONITORING PROGRAM
PREGNANCY HISTORY

CODE: _____

FOR LIVE BIRTH, OR STILLBIRTH IF YOU KNOW THE INFORMATION:
(IF YOU HAVE HAD A MULTIPLE BIRTH, PLEASE ASK FOR A BLUE SHEET FOR THE SECOND CHILD.)

PREGNANCY NUMBER	First Pregnancy	Second Pregnancy	Third Pregnancy	Fourth Pregnancy
5. How much did the baby weigh? (e.g., 7lb 7oz=07/07)	__ __/__ __ lbs oz	__ __/__ __ lbs oz	__ __/__ __ lbs oz	__ __/__ __ lbs oz
6. What is the child's sex?	1. Boy ☐ 2. Girl ☐	1. Boy ☐ 2. Girl ☐	1. Boy ☐ 2. Girl ☐	1. Boy ☐ 2. Girl ☐
7. Did the baby have any birth defects recognized within the first year of life?	1. Yes ☐ 0. No ☐	1. Yes ☐ 0. No ☐	1. Yes ☐ 0. No ☐	1. Yes ☐ 0. No ☐
If yes, please describe in your own words.	_____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____

FOR ALL PREGNANCIES:

PREGNANCY NUMBER	First Pregnancy	Second Pregnancy	Third Pregnancy	Fourth Pregnancy
8. In what week of your pregnancy did you begin seeing a physician/midwife about your pregnancy	__ __ WEEKS	__ __ WEEKS	__ __ WEEKS	__ __ WEEKS
9. At the time you became pregnant, was the child's father employed in a job where he worked with chemicals?	1. Yes ☐ 0. No ☐	1. Yes ☐ 0. No ☐	1. Yes ☐ 0. No ☐	1. Yes ☐ 0. No ☐

MEDICAL MONITORING PROGRAM
PREGNANCY HISTORY

CODE: _____

FOR ALL PREGNANCIES:

PREGNANCY NUMBER	First Pregnancy	Second Pregnancy	Third Pregnancy	Fourth Pregnancy
10. Did you have any of the following complication(s) which required medical attention with this pregnancy? (CHECK ALL THAT APPLY)				
a. Toxemia	a. ☐	a. ☐	a. ☐	a. ☐
b. High Blood Pressure	b. ☐	b. ☐	b. ☐	b. ☐
c. Bleeding First Three Months	c. ☐	c. ☐	c. ☐	c. ☐
d. Bleeding Last Six Months	d. ☐	d. ☐	d. ☐	d. ☐
e. Severe Vomiting	e. ☐	e. ☐	e. ☐	e. ☐
f. Severe Swelling/ Bloating	f. ☐	f. ☐	f. ☐	f. ☐
g. Fever of 100° of greater	g. ☐	g. ☐	g. ☐	g. ☐
h. Early Labor	h. ☐	h. ☐	h. ☐	h. ☐
i. Diabetes – Taking Insulin	i. ☐	i. ☐	i. ☐	i. ☐
j. Diabetes – Not Taking Insulin	j. ☐	j. ☐	j. ☐	j. ☐
k. Accidents	k. ☐	k. ☐	k. ☐	k. ☐
l. Infection Due To Ruptured Membrane	l. ☐	l. ☐	l. ☐	l. ☐
m. Other Describe:	m. ☐	m. ☐	m. ☐	m. ☐
n. None	n. ☐	n. ☐	n. ☐	n. ☐
11. On the average about how many cigarettes did you smoke each day during this pregnancy? IF YOU DID NOT SMOKE WRITE "00".	___ ___ cigarettes per day	___ ___ cigarettes per day	___ ___ cigarettes per day	___ ___ cigarettes per day

MEDICAL MONITORING PROGRAM
PREGNANCY HISTORY

CODE: ________

FOR ALL PREGNANCIES:

PREGNANCY NUMBER	First Pregnancy	Second Pregnancy	Third Pregnancy	Fourth Pregnancy
12. On the average, during this pregnancy, about how many alcoholic beverages did you usually have? (1 drink=1 beer or 1 glass of wine or 1 mixed drink).	1.☐ 3 or more/day 2.☐ 1-2 per day 3.☐ 4-6 per week 4.☐ 2-3 per week 5.☐ 1 per week 6.☐ 1-3 /month 7.☐ Less than one per month 8.☐ Never	1.☐ 3 or more/day 2.☐ 1-2 per day 3.☐ 4-6 per week 4.☐ 2-3 per week 5.☐ 1 per week 6.☐ 1-3 /month 7.☐ Less than one per month 8.☐ Never	1.☐ 3 or more/day 2.☐ 1-2 per day 3.☐ 4-6 per week 4.☐ 2-3 per week 5.☐ 1 per week 6.☐ 1-3 /month 7.☐ Less than one per month 8.☐ Never	1.☐ 3 or more/day 2.☐ 1-2 per day 3.☐ 4-6 per week 4.☐ 2-3 per week 5.☐ 1 per week 6.☐ 1-3 /month 7.☐ Less than one per month 8.☐ Never
13. Did you take birth control pills during the 3 months right before you became pregnant?	1. Yes ☐ 0. No ☐	1. Yes ☐ 0. No ☐	1. Yes ☐ 0. No ☐	1. Yes ☐ 0. No ☐
14. Were you employed during the first 6 months of this pregnancy?	0.☐ NO 1.☐ Part Time (less than 36 hours per week) 2.☐ Full Time (36 hrs/wk or more)	0.☐ NO 1.☐ Part Time (less than 36 hours per week) 2.☐ Full Time (36 hrs/wk or more)	0.☐ NO 1.☐ Part Time (less than 36 hours per week) 2.☐ Full Time (36 hrs/wk or more)	0.☐ NO 1.☐ Part Time (less than 36 hours per week) 2.☐ Full Time (36 hrs/wk or more)
15. Is this child still living?	1. Yes ☐ 0. No ☐	1. Yes ☐ 0. No ☐	1. Yes ☐ 0. No ☐	1. Yes ☐ 0. No ☐
A. IF NO: When did this child die?	0.☐ During first 7 days of life 1.☐ 8 – 28 Days 2.☐ After 28 Days	0.☐ During first 7 days of life 1.☐ 8 – 28 Days 2.☐ After 28 Days	0.☐ During first 7 days of life 1.☐ 8 – 28 Days 2.☐ After 28 Days	0.☐ During first 7 days of life 1.☐ 8 – 28 Days 2.☐ After 28 Days