

Participant Number -

Hospital/Clinic Code

Maternal Hospital Record No.

Maternal Date of Birth

Please answer all yes/no questions by placing a 'X' in the corresponding box

Section 1: Demographic, socio-economic and nutritional characteristics

1. Age: (years) yrs 2. Maternal height: (cm) ▪ cm

3. 1st trimester or pre-pregnancy weight: (kg) ▪ kg

During this pregnancy:

4. Has she smoked? yes no If yes, how many cigarettes/cigars per day?

5. Has she sniffed/chewed tobacco? yes no If yes, how many times per day?

6. Has she chewed betelnut? yes no If yes, how many nuts per day?

7. On average, how many units of alcohol per week has she had?
(1 unit = small glass (125ml) of wine or one bottle/can (330ml) of beer; see table)

8. Has she used any of the following recreational drugs? (cross all that apply; see table)

Heroin	<input type="checkbox"/>	Amphetamines	<input type="checkbox"/>	Benzodiazepines	<input type="checkbox"/>
Methadone	<input type="checkbox"/>	Hallucinogens	<input type="checkbox"/>	Inhalants/Solvents	<input type="checkbox"/>
Crack/Cocaine	<input type="checkbox"/>	Cannabis	<input type="checkbox"/>	Other recreational drugs	<input type="checkbox"/>

9. Has she been involved in any of the following high-risk occupations or activities? (cross all that apply; see table)

Frequent exposure to chemical/toxic substances	<input type="checkbox"/>
Frequent physically demanding work	<input type="checkbox"/>
Frequent high-risk sports/vigorous exercise	<input type="checkbox"/>

10. Has she followed any of the following special diets? (cross all that apply; see table)

Vegetarian with no animal products	<input type="checkbox"/>	Gluten-free	<input type="checkbox"/>
Weight loss programme	<input type="checkbox"/>	Malabsorption treatment	<input type="checkbox"/>

11. Marital status: (cross one box only)

Single	<input type="checkbox"/>	Widowed	<input type="checkbox"/>
Married/Cohabiting	<input type="checkbox"/>	Separated/Divorced	<input type="checkbox"/>

12. Total number of years of formal education:

13. Highest level of education attended: (cross one box only)

No school attended	<input type="checkbox"/>	Primary	<input type="checkbox"/>	Professional/technical training	<input type="checkbox"/>
		Secondary	<input type="checkbox"/>	University	<input type="checkbox"/>

14. Which of the following best describes her occupational status? (cross one box only)

Housework	<input type="checkbox"/>	Skilled manual work	<input type="checkbox"/>	Managerial/professional/technical	<input type="checkbox"/>
Student	<input type="checkbox"/>	Unskilled manual work	<input type="checkbox"/>	Clerical support, service or sales	<input type="checkbox"/>
Other	<input type="checkbox"/>				

15. On average, about how much is the take-home family income each week (include social benefits etc.)? (cross one box only)

Less than £100	<input type="checkbox"/>	£300 - £399	<input type="checkbox"/>
£100 - £199	<input type="checkbox"/>	£400 or more	<input type="checkbox"/>
£200 - £299	<input type="checkbox"/>		

For UK only.
This question is optional for other countries

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Section 2: Medical history

Before this pregnancy, was she diagnosed with, or treated for, any of the following conditions?

- | | |
|--|--|
| <p>16. Diabetes <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>17. Thyroid disease <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>18. Other endocrinological condition <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>19. Any type of malignancy/cancer (including leukaemia or lymphoma) <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>20. Cardiac disease <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>21. Epilepsy <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>22. Mental illness e.g. Clinical depression <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>23. Hypertension/chronic hypertension with treatment <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>24. A chronic respiratory disease (including chronic asthma) <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>25. Proteinuria, kidney disease or chronic renal disease <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>26. Crohn's disease, coeliac disease, ulcerative colitis or any severe malabsorption condition <input type="checkbox"/> yes <input type="checkbox"/> no</p> | <p>27. Lupus erythematosus <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>28. HIV or AIDS <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>29. Hepatitis B or C <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>30. Malaria - <i>within past 5 years</i> <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>31. Tuberculosis <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>32. Thalassaemia <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>33. Sickle-cell anaemia <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>34. Thrombophilia <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>35. Glucose-6-phosphate dehydrogenase deficiency <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>36. Any congenital abnormality or genetic disease <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>37. Any other clinically relevant condition <input type="checkbox"/> yes <input type="checkbox"/> no</p> |
|--|--|

Section 3: Gynaecological history

38. Did she have regular (24-32 day) menstrual cycles in the 3 months prior to this pregnancy? yes no
39. What is the average length of her menstrual cycle? days
40. Had she used hormonal contraceptives or been breastfeeding in the 2 months prior to this pregnancy? yes no
41. Is the first day of the last menstrual period (LMP) known? yes no
42. If yes, date: 43. Was she certain of the date of her LMP? yes no

Section 4: Obstetric history

44. Number of previous pregnancies, excluding this pregnancy (if 0, skip to Question 57):
45. Date of last delivery, miscarriage or termination:
46. Has she ever had a molar pregnancy or choriocarcinoma? yes no
47. Has she ever had an extrauterine or ectopic pregnancy? yes no
48. Number of previous miscarriages: 49. Number of previous terminations:
50. Number of previous births (if 0, skip to Question 57):
51. Birthweight of the immediately previous newborn: g
52. Gestational age at birth of the immediately previous newborn: weeks days
53. Have ANY of her other babies weighed less than 2500g? yes no
54. Have ANY of her other babies been born preterm (<37⁺⁰ weeks' gestation)? yes no
55. Has she had ANY previous stillbirths? yes no 56. Has she had ANY previous neonatal deaths? yes no

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Section 5: Vaccination history

Has she been vaccinated against the following medical conditions?

Influenza:	57. Before this pregnancy:	<input type="text"/>	<input type="text"/>	58. During this pregnancy:	<input type="text"/>	<input type="text"/>
Tetanus:	59. Before this pregnancy:	<input type="text"/>	<input type="text"/>	60. During this pregnancy:	<input type="text"/>	<input type="text"/>

Section 6: Clinical conditions

During this pregnancy was she diagnosed with, or treated for, any of the following conditions?

<p>61. Diabetes, thyroid disease or any other endocrinological condition <input type="text"/> <input type="text"/></p> <p>62. Any type of malignancy/cancer (including leukaemia or lymphoma) <input type="text"/> <input type="text"/></p> <p>63. Cardiac disease <input type="text"/> <input type="text"/></p> <p>64. Epilepsy <input type="text"/> <input type="text"/></p> <p>65. Mental illness e.g. Clinical depression <input type="text"/> <input type="text"/></p> <p>66. Symptomatic malaria <input type="text"/> <input type="text"/></p> <p>67. Symptomatic malaria with parasite count <input type="text"/> <input type="text"/></p> <p>68. Respiratory disease (including asthma) <input type="text"/> <input type="text"/></p> <p>69. Pyelonephritis or kidney disease <input type="text"/> <input type="text"/></p> <p>70. Lower urinary tract infection requiring antibiotic treatment <input type="text"/> <input type="text"/></p>	<p>71. Respiratory tract infection requiring antibiotic/antiviral treatment <input type="text"/> <input type="text"/></p> <p>72. Any other infection requiring antibiotic/antiviral treatment <input type="text"/> <input type="text"/></p> <p>73. Group B streptococcus carrier <input type="text"/> <input type="text"/></p> <p>74. Positive syphilis test <input type="text"/> <input type="text"/></p> <p>75. HIV or AIDS <input type="text"/> <input type="text"/></p> <p>76. Any genital tract or sexually transmitted infection <input type="text"/> <input type="text"/></p> <p>77. Cholestasis <input type="text"/> <input type="text"/></p> <p>78. Any other medical/surgical condition requiring treatment/referral <input type="text"/> <input type="text"/></p> <p>79. Any accident or maternal trauma requiring hospital admission or referral to a higher level of care <input type="text"/> <input type="text"/></p>
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Section 7: Pregnancy-related complications

During this pregnancy was she diagnosed with, or treated for, any of the following conditions?

<p>80. Severe vomiting requiring hospitalisation <input type="text"/> <input type="text"/></p> <p>81. Gestational diabetes <input type="text"/> <input type="text"/></p> <p>82. Vaginal bleeding before 15 weeks <input type="text"/> <input type="text"/></p> <p>83. Vaginal bleeding at 15-27 weeks <input type="text"/> <input type="text"/></p> <p>84. Vaginal bleeding after 27 weeks <input type="text"/> <input type="text"/></p> <p>85. Pregnancy-induced hypertension (BP>140/90, no proteinuria) <input type="text"/> <input type="text"/></p> <p>86. Preeclampsia (BP>140/90 and proteinuria) <input type="text"/> <input type="text"/></p> <p>87. Severe preeclampsia/Eclampsia/HELLP syndrome <input type="text"/> <input type="text"/></p> <p>88. Rhesus disease or anti-Kell antibodies <input type="text"/> <input type="text"/></p> <p>89. Preterm labour <input type="text"/> <input type="text"/></p>	<p>90. Fetal anaemia <input type="text"/> <input type="text"/></p> <p>91. Fetal distress (abnormal fetal heart rate [FHR] or biophysical profile [BPP]) <input type="text"/> <input type="text"/></p> <p>92. Suspected impaired fetal growth <input type="text"/> <input type="text"/></p> <p>93. Oligohydramnios <input type="text"/> <input type="text"/></p> <p>94. Polyhydramnios <input type="text"/> <input type="text"/></p> <p>95. A condition requiring amniocentesis or fetal blood sampling (FBS) <input type="text"/> <input type="text"/></p> <p>96. Abruption placentae <input type="text"/> <input type="text"/></p> <p>97. Clinical chorioamnionitis <input type="text"/> <input type="text"/></p> <p>98. Other pregnancy-related infection <input type="text"/> <input type="text"/></p> <p>99. Other pregnancy-related condition <input type="text"/> <input type="text"/></p>
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<p>100. Lowest haemoglobin level: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> g/dl</p> <p>OR Lowest haematocrit: <input type="text"/> <input type="text"/> <input type="text"/> %</p>	<p style="text-align: center;"><15 weeks</p> <p style="text-align: center;">15-27 weeks</p> <p style="text-align: center;">>27 weeks</p> <p style="text-align: center;">15-27 weeks</p> <p style="text-align: center;">>27 weeks</p>	<p style="text-align: center;"><15 weeks</p> <p style="text-align: center;">15-27 weeks</p> <p style="text-align: center;">>27 weeks</p> <p style="text-align: center;">15-27 weeks</p> <p style="text-align: center;">>27 weeks</p>
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Section 8: Ultrasound examination (for women in the Neonatal Study)

101. How many ultrasound examinations were carried out during the woman's pregnancy?

Please complete an Ultrasound Form for each ultrasound examination available in the woman's medical records.

Participant Number	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> - <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	Hospital/Clinic Code	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
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Section 9: Length of the uterine cervix - during this pregnancy

102. During the course of her pregnancy (before hospital admission for this birth), did she have any evaluations of uterine cervix length by vaginal examination? <i>If no, skip to Question 112.</i>			<input type="checkbox"/> yes <input type="checkbox"/> no
103. Date of 1 st examination:	106. Date of 2 nd examination:	109. Date of 3 rd examination:	
<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	
104. Uterine cervix length by digital examination:	107. Uterine cervix length by digital examination:	110. Uterine cervix length by digital examination:	
<input style="width: 20px; height: 20px;" type="text"/> . <input style="width: 20px; height: 20px;" type="text"/> cm	<input style="width: 20px; height: 20px;" type="text"/> . <input style="width: 20px; height: 20px;" type="text"/> cm	<input style="width: 20px; height: 20px;" type="text"/> . <input style="width: 20px; height: 20px;" type="text"/> cm	
105. Cervical dilation:	108. Cervical dilation:	111. Cervical dilation:	
<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> . <input style="width: 20px; height: 20px;" type="text"/> cm	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> . <input style="width: 20px; height: 20px;" type="text"/> cm	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> . <input style="width: 20px; height: 20px;" type="text"/> cm	

Section 10: Nutritional supplements/Medications

During this pregnancy, has she routinely taken any of the following nutritional supplements?

112. Multi-vitamins/minerals	<input type="checkbox"/> yes <input type="checkbox"/> no	115. Vitamin D	<input type="checkbox"/> yes <input type="checkbox"/> no	118. Food supplements	<input type="checkbox"/> yes <input type="checkbox"/> no
113. Iron	<input type="checkbox"/> yes <input type="checkbox"/> no	116. Calcium	<input type="checkbox"/> yes <input type="checkbox"/> no	119. Cod liver oil	<input type="checkbox"/> yes <input type="checkbox"/> no
114. Folic acid	<input type="checkbox"/> yes <input type="checkbox"/> no	117. Selenium	<input type="checkbox"/> yes <input type="checkbox"/> no	120. Other fish oil	<input type="checkbox"/> yes <input type="checkbox"/> no

During this pregnancy, has she routinely taken any of the following medications?

21. Aspirin	<input type="checkbox"/> yes <input type="checkbox"/> no	26. Insulin	<input type="checkbox"/> yes <input type="checkbox"/> no
22. Non-steroidal anti-inflammatories	<input type="checkbox"/> yes <input type="checkbox"/> no	27. Prophylactic steroids for preterm labour	<input type="checkbox"/> yes <input type="checkbox"/> no
23. Antibiotics used for PPRM	<input type="checkbox"/> yes <input type="checkbox"/> no	28. Progesterone	<input type="checkbox"/> yes <input type="checkbox"/> no
24. Any other antibiotics/antivirals	<input type="checkbox"/> yes <input type="checkbox"/> no	29. Any other treatment	<input type="checkbox"/> yes <input type="checkbox"/> no
25. Antihypertensives	<input type="checkbox"/> yes <input type="checkbox"/> no		

Section 11: Delivery

130. Onset of labour: (cross one box only)	Spontaneous	<input type="checkbox"/>	Induced	<input type="checkbox"/>	No labour	<input type="checkbox"/>
131. Prelabour premature rupture of membranes (PPROM)?						<input type="checkbox"/> yes <input type="checkbox"/> no
132. Place of delivery: (cross one box only)	Home	<input type="checkbox"/>	Health facility	<input type="checkbox"/>		
133. Mode of delivery: (cross one box only)	Vaginal spontaneous	<input type="checkbox"/>	Vaginal assisted (e.g. forceps, vacuum)	<input type="checkbox"/>		
	Caesarean section	<input type="checkbox"/>	Assisted breech or breech extraction	<input type="checkbox"/>		

If labour was induced or a Caesarean section performed, please cross all that apply:

134. Vaginal bleeding	<input type="checkbox"/> yes <input type="checkbox"/> no	148. Worsening of a pre-existing clinical condition	<input type="checkbox"/> yes <input type="checkbox"/> no
135. Placenta praevia	<input type="checkbox"/> yes <input type="checkbox"/> no	149. Suspected intrauterine growth restriction (IUGR)	<input type="checkbox"/> yes <input type="checkbox"/> no
136. Fetal death	<input type="checkbox"/> yes <input type="checkbox"/> no	150. Post term (>42 ⁺⁰ weeks gestation)	<input type="checkbox"/> yes <input type="checkbox"/> no
137. Pregnancy-induced hypertension (BP>140/90, no proteinuria)	<input type="checkbox"/> yes <input type="checkbox"/> no	151. Rhesus disease or anti-Kell antibodies	<input type="checkbox"/> yes <input type="checkbox"/> no
138. Preeclampsia (BP>140/90 and proteinuria)	<input type="checkbox"/> yes <input type="checkbox"/> no	152. Intrahepatic cholestasis of pregnancy	<input type="checkbox"/> yes <input type="checkbox"/> no
139. Severe preeclampsia/Eclampsia/HELLP syndrome	<input type="checkbox"/> yes <input type="checkbox"/> no	153. HIV or AIDS	<input type="checkbox"/> yes <input type="checkbox"/> no
140. Breech presentation	<input type="checkbox"/> yes <input type="checkbox"/> no	154. Any genital tract or sexually transmitted infection	<input type="checkbox"/> yes <input type="checkbox"/> no
141. Fetal distress (abnormal fetal heart rate [FHR] or biophysical profile [BPP])	<input type="checkbox"/> yes <input type="checkbox"/> no	155. Any infection requiring antibiotic/antiviral treatment	<input type="checkbox"/> yes <input type="checkbox"/> no
142. Reduced fetal movement	<input type="checkbox"/> yes <input type="checkbox"/> no	156. Any accident/maternal trauma	<input type="checkbox"/> yes <input type="checkbox"/> no
143. Failure to progress	<input type="checkbox"/> yes <input type="checkbox"/> no	157. Pregnancy termination	<input type="checkbox"/> yes <input type="checkbox"/> no
144. Cephalo-pelvic disproportion	<input type="checkbox"/> yes <input type="checkbox"/> no	158. Previous Caesarean section	<input type="checkbox"/> yes <input type="checkbox"/> no
145. PPRM	<input type="checkbox"/> yes <input type="checkbox"/> no	159. Maternal request	<input type="checkbox"/> yes <input type="checkbox"/> no
146. Uterine rupture	<input type="checkbox"/> yes <input type="checkbox"/> no	160. Any other maternal reason	<input type="checkbox"/> yes <input type="checkbox"/> no
147. Abruptio placentae	<input type="checkbox"/> yes <input type="checkbox"/> no	161. Any other fetal reason	<input type="checkbox"/> yes <input type="checkbox"/> no

Participant Number - Hospital/Clinic Code

Maternal Hospital Record No.

Maternal Date of Birth

Section 12: Newborn outcomes and care

<p>162. Date of delivery: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>163. Time of delivery: <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> (24-hour clock)</p> <p>164. Gestational age at birth based on the best obstetric estimate: <input type="text"/> <input type="text"/> weeks <input type="text"/> days</p> <p>165. Fetal presentation at delivery: (cross one box only) Cephalic <input type="checkbox"/> Breech <input type="checkbox"/> Other <input type="checkbox"/></p> <p>166. Newborn status at birth: (cross one box only) Alive <input type="checkbox"/> Intrapartum death <input type="checkbox"/> Antepartum death <input type="checkbox"/></p>	<p>167. Newborn sex: Male <input type="checkbox"/> Female <input type="checkbox"/></p> <p>168. Apgar score at 5 minutes: <input type="text"/> <input type="text"/></p> <p>169. Was the newborn admitted to intensive care or any special care unit? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>170. If yes, total amount of days spent in intensive care or special care unit: (if less than 24 hours please enter 1 day) <input type="text"/> <input type="text"/> <input type="text"/> days</p>
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Was the newborn diagnosed with, or treated for, any of the following conditions before hospital discharge?

<p>171. Respiratory distress syndrome <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>172. Transient tachypnea of the newborn <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>173. Apnea of prematurity <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>174. Bronchopulmonary dysplasia <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>175. Pneumothorax <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>176. Meconium aspiration with respiratory distress <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>177. No oral feeds for more than 24 hours <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>178. Retinopathy of prematurity <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>179. Hypoxic-ischaemic encephalopathy <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>180. Hyperbilirubinaemia <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>181. TORCH or any other intrauterine infection <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>182. HIV <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>183. Neonatal sepsis <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>184. Fetal infection <input type="checkbox"/> yes <input type="checkbox"/> no</p>	<p>185. Fetal inflammatory response syndrome <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>186. Seizures <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>187. Necrotising enterocolitis, Bell's staging stage 2 or greater <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>188. Meningitis <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>189. Hypoglycaemia <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>190. Anaemia (requiring transfusion) <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>191. Hypotension (requiring inotropic treatment or steroids) <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>192. Intraventricular haemorrhage grade 2 or greater, periventricular haemorrhage or leukomalacia <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>193. Polycythaemia <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>194. Patent ductus arteriosus (requiring pharmacological treatment or surgery) <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>195. Any other serious condition <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>196. Congenital abnormality (complete a Neonatal Abnormality Form) <input type="checkbox"/> yes <input type="checkbox"/> no</p>
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Section 13: Newborn anthropometry (please carry out as soon as possible, no later than 24 hours after birth)

197. Date of measurement: Time of measurement: :

First set of anthropometric measurements

198. Weight: g

199. Length: . cm

200. Head circumference: . cm

Participant Number

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Hospital/Clinic Code

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Maternal Hospital Record No.

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Maternal Date of Birth

D	D	M	M	Y	Y
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Section 13: Newborn anthropometry (continued)

Second set of anthropometric measurements

201. Weight:

				g
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202. Length:

		.		cm
--	--	---	--	----

203. Head circumference:

		.		cm
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Section 14: Newborn outcomes

204. Newborn status at hospital discharge: (cross one box only)

Alive

Alive but referred to a lower
dependency unit or clinic

Alive but referred to a higher level
of care

Dead

205. Date of neonatal hospital discharge or date of death:

D	D	M	M	Y	Y
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Section 15: Nutritional practices

206. What was the main mode of feeding in the 24 hours prior to hospital discharge? (cross one box only)

Exclusive
breast milk

Combination feeding:
Predominant breast milk

Combination feeding:
Partial breast milk

Exclusive formula

No oral feeds: Intravenous (IV) fluids only

Section 16: Maternal outcomes

207. Was the mother admitted to intensive care or any special care unit after delivery?

yes	no
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208. If yes, total number of days: (if less than 24 hours, please enter as 1 day)

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209. Maternal status at hospital discharge: (cross one box only)

Alive

Alive but referred to a higher level
of care

Dead

Name of Researcher/Midwife

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Signature

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Researcher Code

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Anthropometrist-1 Code

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Anthropometrist-2 Code

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