



Public reporting burden for this collection of information is estimated to average 04 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0584). Do not return the completed form to this address.

OMB#: xxxx-xxxx  
Exp. xx/xx/xxxx

## HCHS/SOL Visit 2- Pregnancy Complications History

ID NUMBER:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	FORM CODE: PCE	Contact Occasion	<input type="text"/>	<input type="text"/>	SEQ #	<input type="text"/>	<input type="text"/>
								VERSION: 1, 10/09/2013		0	2			

### ADMINISTRATIVE INFORMATION

0a. Completion Date: //

0b. Staff ID:

**Instructions:** Enter the answer given by the participant for each response. Complete one form for each pregnancy of 6 or more months in duration.

### A. PREGNANCY HISTORY QUESTIONS

Now, we would like to ask you some more detailed questions about your pregnancies that lasted more than six months and occurred after SOL Visit 1 on [DATE]

#### BEGIN WITH THE FIRST PREGNANCY SINCE VISIT 1 on [DATE]

1. Tell us about your first through [N]th pregnancy lasting six months or longer

- a. Pregnancy Number
- b. Pregnancy Year
- c. Did you have hypertension or high blood pressure? (*Told you your pressure was increased*)
  - No 0
  - Yes 1
  - Unsure 9
- c1. Did you have high blood pressure or hypertension before this pregnancy?
  - No 0
  - Yes 1
  - Unsure 9
- d. Did you have Preeclampsia or toxemia? (*Told you your blood pressure was increased and had protein in the urine? Did they tell you there was protein in the urine?*)
  - No 0
  - Yes 1
- e. Did you have eclampsia? (convulsions or seizures)
  - No 0
  - Yes 1
- f. Did you have diabetes? (*Did they tell you that your sugar was too high?*)
  - No 0
  - Yes 1
- f1. Did you take medication for your blood sugar during this pregnancy?
  - No 0
  - Yes, pills only 1
  - Yes, insulin only 2
  - Yes, pills and insulin 3
  - Unsure/don't know 9

ID NUMBER:

FORM CODE: PCE  
VERSION: 1, 10/9/13

Contact  
Occasion

0  2

SEQ #

f2. Did you have diabetes before this pregnancy?

- No 0   
Yes 1   
Unsure 9

2. What was the date of this birth? //  
MM/ DD/ YYYY

3. How many months or weeks had you been pregnant when (the baby was born/the [multi] were born/the pregnancy ended)?

Months OR  Weeks → GO TO Question 4

3a. If unknown duration, ask: Preterm delivery is one that occurs at 36 weeks or earlier in pregnancy. As far as you know, did you have a preterm delivery?

- No 0   
Yes 1   
Unsure 9

4. How did this pregnancy end (check one)?

- Vaginal birth 1   
C-section 2   
Stillbirth 3

5. Where did you give birth (check one)?

- In a hospital 1   
In a birthing center 2   
In your home or home other place 3

If this birth happened in a hospital or birthing center, ask:

5a. What was the name of the facility where you gave birth? \_\_\_\_\_

5b. What was the address of the facility? \_\_\_\_\_

5c. Just to be clear, under what name is this in the records?

5c1. First name \_\_\_\_\_

5c2. Second name \_\_\_\_\_

5c3. Last Name \_\_\_\_\_

5c4. Maternal Last Name \_\_\_\_\_

6. How much weight did you gain during this pregnancy?

lbs or  kgs

7. How many babies were born during this birth?

Babies → For each baby born in this birth, complete questions 16-18

ID NUMBER:								
------------	--	--	--	--	--	--	--	--

FORM CODE: PCE  
VERSION: 1, 10/9/13

Contact  
Occasion

0	2
---	---

SEQ #

--	--

8. IF more than 1 baby delivered during this birth, which baby are you discussing now?

8a. Is/was the baby male or female?

Male 0   
Female 1

8b. How much did he/she weigh at birth (probe weight if uncertain)?

Less than 5 ½ lbs (2500g) 1   
Between 5 ½ and 9 lbs 2   
More than 9 lbs (4000g) 3

8c. IF LIVEBIRTH, How old was this baby / these babies when you completely stopped breastfeeding or pumping milk?

Enter Age

8d. If breastfeeding has stopped, ask: Did you breastfeed as long as you wanted to?

No 0   
Yes 1

8e. If breastfed, ask: How old was this baby/these babies when first fed formula or solid foods?

Baby	Sex M/F	Weight in grams or pounds	Age stopped breastfeeding if live birth	Fed breast milk as long as wanted Y/N	Age formula or solids started, if breastfed
1 <input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/>
2 <input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/>
3 <input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/>