PRE-TERM BIRTH STUDY QUESTIONNAIRE FOR MOTHERS

1 – Date of Birth: _____ 2 – Birth Weight: _____

3 – Country where you were born: _____

4 – Please select your gestational age at your time of birth:

- ☐ Full Term weeks:_____
- ☐ Pre-Term weeks: _____
- ☐ Unknown

5 – Weight prior to pregnancy: _____ 6 – Height: _____

7 – Please select any medical conditions you may have and the date of diagnosis:

- ☐ Hypertension Date of diagnosis: _____
- ☐ Hypotension Date of diagnosis: _____
- ☐ Diabetes Type: _____ Date of diagnosis: _____
- ☐ Thyroid Type: _____ Date of diagnosis: _____
- ☐ Cardiac Type: _____ Date of diagnosis: _____
- ☐ Autoimmune Type: _____ Date of diagnosis: _____
- ☐ Cancer Type: _____ Date of diagnosis: _____
- ☐ Chromosomal Abnormality Type: _____ Date of diagnosis: _____
- ☐ Nutrition Disorders Type: _____ Date of diagnosis: _____
- ☐ Other Type: _____ Date of diagnosis: _____

8 – Please list any medications that you take regularly for any medical conditions listed above:

_____
_____
_____

9 – Please list any previous surgeries:

_____
_____
_____

Social History

1 – Marital Status: ☐ Married ☐ Single ☐ Legally Separated

2 – Do you currently live with the babies father? ☐ Yes ☐ No

3 – Current Zip Code: _____

4 – Do you smoke? ☐ Yes, I currently smoke ☐ No, I quit ☐ No, I have never smoked

4a. If you currently smoke or you did smoke, please indicate how long you have (or had) been smoking:
_____ Years _____ Months

4b. How many cigarettes do your smoke in a day? Or if you quit, how many did you smoke in a day?

- ☐ 1 – 10 cigarettes a day
- ☐ 11-20 cigarettes a day
- ☐ More than 1 pack a day

4c. If you quit smoking, please indicate the date that you quit smoking: _____

5 – Do you drink alcohol?

☐ Yes, I currently drink alcohol ☐ No, I quit ☐ No, I have never consumed alcohol before

5a. If you currently drink alcohol or you did drink alcohol, please indicate how long you have (or had) been drinking:

_____ Years _____ Months

5b. How many drinks do you consume in a week? Or if you quit, how many did you consume in a week?

- ☐ 1 – 3 drinks per week
- ☐ 4 – 6 drinks per week
- ☐ 6 – 10 drinks per week
- ☐ More than 10 drinks per week

5c. If you quit drinking, please indicate the date that you quit drinking: _____

6 – Have you been exposed to any hazardous chemicals? ☐ Yes ☐ No

6a. If yes, please indicate the date of exposure: _____

6b. If yes, please indicate the chemical that you were exposed to: _____

Family History

1 – Your mothers country of birth: _____ 2 – Your fathers country of birth: _____

3 – Please select any of the following medical conditions that your parents or siblings have been diagnosis with:

☐ Hypertension	☐ Mother	☐ Father	☐ Sibling	
☐ Hypotension	☐ Mother	☐ Father	☐ Sibling	
☐ Diabetes	☐ Mother	☐ Father	☐ Sibling	Type: _____
☐ Thyroid	☐ Mother	☐ Father	☐ Sibling	Type: _____
☐ Cardiac	☐ Mother	☐ Father	☐ Sibling	Type: _____
☐ Autoimmune	☐ Mother	☐ Father	☐ Sibling	Type: _____
☐ Cancer	☐ Mother	☐ Father	☐ Sibling	Type: _____
☐ Chromosomal Abnormality	☐ Mother	☐ Father	☐ Sibling	Type: _____
☐ Other	☐ Mother	☐ Father	☐ Sibling	Type: _____

4 – Is there a family history of pre-term birth? ☐ Yes ☐ No ☐ Unknown

4a – If yes, please select all that apply: ☐ Mother ☐ Father ☐ Sibling

Life Events Evaluation

Please select any events that have occurred in your life over the past 12 months:

- ☐ Complications with your current pregnancy
- ☐ Personal health problems
- ☐ Personal social problems
- ☐ Problems with current partner
- ☐ Family disruption
- ☐ Problems with your finances
- ☐ Problems with your own children
- ☐ Problems with your in-laws
- ☐ Problems within your close family
- ☐ Serious illness in your close family
- ☐ Death within your close family
- ☐ Loss of job (you or your partner)
- ☐ Problems within your work environment
- ☐ Work transfer (you or your partner)
- ☐ Change in residence
- ☐ Current partner is away often

Patient Signature: _____ Date: _____

Printed Name: _____