

PRE-TERM BIRTH STUDY QUESTIONNAIRE FOR FATHERS

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

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Hypertension | Date of diagnosis: _____ |
| <input type="checkbox"/> Hypotension | Date of diagnosis: _____ |
| <input type="checkbox"/> Diabetes | Type: _____ Date of diagnosis: _____ |
| <input type="checkbox"/> Thyroid | Type: _____ Date of diagnosis: _____ |
| <input type="checkbox"/> Cardiac | Type: _____ Date of diagnosis: _____ |
| <input type="checkbox"/> Autoimmune | Type: _____ Date of diagnosis: _____ |
| <input type="checkbox"/> Cancer | Type: _____ Date of diagnosis: _____ |
| <input type="checkbox"/> Chromosomal Abnormality | Type: _____ Date of diagnosis: _____ |
| <input type="checkbox"/> Other | Type: _____ Date of diagnosis: _____ |

Social History

1 – Marital Status: Married Single Legally Separated

2 – Do you currently live with the babies mother? 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:

- | | | | | |
|--|---------------------------------|---------------------------------|----------------------------------|-------------|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Sibling | Type: _____ |
| <input type="checkbox"/> Hypotension | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Sibling | Type: _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Sibling | Type: _____ |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Sibling | Type: _____ |
| <input type="checkbox"/> Cardiac | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Sibling | Type: _____ |
| <input type="checkbox"/> Autoimmune | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Sibling | Type: _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Sibling | Type: _____ |
| <input type="checkbox"/> Chromosomal Abnormality | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Sibling | Type: _____ |
| <input type="checkbox"/> Other | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> 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

Participant Signature: _____ Date: _____

Printed Name: _____

Family Study ID # _____
Patient Study ID # _____

Patient Initials: _____
Date: _____

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