

Registry ID \_\_\_\_\_

State/Territory ID \_\_\_\_\_



## U.S. Zika Pregnancy Registry and Birth Defects Surveillance — Integrated Maternal Health History Form

*These data are considered confidential and will be stored in a secure database at the Centers for Disease Control and Prevention.*

Please return completed form via secure fax (410-225-7615) or encrypted email  
([dhmmh.zikapregnancy@maryland.gov](mailto:dhmmh.zikapregnancy@maryland.gov)).

Please direct questions to the email listed above or call 410-767-6700 and ask to speak to the ZPR Coordinator

MHH.1. State/Territory ID: _____	MHH.2. Maternal Age at Diagnosis: _____	MHH.3. State/Territory reporting: _____ MHH.4. County reporting: _____
MHH.5. Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino		
MHH.6. Race (check all that apply): <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African-American <input type="checkbox"/> Unknown/Not Specified <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other, specify _____		
MHH.7. Indication for maternal Zika virus testing: <input type="checkbox"/> Exposure history only, no known fetal abnormalities <input type="checkbox"/> Exposure history and fetal abnormalities <input type="checkbox"/> No known exposure (skip to MHH.38)		
<b>Maternal Zika Virus History</b>		
MHH.8. Date of Zika virus symptom onset: _____ OR MHH.9. <input type="checkbox"/> Asymptomatic		
MHH.10. If symptomatic, gestational age at onset: _____ (weeks) _____ (days)		
MHH.11. If gestational age or date not known, trimester of symptom onset _____ (1 <sup>st</sup> , 2 <sup>nd</sup> , 3 <sup>rd</sup> )		
MHH.12. Symptoms of mother's Zika virus disease: (check all that apply) <input type="checkbox"/> Fever (if measured) _____°F or _____°C <input type="checkbox"/> Arthralgia <input type="checkbox"/> Conjunctivitis <input type="checkbox"/> Rash <input type="checkbox"/> Other clinical presentation _____		
MHH.13. If rash, check all that apply <input type="checkbox"/> Maculopapular <input type="checkbox"/> Petechial <input type="checkbox"/> Purpuric <input type="checkbox"/> Pruritic Describe rash distribution _____		
MHH.14. Hospitalized for Zika virus disease <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown		
MHH.15. Maternal Death <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown    MHH.16. If yes, cause of death _____		
MHH.17. If yes, date of death _____		
MHH.18. What was the suspected mode of Zika virus transmission? <input type="checkbox"/> Human-mosquito-human (vector) <input type="checkbox"/> Sexual <input type="checkbox"/> Other, please specify _____ <input type="checkbox"/> Unknown		
MHH.19. Did the woman spend time in any areas <u>outside</u> the US states or US territories where there was active Zika virus transmission during the periconceptional period or during pregnancy? ( <a href="http://www.cdc.gov/zika/geo/active-countries.html">http://www.cdc.gov/zika/geo/active-countries.html</a> ) <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown    (If 'no' or 'unknown', skip to MHH 27)		
MHH.20. If yes, please characterize the type of travel: <input type="checkbox"/> Incoming travel (one way travel to US states <u>from</u> an area with active Zika virus transmission) <input type="checkbox"/> Incoming travel (one way travel to US territories <u>from</u> an area with active Zika virus transmission) <input type="checkbox"/> Outgoing and incoming travel (roundtrip <u>from</u> US states <u>to</u> an area with active Zika virus transmission) <input type="checkbox"/> Outgoing and incoming travel (roundtrip <u>from</u> US territories <u>to</u> an area with active Zika virus transmission)		

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<b>If incoming or outgoing travel, please list location and dates of travel:</b>	
<b>MHH.21.</b> Country of exposure (1) _____	<b>MHH.22.</b> Start Date _____ End Date _____ <input type="checkbox"/> Start date is same as LMP
<b>MHH.23.</b> Country of exposure (2) _____	<b>MHH.24.</b> Start Date _____ End Date _____ <input type="checkbox"/> Start date is same as LMP
<b>MHH.25.</b> Country of exposure (3) _____	<b>MHH.26.</b> Start Date _____ End Date _____ <input type="checkbox"/> Start date is same as LMP
<b>MHH.27.</b> Was the Zika virus exposure within the 50 states, DC, or territories? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	
<b>If yes, separately list each state or territory where Zika virus exposure occurred, and dates of possible exposure:</b>	
<b>MHH.28.</b> State or territory 1 _____	<b>MHH.29.</b> Start Date _____ End Date _____ <input type="checkbox"/> Start date is same as LMP <input type="checkbox"/> Still at location
<b>MHH.30.</b> State or territory 2 _____	<b>MHH.31.</b> Start Date _____ End Date _____ <input type="checkbox"/> Start date is same as LMP <input type="checkbox"/> Still at location
<b>MHH.32.</b> State or territory 3 _____	<b>MHH.33.</b> Start Date _____ End Date _____ <input type="checkbox"/> Start date is same as LMP <input type="checkbox"/> Still at location
<b>MHH.34.</b> If suspected mode of transmission is sexual, was the pregnant woman's sexual partner(s): <input type="checkbox"/> Male <input type="checkbox"/> Female <i>Please check all that apply</i>	
<b>MHH.35.</b> Did any sexual partner(s) have an illness that included fever, rash, joint pain, or pink eye during or within 2 weeks of <u>spending any time in</u> an area with active Zika virus transmission? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	
<b>MHH.36.</b> If yes, was there unprotected sexual contact while partner(s) had this illness? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	
<b>MHH.37.</b> Did partner have a test that demonstrated laboratory evidence of Zika virus infection? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	
<b>Maternal Health History (<u>Underlying maternal illness</u>)</b>	
<b>MHH.38.</b> Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	
<b>MHH.39.</b> Maternal Phenylketonuria (PKU) <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	
<b>MHH.40.</b> Hypothyroidism <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	
<b>MHH.41.</b> High Blood Pressure or Hypertension <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	
<b>MHH.42.</b> Other underlying illness(es): <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	
<b>MHH.43.</b> If yes, specify: _____	
<b>Pregnancy Information</b>	
<b>MHH.44.</b> Last menstrual period (LMP): _____	<b>MHH.45.</b> Estimated delivery date (EDD): _____
<b>MHH.46.</b> Estimated delivery date based on ( <i>check all that apply</i> ): <input type="checkbox"/> LMP <input type="checkbox"/> 1 <sup>st</sup> trimester ultrasound <input type="checkbox"/> 2 <sup>nd</sup> trimester ultrasound <input type="checkbox"/> 3 <sup>rd</sup> trimester ultrasound <input type="checkbox"/> Other, specify _____	

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<b>OB History:</b>	<b>MHH.47.</b> # pregnancies (including current pregnancy) _____	<b>MHH.48.</b> # living children _____
	<b>MHH.49.</b> # miscarriages _____	<b>MHH.50.</b> # elective terminations _____
<b>MHH.51.</b> Prior fetus/infant with microcephaly: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown		
<b>MHH.52.</b> If yes, cause genetic?: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown		
<b>MHH.53. Gestation:</b> <input type="checkbox"/> Single <input type="checkbox"/> Twins <input type="checkbox"/> Triplets+		
<b>Substance use during this pregnancy:</b>	<b>MHH.54.</b> Alcohol use: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	
	<b>MHH.55.</b> Cocaine use: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	
	<b>MHH.56.</b> Smoking: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	
<b>Complications during current pregnancy</b>		
<b>MHH.57.</b>	Toxoplasmosis infection:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
<b>MHH.58.</b>	Cytomegalovirus infection:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
<b>MHH.59.</b>	Herpes Simplex infection:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
<b>MHH.60.</b>	Rubella infection:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
<b>MHH.61.</b>	Lymphocytic choriomeningitis virus infection:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
<b>MHH.62.</b>	Syphilis infection:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
<b>MHH.63.</b> If yes for infection testing during current pregnancy, please describe results:		
<b>MHH.64.</b>	Fetal genetic abnormality:	<input type="checkbox"/> No <input type="checkbox"/> Yes, describe _____ <input type="checkbox"/> Unknown
<b>MHH.65.</b>	Gestational diabetes:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
<b>MHH.66.</b>	Pregnancy-related hypertension:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
<b>MHH.67.</b>	Intrauterine death of a twin:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
<b>MHH.68.</b>	Other: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	
	<b>MHH.69.</b> If yes, please specify _____	
<b>MHH.70. Medications during pregnancy:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown		
<b>MHH.71.</b> If yes, specify ( <i>please specify type and see guide for further instructions</i> ):		
<b>Pregnancy Losses:</b> <i>Please also complete pertinent sections of neonatal assessment form</i>		
<b>MHH.72. Did this pregnancy end in miscarriage (&lt;20 weeks of gestation)?</b>		
<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <b>MHH.73.</b> Date: _____ OR gestational age _____ weeks		
<b>MHH.74. Please describe any abnormalities noted</b> _____		
<b>MHH.75. Did this pregnancy end in stillbirth (intrauterine fetal demise) (≥20 weeks of gestation)?</b>		
<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <b>MHH.76.</b> Date: _____ OR gestational age _____ weeks		
<b>MHH.77. Please describe any abnormalities noted</b> _____		
<b>MHH.78. Was this pregnancy terminated?</b>		
<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <b>MHH.79.</b> Date: _____ OR gestational age _____ weeks		
<b>MHH.80. Please describe any abnormalities noted</b> _____		
<b>Maternal Prenatal Imaging and Diagnostics</b>		
<b>MHH.81.</b>	<b>MHH.84. Overall fetal ultrasound results:</b> <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	

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<b>Date(s) of ultrasound(s):</b>  <input type="checkbox"/> <b>MHH.82.</b> <i>Check if date approximated</i>  <b>MHH.83.</b> <i>If date not known, Gestational age</i> _____ (weeks) _____ (days)	<b>MHH.85.</b> <input type="checkbox"/> Reported by patient/healthcare provider <input type="checkbox"/> Ultrasound report			
	<b>MHH.86.</b> Head circumference (HC) _____ cm			
	<b>MHH.87.</b> <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal ( <i>by physician report</i> )			
	<b>MHH.88.</b> Biparietal diameter (BPD) _____ cm			
	<b>MHH.89.</b> Femur length (FL) _____ cm			
	<b>MHH.90.</b> Abdominal circumference (AC) _____ cm			
	<b>MHH.91.</b> <input type="checkbox"/> Symmetric intrauterine growth restriction (IUGR) <input type="checkbox"/> Asymmetric IUGR (HC%>AC% or HC%>FL%)			
	<b>MHH.92.</b> Microcephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes	<b>MHH.93.</b> Intracranial calcifications	<input type="checkbox"/> No <input type="checkbox"/> Yes
	<b>MHH.94.</b> Cerebral /cortical atrophy	<input type="checkbox"/> No <input type="checkbox"/> Yes	<b>MHH.95.</b> Abnormal cortical gyral patterns (e.g., polymicrogyria, lissencephaly, pachygyria, schizencephaly, gray matter heterotopia)	<input type="checkbox"/> No <input type="checkbox"/> Yes
	<b>MHH.96.</b> Corpus callosum abnormalities	<input type="checkbox"/> No <input type="checkbox"/> Yes	<b>MHH.97.</b> Cerebellar abnormalities	<input type="checkbox"/> No <input type="checkbox"/> Yes
	<b>MHH.98.</b> Porencephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes	<b>MHH.99.</b> Hydranencephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes
	<b>MHH.100.</b> Moderate or severe ventriculomegaly / hydrocephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes	<b>MHH.101.</b> Fetal brain disruption sequence (collapsed skull, overlapping sutures, prominent occipital bone, scalp rugae)	<input type="checkbox"/> No <input type="checkbox"/> Yes
	<b>MHH.102.</b> Other major brain abnormalities	<input type="checkbox"/> No <input type="checkbox"/> Yes	<b>MHH.103.</b> Anencephaly / acrania	<input type="checkbox"/> No <input type="checkbox"/> Yes
	<b>MHH.104.</b> Encephalocele	<input type="checkbox"/> No <input type="checkbox"/> Yes	<b>MHH.105.</b> Spina bifida	<input type="checkbox"/> No <input type="checkbox"/> Yes
<b>MHH.106.</b> Holoprosencephaly / arhinencephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes	<b>MHH.107.</b> Structural eye abnormalities / dysplasia	<input type="checkbox"/> No <input type="checkbox"/> Yes	
<b>MHH.108.</b> Arthrogryposis	<input type="checkbox"/> No <input type="checkbox"/> Yes	<b>MHH.109.</b> Clubfoot	<input type="checkbox"/> No <input type="checkbox"/> Yes	
<b>MHH.110.</b> Hydrops	<input type="checkbox"/> No <input type="checkbox"/> Yes	<b>MHH.111.</b> Ascites	<input type="checkbox"/> No <input type="checkbox"/> Yes	
<b>MHH.112.</b> Other	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, describe:		
<b>MHH.113.</b> Description of abnormal ultrasound findings:				
<b>MHH.114.</b> <b>Date(s) of Ultrasound(s):</b>  <input type="checkbox"/> <b>MHH.115.</b> <i>check if date approximated</i>	<b>MHH.117. Overall fetal ultrasound results:</b> <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal			
	<b>MHH.118.</b> <input type="checkbox"/> Reported by patient/healthcare provider <input type="checkbox"/> Ultrasound report			
	<b>MHH.119.</b> Head circumference (HC) _____ cm			
	<b>MHH.120.</b> <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal ( <i>by physician report</i> )			
	<b>MHH.121.</b> Biparietal diameter (BPD) _____ cm			
<b>MHH.122.</b> Femur length (FL) _____ cm				
<b>MHH.123.</b> Abdominal circumference (AC) _____ cm				

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<b>MHH.116.</b> <i>if date not known, gestational age</i> _____ (weeks) (days)	<b>MHH.124.</b> <input type="checkbox"/> Symmetric IUGR <input type="checkbox"/> Asymmetric IUGR (HC%>AC% or HC%>FL%)			
	<b>MHH.125.</b> Microcephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes	<b>MHH.126.</b> Intracranial calcifications	<input type="checkbox"/> No <input type="checkbox"/> Yes
	<b>MHH.127.</b> Cerebral / cortical atrophy	<input type="checkbox"/> No <input type="checkbox"/> Yes	<b>MHH.128.</b> Abnormal cortical gyral patterns (e.g., polymicrogyria, lissencephaly, pachygyria, schizencephaly, gray matter heterotopia)	<input type="checkbox"/> No <input type="checkbox"/> Yes
	<b>MHH.129.</b> Corpus callosum abnormalities	<input type="checkbox"/> No <input type="checkbox"/> Yes	<b>MHH.130.</b> Cerebellar abnormalities	<input type="checkbox"/> No <input type="checkbox"/> Yes
	<b>MHH.131.</b> Porencephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes	<b>MHH.132.</b> Hydranencephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes
	<b>MHH.133.</b> Moderate or severe ventriculomegaly / hydrocephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes	<b>MHH.134.</b> Fetal brain disruption sequence (collapsed skull, overlapping sutures, prominent occipital bone, scalp rugae)	<input type="checkbox"/> No <input type="checkbox"/> Yes
	<b>MHH.135.</b> Other major brain abnormalities	<input type="checkbox"/> No <input type="checkbox"/> Yes	<b>MHH.136.</b> Anencephaly / acrania	<input type="checkbox"/> No <input type="checkbox"/> Yes
	<b>MHH.137.</b> Encephalocele	<input type="checkbox"/> No <input type="checkbox"/> Yes	<b>MHH.138.</b> Spina bifida	<input type="checkbox"/> No <input type="checkbox"/> Yes
	<b>MHH.139.</b> Holoprosencephaly / arhinencephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes	<b>MHH.140.</b> Structural eye abnormalities / dysplasia	<input type="checkbox"/> No <input type="checkbox"/> Yes
	<b>MHH.141.</b> Arthrogryposis	<input type="checkbox"/> No <input type="checkbox"/> Yes	<b>MHH.142.</b> Clubfoot	<input type="checkbox"/> No <input type="checkbox"/> Yes
	<b>MHH.143.</b> Hydrops	<input type="checkbox"/> No <input type="checkbox"/> Yes	<b>MHH.144.</b> Ascites	<input type="checkbox"/> No <input type="checkbox"/> Yes
	<b>MHH.145.</b> Other	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, describe:	
<b>MHH.146.</b> Description of abnormal ultrasound findings:				
<b>MHH.147.</b> <b>Date(s) of Ultrasound(s):</b> _____  <input type="checkbox"/> <b>MHH.148.</b> <i>check if date approximated</i>  <b>MHH.149.</b> <i>if date not known, gestational age</i> _____ (weeks) (days)	<b>MHH.150. Overall fetal ultrasound results:</b> <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal			
	<b>MHH.151.</b> <input type="checkbox"/> Reported by patient/healthcare provider <input type="checkbox"/> Ultrasound report			
	<b>MHH.152.</b> Head circumference (HC) _____ cm			
	<b>MHH.153.</b> <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal ( <i>by physician report</i> )			
	<b>MHH.154.</b> Biparietal diameter (BPD) _____ cm			
	<b>MHH.155.</b> Femur length (FL) _____ cm			
	<b>MHH.156.</b> Abdominal circumference (AC) _____ cm			
	<b>MHH.157.</b> <input type="checkbox"/> Symmetric IUGR <input type="checkbox"/> Asymmetric IUGR (HC%>AC% or HC%>FL%)			
	<b>MHH.158.</b> Microcephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes	<b>MHH.159.</b> Intracranial calcifications	<input type="checkbox"/> No <input type="checkbox"/> Yes
	<b>MHH.160.</b> Cerebral / cortical atrophy	<input type="checkbox"/> No <input type="checkbox"/> Yes	<b>MHH.161.</b> Abnormal cortical gyral patterns (e.g., polymicrogyria, lissencephaly, pachygyria, schizencephaly, gray matter heterotopia)	<input type="checkbox"/> No <input type="checkbox"/> Yes
<b>MHH.162.</b> Corpus callosum	<input type="checkbox"/> No <input type="checkbox"/> Yes	<b>MHH.163.</b> Cerebellar	<input type="checkbox"/> No <input type="checkbox"/> Yes	

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	abnormalities		abnormalities
	<b>MHH.164.</b> Porencephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes	<b>MHH.165.</b> Hydranencephaly
	<b>MHH.166.</b> Moderate or severe ventriculomegaly / hydrocephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes	<b>MHH.167.</b> Fetal brain disruption sequence (collapsed skull, overlapping sutures, prominent occipital bone, scalp rugae)
	<b>MHH.168.</b> Other major brain abnormalities	<input type="checkbox"/> No <input type="checkbox"/> Yes	<b>MHH.169.</b> Anencephaly / Acrania
	<b>MHH.170.</b> Encephalocele	<input type="checkbox"/> No <input type="checkbox"/> Yes	<b>MHH.171.</b> Spina bifida
	<b>MHH.172.</b> Holoprosencephaly / arhinencephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes	<b>MHH.173.</b> Structural eye abnormalities / dysplasia
	<b>MHH.174.</b> Arthrogryposis	<input type="checkbox"/> No <input type="checkbox"/> Yes	<b>MHH.175.</b> Clubfoot
	<b>MHH.176.</b> Hydrops	<input type="checkbox"/> No <input type="checkbox"/> Yes	<b>MHH.177.</b> Ascites
	<b>MHH.178.</b> Other	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, describe:
<b>MHH.179.</b> Description of abnormal ultrasound findings:			
<b>**For additional ultrasounds, please request a supplementary imaging form**</b>			
<b>MHH.180.</b> Fetal MRI performed: <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, please answer questions below)			
<b>MHH.181.</b> Date(s) of MRI(s):  _____  <input type="checkbox"/> <b>MHH.182.</b> check if date is approximated	<b>MHH.184.</b> Overall fetal MRI results: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		
	<b>MHH.185.</b> <input type="checkbox"/> Reported by patient/healthcare provider <input type="checkbox"/> MRI report		
	<b>MHH.186.</b> Head circumference (HC) ____cm		
	<b>MHH.187.</b> <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal ( <i>by physician report</i> )		
	<b>MHH.188.</b> Biparietal diameter (BPD) ____cm		
	<b>MHH.189.</b> Femur length (FL) ____cm		
	<b>MHH.190.</b> Abdominal circumference (AC) ____cm		
<b>MHH.191.</b> <input type="checkbox"/> Symmetric IUGR <input type="checkbox"/> Asymmetric IUGR (HC%>AC% or HC%>FL%)			
<b>MHH.183.</b> if date not known, gestational age  ____ (weeks) ____ (days)	<b>MHH.192.</b> Microcephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes	<b>MHH.193.</b> Intracranial calcifications
	<b>MHH.194.</b> Cerebral / cortical atrophy	<input type="checkbox"/> No <input type="checkbox"/> Yes	<b>MHH.195.</b> Abnormal cortical gyral patterns (e.g., polymicrogyria, lissencephaly, pachygyria, schizencephaly, gray matter heterotopia)
	<b>MHH.196.</b> Corpus callosum abnormalities	<input type="checkbox"/> No <input type="checkbox"/> Yes	<b>MHH.197.</b> Cerebellar abnormalities
	<b>MHH.198.</b> Porencephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes	<b>MHH.199.</b> Hydranencephaly
	<b>MHH.200.</b> Moderate or severe ventriculomegaly / hydrocephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes	<b>MHH.201.</b> Fetal brain disruption sequence (collapsed skull, overlapping sutures, prominent occipital bone, scalp rugae)

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	<b>MHH.202.</b> Other major brain abnormalities	<input type="checkbox"/> No <input type="checkbox"/> Yes	<b>MHH.203.</b> Anencephaly / acrania	<input type="checkbox"/> No <input type="checkbox"/> Yes
	<b>MHH.204.</b> Encephalocele	<input type="checkbox"/> No <input type="checkbox"/> Yes	<b>MHH.205.</b> Spina bifida	<input type="checkbox"/> No <input type="checkbox"/> Yes
	<b>MHH.206.</b> Holoprosencephaly / arhinencephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes	<b>MHH.207.</b> Structural eye abnormalities / dysplasia	<input type="checkbox"/> No <input type="checkbox"/> Yes
	<b>MHH.208.</b> Arthrogryposis	<input type="checkbox"/> No <input type="checkbox"/> Yes	<b>MHH.209.</b> Clubfoot	<input type="checkbox"/> No <input type="checkbox"/> Yes
	<b>MHH.210.</b> Hydrops	<input type="checkbox"/> No <input type="checkbox"/> Yes	<b>MHH.211.</b> Ascites	<input type="checkbox"/> No <input type="checkbox"/> Yes
	<b>MHH.212.</b> Other	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, describe:	
<b>MHH.213.</b> Description of abnormal MRI findings:				
<b>MHH.214. Amniocentesis performed:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If Zika virus testing performed on amniotic fluid, please enter in Laboratory Results Form.</i> <i>If cytogenetic testing performed on amniotic fluid, please enter below.</i>				
<b>Prenatal (Fetal) Cytogenetic Testing</b>				
<b>MHH.215. Prenatal (fetal) cytogenetic testing performed:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, please answer questions below)				
<b>MHH.216. Cytogenetic Tests</b> <input type="checkbox"/> Karyotype <input type="checkbox"/> FISH <input type="checkbox"/> CGH microarray <input type="checkbox"/> Cell-free DNA <input type="checkbox"/> Other, specify _____	<b>MHH.217. Date of test:</b> _____ <b>MHH.218. Gestational Age:</b> _____(weeks)_____ (days) or <b>Trimester:</b> <input type="checkbox"/> 1 <sup>st</sup> <input type="checkbox"/> 2 <sup>nd</sup> <input type="checkbox"/> 3 <sup>rd</sup>	<b>MHH.219. Specimen type:</b> <input type="checkbox"/> Amniocentesis <input type="checkbox"/> Chorionic Villus Sampling (CVS) <input type="checkbox"/> Maternal Serum <input type="checkbox"/> Other, specify _____	<b>MHH.220. Test Result</b> <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown	
<b>MHH.221. Description of abnormal cytogenetic testing findings:</b>				
<b>Prenatal (Fetal) Cytogenetic Testing</b>				
<b>MHH.222. Prenatal (fetal) cytogenetic testing performed:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, please answer questions below)				
<b>MHH.223. Cytogenetic Tests</b> <input type="checkbox"/> Karyotype <input type="checkbox"/> FISH <input type="checkbox"/> CGH microarray <input type="checkbox"/> Cell-free DNA <input type="checkbox"/> Other, specify _____	<b>MHH.224. Date of test</b> _____ <b>MHH.225. Gestational Age:</b> _____(weeks)_____ (days) or <b>Trimester:</b> <input type="checkbox"/> 1 <sup>st</sup> <input type="checkbox"/> 2 <sup>nd</sup> <input type="checkbox"/> 3 <sup>rd</sup>	<b>MHH.226. Specimen type:</b> <input type="checkbox"/> Amniocentesis <input type="checkbox"/> Chorionic Villus Sampling (CVS) <input type="checkbox"/> Maternal Serum <input type="checkbox"/> Other, specify _____	<b>MHH.227. Test Result</b> <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown	

Registry ID \_\_\_\_\_

State/Territory ID \_\_\_\_\_

## U.S. Zika Pregnancy Registry and Birth Defects Surveillance — Integrated Maternal Health History Form

*These data are considered confidential and will be stored in a secure database at the Centers for Disease Control and Prevention.*

**MHH.228. Description of abnormal cytogenetic testing findings:**

### Health Department Information

**MHH.229. Name of person completing form:** \_\_\_\_\_

**MHH.230. Phone:** \_\_\_\_\_ **MHH.231. Email:** \_\_\_\_\_

**MHH.232. Date form completed** \_\_\_\_\_

### Internal use only

**Date entered** \_\_\_\_\_

**Data Entry POC Initials:** \_\_\_\_\_

**Data Entry Notes:**

Public reporting burden of this collection of information is estimated to average 15 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 CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS E-11, Atlanta, Georgia 30333; ATTN: PRA (0920-1101).