Study ID: __ __ __ __ __ __

Date completed (MM-DD-YY): __ __ / __ __ / __ __

Name of Abstracter: _____

Prenatal Clinic: ☐ Chinle ☐ Gallup ☐ Shiprock ☐ Ft. Defiance ☐ Tuba City ☐ Other (Specify) _____

PRENATAL AND PREGNANCY MEDICAL RECORD ABSTRACTION FORM

PREGNANCY HISTORY

Grav ___ ___ Para ___ ___

Term ___ ___ Premature ___ ___

Abs ___ ___ Living ___ ___ Stillbirth ___ ___ Neonatal death ___ ___

Previous Pregnancies (Provide details for all live-born children):

1) Date of Birth __ __ / __ __ / __ __ Weeks Gestation ___ ___ ☐ Singleton ☐ Multiple (Number___)

Type of Delivery ☐ Vaginal ☐ Vaginal-assisted ☐ Scheduled Cesarean ☐ Emergency Cesarean

Infant Sex ☐ Male ☐ Female [If more than one, place number in box for each infant sex]

2) Date of Birth __ __ / __ __ / __ __ Weeks Gestation ___ ___ ☐ Singleton ☐ Multiple (Number___)

Type of Delivery ☐ Vaginal ☐ Vaginal-assisted ☐ Scheduled Cesarean ☐ Emergency Cesarean

Infant Sex ☐ Male ☐ Female [If more than one, place number in box for each infant sex]

3) Date of Birth __ __ / __ __ / __ __ Weeks Gestation ___ ___ ☐ Singleton ☐ Multiple (Number___)

Type of Delivery ☐ Vaginal ☐ Vaginal-assisted ☐ Scheduled Cesarean ☐ Emergency Cesarean

Infant Sex ☐ Male ☐ Female [If more than one, place number in box for each infant sex]

4) Date of Birth __ __ / __ __ / __ __ Weeks Gestation ___ ___ ☐ Singleton ☐ Multiple (Number___)

Type of Delivery ☐ Vaginal ☐ Vaginal-assisted ☐ Scheduled Cesarean ☐ Emergency Cesarean

Infant Sex ☐ Male ☐ Female [If more than one, place number in box for each infant sex]

5) Date of Birth __ __ / __ __ / __ __ Weeks Gestation ___ ___ ☐ Singleton ☐ Multiple (Number___)

Type of Delivery ☐ Vaginal ☐ Vaginal-assisted ☐ Scheduled Cesarean ☐ Emergency Cesarean

Infant Sex ☐ Male ☐ Female [If more than one, place number in box for each infant sex]

6) Date of Birth __ __ / __ __ / __ __ Weeks Gestation ___ ___ ☐ Singleton ☐ Multiple (Number___)

Type of Delivery ☐ Vaginal ☐ Vaginal-assisted ☐ Scheduled Cesarean ☐ Emergency Cesarean

Infant Sex ☐ Male ☐ Female [If more than one, place number in box for each infant sex]

7) Date of Birth __ __ / __ __ / __ __ Weeks Gestation ___ ___ ☐ Singleton ☐ Multiple (Number___)

Type of Delivery ☐ Vaginal ☐ Vaginal-assisted ☐ Scheduled Cesarean ☐ Emergency Cesarean

Infant Sex ☐ Male ☐ Female [If more than one, place number in box for each infant sex]

8) Date of Birth __ __ / __ __ / __ __ Weeks Gestation ___ ___ ☐ Singleton ☐ Multiple (Number___)

Type of Delivery ☐ Vaginal ☐ Vaginal-assisted ☐ Scheduled Cesarean ☐ Emergency Cesarean

Infant Sex ☐ Male ☐ Female [If more than one, place number in box for each infant sex]

9) Date of Birth __ __ / __ __ / __ __ Weeks Gestation ___ ___ ☐ Singleton ☐ Multiple (Number___)

Type of Delivery ☐ Vaginal ☐ Vaginal-assisted ☐ Scheduled Cesarean ☐ Emergency Cesarean

Infant Sex ☐ Male ☐ Female [If more than one, place number in box for each infant sex]

Check this box if more than 9 (nine) live-born children ☐

PRENATAL RISK ASSESSMENT

Reproductive History:

Age Under 16 or Over 35	____ (1)
Parity 0 or Over 5	____ (1)
Habitual Abortion	____ (1)
Infertility	____ (1)
P P Hem, Manual Removal	____ (1)
Previous baby >9lbs (4050 gms)	____ (1)
<5 ½ lbs (2500 gms)	____ (2)
Previous Toxemia, Hypertension	____ (1)
Previous Cesarean Section	____ (3)
Previous Stillbirth or N N D	____ (3)
Prolonged Labor (>30 Hrs.) or Difficult Delivery	____ (1)
Other_____	____ (1)
Other_____	____ (1)

Associated Conditions:

Chronic Renal Disease	____ (2)
Diabetes: Gestational	____ (2)
Class B or Higher	____ (3)
Cardiac Disease	____ (1-3)
Major Gyn Surgery, Cone Bx	____ (2)
Other_____	____ (1-3)
Other_____	____ (1-3)
Other_____	____ (1-3)
Cigarette Smoking	____ (1)
Alcohol Use	____ (1-2)
Teratogen/Drug Exposure _____	____ (1-2)
Significant Social Problem _____	____ (1-3)

Present Pregnancy:

Bleeding Less than 20 wks	____ (1)
Bleeding After 20 wks	____ (1-3)
Anemia: Hematocrit <34	____ (1)
Prolonged Pregnancy >42 wks	____ (3)
Hypertension, Preeclampsia	____ (2-3)
Premature Rupture Membranes	____ (3)
Polyhydramnios	____ (2)
Small for Dates	____ (3)
Multiple Pregnancy	____ (3)
Breech > 36 weeks	____ (3)
Rh Negative, Sensitized?	____ (1-3)
Genital Herpes, active	____ (3)
Excessive or inadequate wt. gain	____ (1-2)
Other_____	____ (1-3)

TOTAL RISK SCORE ☐☐

CURRENT PREGNANCY

Gestational Assessments:

Menstrual History LNMP __ __ / __ __ / __ __ Certainty of Date ☐ Yes ☐ No ☐ Don't know

Use of BCPs ☐ Yes ☐ No ☐ Don't know If yes, last date taken __ __ / __ __ / __ __ ☐ Don't know

Attitude Towards Pregnancy: ☐ Planned ☐ Unplanned ☐ Don't know

Clinical Evaluation:

Is there evidence of a positive pregnancy test (hCG)? ☐ Yes ☐ No ☐ Don't know

Pregnancy Test Date __ __ / __ __ / __ __

First uterine size estimate by bimanual examination __ __ / __ __ / __ __ Gestational Age __ __ weeks

Predicted EDC __ __ / __ __ / __ __ Reliability of Estimate: ☐ Poor ☐ Good ☐ Excellent ☐ Don't know

First Ultrasound Date __ __ / __ __ / __ __ Gestational Age __ __ weeks Sonar EDC __ __ / __ __ / __ __

Last Ultrasound Date __ __ / __ __ / __ __ Gestational Age __ __ weeks Sonar EDC __ __ / __ __ / __ __

Number of fetuses ☐ Singleton ☐ Multiple If Multiple fetuses, how many? ___ ___

Fetal heart tones first heard by Doppler Date: __ __ / __ __ / __ __

Fetal heart tones first heard by fetoscope Date: __ __ / __ __ / __ __

Fetal movement first perceived by patient (quickening) Date: __ __ / __ __ / __ __

Prenatal Visit History:

Total Number of Prenatal Visits ___ ___ [Check box if unknown ☐]

First Prenatal Visit Date __ __ / __ __ / __ __ [Check box if unknown ☐]

Pre-pregnancy weight _____ _____ _____ *lb*, _____ _____ *oz*. ***or*** _____ _____**.** _____ *kg*

Term pregnancy weight _____ _____ _____ *lb*, _____ _____ *oz*. ***or*** _____ _____**.** _____ *kg*

Was RHO (D) immune globulin (Gamulin Rh, HypRho-D, Rhesonativ, RhoGAM) given to the patient during this pregnancy? ☐ Yes ☐ No ☐ Don't know If yes, date: __ __ / __ __ / __ __

Behavioral Assessment:

Smoking Tobacco Cigarettes during pregnancy ☐ Yes ☐ No ☐ Don't know
Number of Cigarettes per day during pregnancy ___ ___

Smoking Tobacco Cigarettes before pregnancy ☐ Yes ☐ No ☐ Don't know
Number of Cigarettes per day before pregnancy ___ ___

Alcohol use during pregnancy ☐ Yes ☐ No ☐ Don't know

Number of Alcoholic drinks per week during pregnancy ___ ___

Alcohol use before pregnancy ☐ Yes ☐ No ☐ Don't know
Number of Alcoholic drinks per week before pregnancy ___ ___

Ceremonial drug use during pregnancy (e.g. peyote) ☐ Yes ☐ No ☐ Don't know
If yes, specify type _____

Prescription drug use during pregnancy ☐ Yes ☐ No ☐ Don't know
If yes, specify type _____

Illicit drug use during pregnancy ☐ Yes ☐ No ☐ Don't know
If yes, specify type _____

Prenatal vitamin use during pregnancy ☐ Yes ☐ No ☐ Don't know
If yes, specify brand/type_____

Estimated start of use ____ _____ (weeks of gestation)

Estimated compliance: ☐ Poor ☐ Good ☐ Excellent ☐ Don't know

Referrals/Counseling:

Did the patient receive any of the following types of **referrals or counseling** during her prenatal care?

Diabetic diet ☐ Yes ☐ No ☐ Don't know

Alcohol abuse ☐ Yes ☐ No ☐ Don't know

Drug abuse ☐ Yes ☐ No ☐ Don't know

Smoking cessation ☐ Yes ☐ No ☐ Don't know

Other (specify:_____) ☐ Yes ☐ No ☐ Don't know

PRENATAL FLOW RECORD

Summary of Prenatal Visits

Date	Weight (lbs)	Systolic BP	Diastolic BP	Urine protein	Urine glucose	Fundal height (cm)	Estimated gest. age (weeks)
__ __/__ __/__ __	__ __ __	__ __ __	__ __	__	__	__ __.__	__ __
__ __/__ __/__ __	__ __ __	__ __ __	__ __	__	__	__ __.__	__ __
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Condition of Cervix / Station / Fetal Presentation
(During last two months of prenatal care)

Date	Dilation (cm)	Effacement (%)	Station (-3 to +3)	Fetal presentation
__ __/__ __/__ __	__ __.__	__ __	__	__
__ __/__ __/__ __	__ __.__	__ __	__	__
__ __/__ __/__ __	__ __.__	__ __	__	__
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__ __/__ __/__ __	__ __.__	__ __	__	__
__ __/__ __/__ __	__ __.__	__ __	__	__
__ __/__ __/__ __	__ __.__	__ __	__	__
__ __/__ __/__ __	__ __.__	__ __	__	__

ROUTINE LABORATORY TEST RESULTS (First Prenatal Visit -or- First Available)

GC ☐ Pos ☐ Neg ☐ Don't know/missing Date __ __ / __ __ / __ __

Chlamydia ☐ Pos ☐ Neg ☐ Don't know/missing Date __ __ / __ __ / __ __

B Strep ☐ Pos ☐ Neg ☐ Don't know/missing Date __ __ / __ __ / __ __

Creatinine clearance (mL/min) __ __ __ Date __ __ / __ __ / __ __

Urine 24 hours protein (mg/24 hour) __ __ __ Date __ __ / __ __ / __ __

Hgb (g/dL) __ __ . __ Date __ __ / __ __ / __ __

Hct (%) __ __ Date __ __ / __ __ / __ __

MCV (fL) __ __ __ Date __ __ / __ __ / __ __

RDW (%) __ __ Date __ __ / __ __ / __ __

Folate (ng/ml) __ __ . __ Date __ __ / __ __ / __ __

E3 __ __ . __ Date __ __ / __ __ / __ __

Serum AFP ☐ High ☐ Normal/Neg ☐ Low ☐ Don't know/missing Date __ __ / __ __ / __ __

Rubella ☐ Immune ☐ Not Immune ☐ Don't know/missing Date __ __ / __ __ / __ __

Hepatitis B (HBsAg) ☐ Positive ☐ Negative ☐ Don't know/missing Date __ __ / __ __ / __ __

Syphillis ☐ Positive ☐ Negative ☐ Don't know/missing Date __ __ / __ __ / __ __

VDRL (quantitative) ___ ___ ___ Date __ __ / __ __ / __ __

Urine C&S ☐ Pos ☐ Neg ☐ Don't know/missing Date __ __ / __ __ / __ __

Was patient ever treated for urinary tract infection (UTI) in current pregnancy? ☐ Yes ☐ No ☐ Don't know

If yes, how was patient treated? (specify)_____ Date __ __ / __ __ / __ __

OTHER TESTING

Did the patient have an **amniocentesis** during the current pregnancy? ☐ Yes ☐ No ☐ Refused ☐ Don't know

If yes, date: __ __ / __ __ / __ __

Chromosomal type ☐ Normal ☐ Abnormal ☐ Don't know/missing

Alpha-fetoprotein (AFP) ☐ High ☐ Normal/Neg ☐ Low ☐ Don't know/missing

Lecithin/Sphingomyelin (LS) ratio __ . __

Phosphatidyl-glycerol (PG) ☐ Trace ☐ Present ☐ Absent ☐ Don't know/missing

Other abnormality ☐ Yes ☐ No ☐ Don't know/missing If yes, specify:______________________

Did the patient have an **chorionic villus sampling (CVS)** during the current pregnancy?

☐ Yes ☐ No ☐ Refused ☐ Don't know If yes, date: __ __ / __ __ / __ __

Chromosomal abnormality ☐ Yes ☐ No ☐ Don't know/missing If yes, specify:______________________

Other abnormality ☐ Yes ☐ No ☐ Don't know/missing If yes, specify:______________________

Gestational Diabetes Screening

Is patient known to have (pre-existing) diabetes? ☐ Yes ☐ No ☐ Don't know

Glucose Tests:

Glucose___ ___ ___ mg/dL Date: __ __ / __ __ / __ __ Fasting?: ☐ Yes ☐ No ☐ Don't know

Glucose___ ___ ___ mg/dL Date: __ __ / __ __ / __ __ Fasting?: ☐ Yes ☐ No ☐ Don't know

Glucose___ ___ ___ mg/dL Date: __ __ / __ __ / __ __ Fasting?: ☐ Yes ☐ No ☐ Don't know

Glucose___ ___ ___ mg/dL Date: __ __ / __ __ / __ __ Fasting?: ☐ Yes ☐ No ☐ Don't know

Glucose___ ___ ___ mg/dL Date: __ __ / __ __ / __ __ Fasting?: ☐ Yes ☐ No ☐ Don't know

Glucose___ ___ ___ mg/dL Date: __ __ / __ __ / __ __ Fasting?: ☐ Yes ☐ No ☐ Don't know

Glucose Tolerance Testing:

Did patient complete a 1-hour, 50-g glucose load random screening test? ☐ Yes ☐ No ☐ Don't know

If yes, result ___ ___ ___ mg/dL Date of 1-hour screening test: __ __ / __ __ / __ __

If yes, result ___ ___ ___ mg/dL Date of 1-hour screening test: __ __ / __ __ / __ __

If yes, result ___ ___ ___ mg/dL Date of 1-hour screening test: __ __ / __ __ / __ __

Did patient complete a 3-hour, 100-g glucose load test after overnight fasting? ☐ Yes ☐ No ☐ Don't know

If yes, results: Fasting ___ ___ ___ mg/dL Date of 3-hour test: __ __ / __ __ / __ __

1-hour ___ ___ ___ mg/dL 2-hour ___ ___ ___ mg/dL 3-hour ___ ___ ___ mg/dL

If yes, results: Fasting ___ ___ ___ mg/dL Date of 3-hour test: __ __ / __ __ / __ __

1-hour ___ ___ ___ mg/dL 2-hour ___ ___ ___ mg/dL 3-hour ___ ___ ___ mg/dL

If yes, results: Fasting ___ ___ ___ mg/dL Date of 3-hour test: __ __ / __ __ / __ __

1-hour ___ ___ ___ mg/dL 2-hour ___ ___ ___ mg/dL 3-hour ___ ___ ___ mg/dL

Did the patient develop gestational diabetes during the current pregnancy? ☐ Yes ☐ No ☐ Don't know

If yes, date of diagnosis: __ __ / __ __ / __ __

Was patient given medication for diabetes during the current pregnancy? ☐ Yes ☐ No ☐ Don't know

If yes, type of medication (specify)______________________ Date started: __ __ / __ __ / __ __

Pregnancy-Induced Hypertension

During the current pregnancy, was the patient ever diagnosed as having eclampsia, preeclampsia, toxemia, or pregnancy-induced hypertension?

☐ Yes ☐ No ☐ Don't know If yes, date of diagnosis: __ __ / __ __ / __ __

Was patient given medication for hypertension during the current pregnancy? ☐ Yes ☐ No ☐ Don't know

If yes, type of medication (specify)______________________ Date started: __ __ / __ __ / __ __

Was patient ever hospitalized for hypertension-related conditions during the current pregnancy?

☐ Yes ☐ No ☐ Don't know If yes, (specify reason)_____________________ Date: __ __ / __ __ / __ __

SYMPTOMS /FINDINGS

At any time during the **current pregnancy**, did the patient have any of the following **symptoms or findings**?

Severe headache	☐ Yes ☐ No ☐ Don't know
Mental status change	☐ Yes ☐ No ☐ Don't know
Visual disturbances	☐ Yes ☐ No ☐ Don't know
Right upper quadrant or epigastric pain	☐ Yes ☐ No ☐ Don't know
Oliguria	☐ Yes ☐ No ☐ Don't know
Pulmonary edema	☐ Yes ☐ No ☐ Don't know
Seizures	☐ Yes ☐ No ☐ Don't know

Were any of the following noted as **possible problems** during the **current pregnancy**?

Oligohydramnios	☐ Yes ☐ No ☐ Don't know
Polyhydramnios	☐ Yes ☐ No ☐ Don't know
Fetal growth retardation (IUGR)	☐ Yes ☐ No ☐ Don't know
Large uterus for dates	☐ Yes ☐ No ☐ Don't know
Preterm labor, premature rupture of membranes	☐ Yes ☐ No ☐ Don't know
Other (specify_____)	☐ Yes ☐ No ☐ Don't know

RESTRICTED ACTIVITY

Did the patient ever **discontinue employment or reduce her usual activities** (other than bedrest) during this pregnancy?

☐ Yes ☐ No ☐ Don't know If yes, date first stopped working /reduced: __ __ / __ __ / __ __

Was the patient ever put on **bedrest** at home during this pregnancy? ☐ Yes ☐ No ☐ Don't know

If yes, date **bedrest** first started: __ __ / __ __ / __ __

TRANSFER OF CARE

Is there evidence in the medical record indicating that a part of the patient's **regular prenatal care** was administered elsewhere (at another clinic or facility)? ☐ Yes ☐ No ☐ Don't know

HOSPITALIZATIONS DURING PREGNANCY

Were there **any hospitalizations** during the current pregnancy? ☐ Yes ☐ No ☐ Don't know

If yes, date of admission: __ __ / __ __ / __ __ date of discharge: __ __ / __ __ / __ __

Specify reason for admission: _____

If yes, date of admission: __ __ / __ __ / __ __ date of discharge: __ __ / __ __ / __ __

Specify reason for admission: _____

If yes, date of admission: __ __ / __ __ / __ __ date of discharge: __ __ / __ __ / __ __

Specify reason for admission: _____

If yes, date of admission: __ __ / __ __ / __ __ date of discharge: __ __ / __ __ / __ __

Specify reason for admission: _____

If yes, date of admission: __ __ / __ __ / __ __ date of discharge: __ __ / __ __ / __ __

Specify reason for admission: _____

LABOR AND DELIVERY MEDICAL RECORD ABSTRACTION FORM

Admission Date __ __ / __ __ / __ __ Admission Time ___ ___ : ___ ___ AM ☐ PM ☐

Delivery Hospital: ☐ Chinle ☐ Gallup ☐ Shiprock ☐ Ft.Defiance ☐ Tuba City ☐ Other (Specify)_____

MATERNAL CHARACTERISTICS AT ADMISSION

Maternal weight at admission _____ _____ _____ *lb*, _____ _____ *oz.* ***or*** _____ _____. _____ *kg*

Maternal height at admission _____ *ft*, _____ _____ *in.* ***or*** _____ _____ _____ *cm*

Blood Pressure at admission: SBP__ __ __ DBP__ __

Cervical Dilation (cm) __ __ . __ Effacement (%)__ __ Station __ (-3 to +3) ☐ Check if no data

Onset of Labor: Date__ __ / __ __ / __ __ Time ___ ___ : ___ ___ AM ☐ PM ☐ ☐ Don't know

ADMISSION COMPLICATIONS

Did any of the following conditions or problems occur during this admission, but prior to delivery?

Uterine bleeding, placenta previa/abruption	☐ Yes ☐ No ☐ Don't know
Premature rupture of membranes	☐ Yes ☐ No ☐ Don't know
Preterm labor	☐ Yes ☐ No ☐ Don't know
Secondary arrest/abnormal duration of labor	☐ Yes ☐ No ☐ Don't know
Failed forceps or vacuum	☐ Yes ☐ No ☐ Don't know
Cord prolapse	☐ Yes ☐ No ☐ Don't know
Shoulder dystocia	☐ Yes ☐ No ☐ Don't know
Meconium staining	☐ Yes ☐ No ☐ Don't know
Fetal distress	☐ Yes ☐ No ☐ Don't know
Amnionitis	☐ Yes ☐ No ☐ Don't know
Preeclampsia, eclampsia, toxemia, or pregnancy-induced hypertension	☐ Yes ☐ No ☐ Don't know
Other (Specify_____)	☐ Yes ☐ No ☐ Don't know

DELIVERY CHARACTERISTICS

Attending Provider: ☐ Obstetrician ☐ Family Practice ☐ Midwife ☐ Other (Specify)_____ ☐ Don't know

Type of Delivery: ☐ Vaginal ☐ Vaginal-Assisted ☐ Scheduled Cesarean ☐ Emergency Cesarean ☐ Don't know

If delivery was an **unscheduled C-Section**, what was reason(s) given? (specify)_____

Was the **delivery induced** using drugs to stimulate labor? ☐ Yes ☐ No ☐ Don't know

If yes, type? (specify)_____ When ___ ___ : ___ ___ AM ☐ PM ☐

If yes, type? (specify)_____ When ___ ___ : ___ ___ AM ☐ PM ☐

If yes, type? (specify)_____ When ___ ___ : ___ ___ AM ☐ PM ☐

Which of the following **methods of anesthesia** were used during labor or delivery?

Paracervical block, pudendal block, local infiltration ☐ Yes ☐ No ☐ Don't know

Epidural, spinal ☐ Yes ☐ No ☐ Don't know

General ☐ Yes ☐ No ☐ Don't know

PREGNANCY OUTCOME

☐ Live birth ☐ Stillbirth ☐ Miscarriage ☐ Don't know

If Stillbirth or Miscarriage, Date __ __ / __ __ / __ __ ☐ Don't know

Multiple fetuses? ☐ Yes ☐ No If yes, number of live births ☐

(If multiple birth, please complete birth characteristics for each infant below)

INFANT BIRTH CHARACTERISTICS

Infant 1: Date of Birth __ __ / __ __ / __ __ Time of Birth ___ ___ : ___ ___ AM ☐ PM ☐

Sex ☐ Male ☐ Female

Weight _____ _____ *lb*, _____ _____ *oz.* ***or*** _____ _____ _____ _____ *gm*

Length _____ _____ *in* ***or*** _____ _____ *cm*

Occipitofrontal head circumference _____ _____ *in* ***or*** _____ _____ *cm*

Gestational age at birth _____ _____ (weeks)

How estimated: ☐ Ballard ☐ Dubowitz ☐ Other (Specify)_____ ☐ Don't know or missing

Apgar Scores: 1 minute ___ ___ 5 minute ___ ___ 10 minute ___ ___

Initiation of breastfeeding: ☐ Yes ☐ No ☐ Don't know

Infant 2: Date of Birth __ __ / __ __ / __ __ Time of Birth ___ ___ : ___ ___ AM ☐ PM ☐

Sex ☐ Male ☐ Female

Weight _____ _____ *lb*, _____ _____ *oz.* ***or*** _____ _____ _____ _____ *gm*

Length _____ _____ *in* ***or*** _____ _____ *cm*

Occipitofrontal head circumference _____ _____ *in* ***or*** _____ _____ *cm*

Gestational age at birth _____ _____ (weeks)

How estimated: ☐ Ballard ☐ Dubowitz ☐ Other (Specify)_____ ☐ Don't know or missing

Apgar Scores: 1 minute ___ ___ 5 minute ___ ___ 10 minute ___ ___

Initiation of breastfeeding: ☐ Yes ☐ No ☐ Don't know

Infant 3: Date of Birth __ __ / __ __ / __ __ Time of Birth ___ ___ : ___ ___ AM ☐ PM ☐

Sex ☐ Male ☐ Female

Weight _____ _____ *lb*, _____ _____ *oz.* ***or*** _____ _____ _____ _____ *gm*

Length _____ _____ *in* ***or*** _____ _____ *cm*

Occipitofrontal head circumference _____ _____ *in* ***or*** _____ _____ *cm*

Gestational age at birth _____ _____ (weeks)

How estimated: ☐ Ballard ☐ Dubowitz ☐ Other (Specify)_____ ☐ Don't know or missing

Apgar Scores: 1 minute ___ ___ 5 minute ___ ___ 10 minute ___ ___

Initiation of breastfeeding: ☐ Yes ☐ No ☐ Don't know

NEWBORN COMPLICATIONS DURING DELIVERY

Indicate if one or more newborns had any of the following **complications during delivery**:

Lacerations ☐ Yes ☐ No ☐ Don't know

Erb's plasy/brachial plexus injury ☐ Yes ☐ No ☐ Don't know

Facial paralysis ☐ Yes ☐ No ☐ Don't know

Cephalohematoma	☐ Yes ☐ No ☐ Don't know
Fracture of skull, clavicle, or femur	☐ Yes ☐ No ☐ Don't know
Hyaline membrane disease (HMD)	☐ Yes ☐ No ☐ Don't know
Meconium aspiration	☐ Yes ☐ No ☐ Don't know
Nuchal cord	☐ Yes ☐ No ☐ Don't know
Respiratory distress	☐ Yes ☐ No ☐ Don't know
Seizures, intercranial hemorrhage	☐ Yes ☐ No ☐ Don't know
Congenital anomaly	☐ Yes ☐ No ☐ Don't know
Stillbirth	☐ Yes ☐ No ☐ Don't know
Nenonatal death	☐ Yes ☐ No ☐ Don't know
Admission to NICU	☐ Yes ☐ No ☐ Don't know

MATERNAL POSTPARTUM COMPLICATIONS

Indicate if mother had any of the following **complications during or after delivery**:

Bladder/ureteral injury	☐ Yes ☐ No ☐ Don't know
Bowel injury	☐ Yes ☐ No ☐ Don't know
Perineal lacerations/episiotomy extension	☐ Yes ☐ No ☐ Don't know
Abdominal wound infection	☐ Yes ☐ No ☐ Don't know
Endometritis	☐ Yes ☐ No ☐ Don't know
Pelvic abcess/cellulitis/septic pelvis thrombophlebitis	☐ Yes ☐ No ☐ Don't know
Pneumonia	☐ Yes ☐ No ☐ Don't know
Sepsis	☐ Yes ☐ No ☐ Don't know
Deep vein thrombosis or pulmonary embolism	☐ Yes ☐ No ☐ Don't know

(confirmed)

Blood transfusion ☐ Yes ☐ No ☐ Don't know

Return to operating or delivery room ☐ Yes ☐ No ☐ Don't know
(Specify_____)

DISCHARGE SUMMARY

Mother's Discharge Date __ __ / __ __ / __ __ Mother's Discharge Time ___ ___ : ___ ___ AM ☐ PM ☐

Status of mother at discharge: ☐ Alive ☐ Dead ☐ Don't know

Was infant(s) discharged at the same date/time as mother? ☐ Yes ☐ No ☐ Don't know

If **no**, date and time of infant(s) discharge:

Infant Discharge Date __ __ / __ __ / __ __ Infant Discharge Time ___ ___ : ___ ___ AM ☐ PM ☐

Study ID: __ __ __ __ __ __

Date completed (MM-DD-YY): __ __ / __ __ / __ __

Name of Abstracter:_____

Clinic: ☐ Chinle ☐ Gallup ☐ Shiprock ☐ Ft. Defiance ☐ Tuba City ☐ Other (Specify)_____

INFANT MEDICAL RECORD ABSTRACTION
(up to 1 year of Age)

Date of Birth __ __ / __ __ / __ __ Sex: ☐ Male ☐ Female

Is this child from a set of twins or a multiple birth? ☐ Yes ☐ No ☐ Don't know

If yes, siblings with: Study ID __ __ __ __ __ __ Study ID __ __ __ __ __ __ Study ID __ __ __ __ __ __

Newborn Screening Results (within 24-48 hours of birth) Date of Test __ __ / __ __ / __ __

Did the child **screen positive** for *any* of the following conditions? **(Check one box for each condition below)**

Endocrine disorders:

1. Congenital Adrenal Hyperplasia (CAH) ☐ Yes ☐ No ☐ Don't know
2. Congenital hypothyroidism (CH) ☐ Yes ☐ No ☐ Don't know

Hemoglobinopathies:

3. Sickle Cell Anemia (HB S/S) ☐ Yes ☐ No ☐ Don't know
4. S-βeta thalassemia (HB S/A) ☐ Yes ☐ No ☐ Don't know
5. Sickle C-disease (HB S/C) ☐ Yes ☐ No ☐ Don't know

Other core condition(s):

6. Cystic Fibrosis (CF) ☐ Yes ☐ No ☐ Don't know
7. Biotinidase Deficiency (BIO) ☐ Yes ☐ No ☐ Don't know
8. Galactosemia(GALT) ☐ Yes ☐ No ☐ Don't know

9. Severe Combined Immunodeficiency Disorder (SCIDs) ☐ Yes ☐ No ☐ Don't know

Fatty Acid Oxidation disorders (FOA):

10. Carnitine uptake defect (CUD) ☐ Yes ☐ No ☐ Don't know

11. Long-chain L-3-OH acyl-CoA dehydrogenase deficiency (LCHAD) ☐ Yes ☐ No ☐ Don't know

12. Medium chain acyl-CoA dehydrogenase deficiency (MCAD) ☐ Yes ☐ No ☐ Don't know

13. Trifunctional protein deficiency (TFP) ☐ Yes ☐ No ☐ Don't know

14. Very long-chain acyl-CoA dehydrogenase deficiency (VLCAD) ☐ Yes ☐ No ☐ Don't know

Amino Acid Disorders:

15. Homocystinuria (HCY) ☐ Yes ☐ No ☐ Don't know

16. Tyrosinemia type I (TYR-1) ☐ Yes ☐ No ☐ Don't know

17. Phenylketonuria (PKU) ☐ Yes ☐ No ☐ Don't know

18. Maple syrup urine disease (MSUD) ☐ Yes ☐ No ☐ Don't know

Urea Cycle disorders:

19. Argininosuccinic acidemia (ASA) ☐ Yes ☐ No ☐ Don't know

20. Citrullinemia type I (CIT-1) ☐ Yes ☐ No ☐ Don't know

Organic Acidemia disorders:

21. 3-Hydroxy 3-Methyl Glutaric Aciduria (HGM) ☐ Yes ☐ No ☐ Don't know

22. 3-methylcrotonyl-CoA deficiency (3-MCC) ☐ Yes ☐ No ☐ Don't know

23. Beta-kitothiolase /Mitochondrial acetoacetyl-CoA thiolase deficiency (BKT) ☐ Yes ☐ No ☐ Don't know

24. Isovaleric acidemia (IVA) ☐ Yes ☐ No ☐ Don't know

25. Methylmalonic acidemia (MUT) ☐ Yes ☐ No ☐ Don't know

26. Proponic acidemia (PROP) ☐ Yes ☐ No ☐ Don't know

27. Multiple carboxylase deficiency (MCD) ☐ Yes ☐ No ☐ Don't know

28. Glutaric acidemia type I (GA-1) ☐ Yes ☐ No ☐ Don't know

Newborn Hearing Screening Test Date of Test __ __ / __ __ / __ __ Time ___ ___ : ___ ___ AM ☐ PM ☐

Right ear: ☐ Pass ☐ Refer ☐ Don't know

Left ear: ☐ Pass ☐ Refer ☐ Don't know

Newborn Screening Results (repeat, 1-2 weeks after birth) Date of Test __ __ / __ __ / __ __

Did the child **screen positive** for *any* of the following conditions? **(Check one box for each condition below)**

Endocrine disorders:

1. Congenital Adrenal Hyperplasia (CAH) ☐ Yes ☐ No ☐ Don't know

2. Congenital hypothyroidism (CH) ☐ Yes ☐ No ☐ Don't know

Hemoglobinopathies:

3. Sickle Cell Anemia (HB S/S) ☐ Yes ☐ No ☐ Don't know

4. S-βeta thalassemia (HB S/A) ☐ Yes ☐ No ☐ Don't know

5. Sickle C-disease (HB S/C) ☐ Yes ☐ No ☐ Don't know

Other core condition(s):

6. Cystic Fibrosis (CF) ☐ Yes ☐ No ☐ Don't know

7. Biotinidase Deficiency (BIO) ☐ Yes ☐ No ☐ Don't know

8. Galactosemia(GALT) ☐ Yes ☐ No ☐ Don't know

9. Severe Combined Immunodeficiency Disorder (SCIDs) ☐ Yes ☐ No ☐ Don't know

Fatty Acid Oxidation disorders (FOA):

10. Carnitine uptake defect (CUD) ☐ Yes ☐ No ☐ Don't know

11. Long-chain L-3-OH acyl-CoA dehydrogenase deficiency (LCHAD) ☐ Yes ☐ No ☐ Don't know

12. Medium chain acyl-CoA dehydrogenase deficiency (MCAD) ☐ Yes ☐ No ☐ Don't know

13. Trifunctional protein deficiency (TFP) ☐ Yes ☐ No ☐ Don't know

14. Very long-chain acyl-CoA dehydrogenase deficiency (VLCAD) ☐ Yes ☐ No ☐ Don't know

Amino Acid Disorders:

15. Homocystinuria (HCY) ☐ Yes ☐ No ☐ Don't know

16. Tyrosinemia type I (TYR-1) ☐ Yes ☐ No ☐ Don't know

17. Phenylketonuria (PKU) ☐ Yes ☐ No ☐ Don't know

18. Maple syrup urine disease (MSUD) ☐ Yes ☐ No ☐ Don't know

Urea Cycle disorders:

19. Argininosuccinic acidemia (ASA) ☐ Yes ☐ No ☐ Don't know

20. Citrullinemia type I (CIT-1) ☐ Yes ☐ No ☐ Don't know

Organic Acidemia disorders:

21. 3-Hydroxy 3-Methyl Glutaric Aciduria (HGM) ☐ Yes ☐ No ☐ Don't know

22. 3-methylcrotonyl-CoA deficiency (3-MCC) ☐ Yes ☐ No ☐ Don't know

23. Beta-kitothiolase /Mitochondrial acetoacetyl-CoA thiolase deficiency (BKT) ☐ Yes ☐ No ☐ Don't know

24. Isovaleric acidemia (IVA) ☐ Yes ☐ No ☐ Don't know

25. Methylmalonic acidemia (MUT) ☐ Yes ☐ No ☐ Don't know

26. Proponic acidemia (PROP) ☐ Yes ☐ No ☐ Don't know

27. Multiple carboxylase deficiency (MCD) ☐ Yes ☐ No ☐ Don't know

28. Glutaric acidemia type I (GA-1) ☐ Yes ☐ No ☐ Don't know

2nd Hearing Test (repeat, 1-2 weeks) Date of Test __ __ / __ __ / __ __ Time ___ ___ : ___ ___ AM ☐ PM ☐

Right ear: ☐ Pass ☐ Refer ☐ Don't know

Left ear: ☐ Pass ☐ Refer ☐ Don't know

Did child require a **third newborn screening test** (*due to premature birth or NICU admission*)?

☐ Yes ☐ No ☐ Don't know If **yes**, Date of Test __ __ / __ __ / __ __

Regularly-Scheduled Well-Child Follow-up Visits

Age: 1 week Visit Date __ __ / __ __ / __ __

Weight _____ _____ *lb*, _____ _____ *oz.* ***or*** _____ _____ _____ _____ *gm*

Length _____ _____ *in* ***or*** _____ _____ *cm*

Occipitofrontal head circumference _____ _____ *in* ***or*** _____ _____ *cm*

Signs of abuse/neglect ☐ Yes ☐ No ☐ Don't know

Has child reached appropriate developmental milestones? ☐ Yes ☐ No ☐ Don't know

Is child **currently breastfeeding**? ☐ Yes ☐ No ☐ Don't know

If yes, **age** when breastfeeding was initiated: ___ _____ hours -or- _____ days

If no, was breastfeeding ever initiated? ☐ Yes ☐ No ☐ Don't know

Age: 2 weeks Visit Date __ __ / __ __ / __ __

Weight _____ _____ *lb*, _____ _____ *oz.* ***or*** _____ _____ _____ _____ *gm*

Length _____ _____ *in* ***or*** _____ _____ *cm*

Occipitofrontal head circumference _____ _____ *in* ***or*** _____ _____ *cm*

Signs of abuse/neglect ☐ Yes ☐ No ☐ Don't know

Has child reached appropriate developmental milestones? ☐ Yes ☐ No ☐ Don't know

Is child **currently breastfeeding**? ☐ Yes ☐ No ☐ Don't know

Age: 6 weeks Visit Date __ __ / __ __ / __ __

Weight ____ ____ *lb*, ____ ____ *oz.* ***or*** ____ ____ ____ ____ *gm*

Length ____ ____ *in* ***or*** ____ ____ *cm*

Occipitofrontal head circumference ____ ____ *in* ***or*** ____ ____ *cm*

Signs of abuse/neglect ☐ Yes ☐ No ☐ Don't know

Has child reached appropriate developmental milestones? ☐ Yes ☐ No ☐ Don't know

Is child **currently breastfeeding**? ☐ Yes ☐ No ☐ Don't know

Age: 4 months Visit Date __ __ / __ __ / __ __

Weight ____ ____ *lb*, ____ ____ *oz.* ***or*** ____ ____ ____ ____ *gm*

Length ____ ____ *in* ***or*** ____ ____ *cm*

Occipitofrontal head circumference ____ ____ *in* ***or*** ____ ____ *cm*

Signs of abuse/neglect ☐ Yes ☐ No ☐ Don't know

Has child reached appropriate developmental milestones? ☐ Yes ☐ No ☐ Don't know

ASQ Screening Test

Communication	__ __
Gross Motor	__ __
Fine Motor	__ __
Problem-solving	__ __
Personal-Social	__ __

Is child **currently breastfeeding**? ☐ Yes ☐ No ☐ Don't know

Age: 6 months Visit Date __ __ / __ __ / __ __

Weight ____ ____ *lb*, ____ ____ *oz.* ***or*** ____ ____ ____ ____ *gm*

Length ____ ____ *in* ***or*** ____ ____ *cm*

Occipitofrontal head circumference ____ ____ *in* ***or*** ____ ____ *cm*

Signs of abuse/neglect ☐ Yes ☐ No ☐ Don't know

Has child reached appropriate developmental milestones? ☐ Yes ☐ No ☐ Don't know

ASQ Screening Test

Communication	__ __
Gross Motor	__ __
Fine Motor	__ __
Problem-solving	__ __
Personal-Social	__ __

Is child **currently breastfeeding**? ☐ Yes ☐ No ☐ Don't know

Age: 9 months Visit Date __ __ / __ __ / __ __

Weight ____ ____ *lb,* ____ ____ *oz.* ***or*** ____ ____ ____ ____ *gm*

Length ____ ____ *in* ***or*** ____ ____ *cm*

Occipitofrontal head circumference ____ ____ *in* ***or*** ____ ____ *cm*

Signs of abuse/neglect ☐ Yes ☐ No ☐ Don't know

Has child reached appropriate developmental milestones? ☐ Yes ☐ No ☐ Don't know

ASQ Screening Test

Communication	__ __
Gross Motor	__ __
Fine Motor	__ __
Problem-solving	__ __
Personal-Social	__ __

Is child **currently breastfeeding**? ☐ Yes ☐ No ☐ Don't know

Age: 12 months Visit Date __ __ / __ __ / __ __

Weight ____ ____ *lb,* ____ ____ *oz.* ***or*** ____ ____ ____ ____ *gm*

Length ____ ____ *in* ***or*** ____ ____ *cm*

Occipitofrontal head circumference ____ ____ *in* ***or*** ____ ____ *cm*

Signs of abuse/neglect ☐ Yes ☐ No ☐ Don't know

Has child reached appropriate developmental milestones? ☐ Yes ☐ No ☐ Don't know

ASQ Screening Test

Communication	__ __
Gross Motor	__ __
Fine Motor	__ __
Problem-solving	__ __
Personal-Social	__ __

Is child **currently breastfeeding**? ☐ Yes ☐ No ☐ Don't know

Age when breastfeeding was discontinued: ____ ____ weeks ***or*** ____ ____ months

Age when solid food was introduced: ____ ____ weeks ***or*** ____ ____ months

Blood Lead Test _____ _____ . _____ mcg/dL Date of test __ __ / __ __ / __ __

Anemia Test Hemoglobin _____ _____ . _____ g/dL Date of test __ __ / __ __ / __ __

Hematocrit _____ _____ . _____ %

NOTE: NEED PEDIATRIC CLINICIANS' INPUT:

- **Are the following developmental screening tests being used? If so, at what age/visit(s)?**

1) Southwest Autism Research and Referral Center (SARRC) Autism Screening

How are scores recorded?

2) Denver Developmental Screening Test-II (DDST-II)

Personal-Social	__ __
Fine motor-Adaptive	__ __
Language	__ __
Gross motor	__ __

- **Is there anything else missing or changes/revisions needed?**

Information to be abstracted from medical record as available.

PREGNANCY			DELIVERY	POSTPARTUM
1st trimester	**2nd trimester**	**3rd trimester**		
Before 13 weeks	13-26 weeks	>27 weeks	Birth	6 weeks
Maternal				
Baseline Questionnaire				
Blood and Urine	Blood and Urine	Blood and Urine	Blood and Urine	Blood and Urine
Prenatal chart review	Prenatal chart review	Prenatal chart review	L&D chart review:	Postpartum chart review
Blood pressure, vital signs, height, weight	Blood pressure, vital signs, height, weight	Blood pressure, vital signs, height, weight	Blood pressure, vital signs, height, weight	Blood pressure, vital signs, height, weight
Complete blood count (CBC): Anemia = Hct<35%	Complete blood count (CBC): Anemia = Hct<35%	Complete blood count (CBC): Anemia = Hct<35%		Follow-up Questionnaire
Blood Type and Rh Antibody Screen			Delivery complications	
Glucose Tolerance Test (1-hour) plus 3-hour if abnormal	serum Alpha-Fetal Protein (AFP) "quad" 4-part also includes: hCG, estriol, inhibin	Glucose Tolerance Test (1-hour) plus 3-hour if abnormal	· Meconium staining (of amniotic fluid)	
HIV	Chorionic villus sampling		· Intrauterine hypoxia	
Hgb A1c	ROM rupture of membranes	ROM rupture of membranes	· Fetal distress	
Serology (Rapid Plasma Reagin (RPR) for Syphilis)	PROM premature rupture of membranes	PROM premature rupture of membranes	· Stillbirth	
Rubella Titer	UOP urine output	UOP urine output	Labor complications	
HBsAg (surface antigen of the Hepatitis-B-Virus (HBV))			- Precipitous labor	
GC Culture (Gonorrhea)			- Prolonged labor	
Chlamydia Culture			- Shoulder dystocia	
Pap Smear as needed			- Breech presentation	
Urinalysis with Culture & Sensitivity	Urinalysis with Culture & Sensitivity	Urinalysis with Culture & Sensitivity	- Nuchal cord	
Group B Streptococcus (GBS)			Delivery Type	
Pregnancy-related medical conditions:	Pregnancy-related medical conditions:	Pregnancy-related medical conditions:	- Vaginal	
- Hypertension (HTN), blood pressure	- Hypertension (HTN), blood pressure	- Hypertension (HTN), blood pressur	- Vaginal Assisted	
- Preeclampsia/Eclampsia	- Preeclampsia/Eclampsia	- Preeclampsia/Eclampsia	- Scheduled Cesarean	
- Preeclampsia with chronic HTN	- Preeclampsia with chronic HTN	- Preeclampsia with chronic HTN	- Emergency Cesarean	
- Gestational diabetes	- Gestational diabetes	- Gestational diabetes	· Placental abruption	
- Hypothyroidism (including subclinical)	- Hypothyroidism (including subclinical)	- Hypothyroidism (including subclinic	· Infection	
- Autoimmune diseases	- Autoimmune diseases	- Autoimmune diseases	- STD	
- Anemia	- Anemia	- Anemia	- TORCH	
- Other pregnancy-onset conditions	- Other pregnancy-onset conditions	- Other pregnancy-onset conditions	- other bacterial	
			- other viral	
			· Postpartum complications	
			- Endometritis	
			- Hemorrhage	
			- Depression	

Fetal			**Baby**	12 months
	Ultrasound	Ultrasound	Cord blood	Breastfeeding patterns
	Kick counts (diary)	Kick counts (diary)	Birth chart review:	Weight, length, head circumference
	Gestational age (weeks)	Gestational age (weeks)	Infant sex (altered sex ratio)	Growth curve results
	Multiple fetuses	Multiple fetuses	Apgar scores	Infections (number and type)
	Fetal growth/ intrauterine growth restriction	Fetal growth/ intrauterine growth restriction	Neonatal complication	immunizations - to date
			- Respiratory distress	Diagnoses of any chronic conditions
			- Meconium aspiration syndrome	Cause of mortality
			- Neonatal jaundice	
			- Infection	
			Gestational age at birth	
			- Very preterm (<32 weeks)	
			- Preterm (<37 weeks)	
			- Postterm (>42 weeks)	
			Birth weight (BW)	
			- Very low BW (<1500g)	
			- Low BW (<2500g)	
			- Macrosomia (>4000g)	
			Birth length	
			OFC - Occipitofrontal circumference (head circumference)	
			Congenital anomalies, major	
			Congenital anomalies, minor	
			· Hearing loss (screening results)	
			· Metabolic (screening results)	
			· Immunodeficiency	
			- Immune function markers	
			Mortality	
			- Neonatal (birth to <28 days)	
			- Postneonatal (>28 to 364 days)	
			- Infant (birth to 364 days)	
			· Sudden infant death syndrome (SIDS)	