

THE U.S. ZIKA PREGNANCY REGISTRY

CALIFORNIA DATA SUBMISSION PROCESS

Maternal Health History Form

The California Department of Public Health (CDPH) is participating in the U.S. Zika Pregnancy Registry and is the point of contact for California data submission to the Centers for Disease Control and Prevention (CDC).

If you require this document in an alternate format, please contact ZikaOutcomes@cdph.ca.gov.

Who Is Eligible for the Registry?

- Pregnant women in the United States with laboratory evidence of Zika virus infection (positive or equivocal test results, regardless of whether they have symptoms) and periconceptionally, prenatally, or perinatally exposed infants born to these women.
- Infants with laboratory evidence of congenital Zika virus infection (positive or equivocal test results, regardless of whether they have symptoms) and their mothers.

To participate, follow the directions below:

Healthcare Provider Instructions	Local Health Department Instructions
<ul style="list-style-type: none"> ▪ Healthcare providers should contact their Local Health Department (LHD) for questions about data submission. ▪ Providers may be contacted by either the LHD or CDPH for Zika pregnancy and infant outcomes data collection. ▪ Visit the US Zika Pregnancy Registry webpage for more information on reporting Zika pregnancy and infant outcomes to CDPH. 	<ul style="list-style-type: none"> ▪ Local Health Departments may choose to follow up with healthcare providers or ask CDPH staff to follow-up. LHDs should inform CDPH of the LHD preference at: ZikaOutcomes@cdph.ca.gov. ▪ Various methods (e.g., medical record abstraction, telephone interview) can be used to collect surveillance information for the Registry. ▪ LHDs contacting providers to complete the Registry forms directly should insert the LHD contact information below for provider submission. ▪ LHDs should ensure completion of the attached form and then submit to CDPH by e-mail or fax as instructed below.

FORM PROCESSING INSTRUCTIONS

Send Registry forms to:

California Department of Public Health

Fax: (510) 620-3152

Phone: (510) 620-3151

Email: ZikaOutcomes@cdph.ca.gov

(Please send a message for instructions **before** submission).

My Local Health Department at the address below:

Phone: _____

Security note:

-Call prior to faxing forms to CDPH or Local Health Department.

*-Please **DO NOT** scan and email documents before receiving instructions.*

HIPAA Privacy Rule permits providers to disclose PHI without authorization to public health authorities for the purposes of preventing or controlling disease.

The CDPH California Birth Defects Monitoring Program (CBDMP) is authorized to conduct studies to investigate the causes of birth defects (H&S section 103840).



Registry ID _____

State/Territory ID _____



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



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Please return completed form via secure fax to 510-620-3152 or encrypted email to ZikaOutcomes@cdph.ca.gov

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)		
Maternal Zika Virus History		
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 st , 2 nd , 3 rd)		
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 outside the US states or US territories where there was active Zika virus transmission during the periconceptional period or during pregnancy? (http://www.cdc.gov/zika/geo/active-countries.html) <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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If incoming or outgoing travel, please list location and dates of travel:	
MHH.21. Country of exposure (1) _____	MHH.22. Start Date _____ End Date _____ <input type="checkbox"/> Start date is same as LMP
MHH.23. Country of exposure (2) _____	MHH.24. Start Date _____ End Date _____
MHH.25. Country of exposure (3) _____	MHH.26. Start Date _____ End Date _____ <input type="checkbox"/> Start date is same as LMP
MHH.27. Was the Zika virus exposure within the 50 states, DC, or territories? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	
If yes, separately list each state or territory where Zika virus exposure occurred, and dates of possible exposure:	
MHH.28. State or territory 1 _____	MHH.29. Start Date _____ End Date _____ <input type="checkbox"/> Start date is same as LMP <input type="checkbox"/> Still at location
MHH.30. State or territory 2 _____	MHH.31. Start Date _____ End Date _____ <input type="checkbox"/> Start date is same as LMP <input type="checkbox"/> Still at location
MHH.32. State or territory 3 _____	MHH.33. Start Date _____ End Date _____ <input type="checkbox"/> Start date is same as LMP <input type="checkbox"/> Still at location
MHH.34. 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>	
MHH.35. 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	
MHH.36. 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	
MHH.37. 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	
Maternal Health History (<u>Underlying maternal illness</u>)	
MHH.38. Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	
MHH.39. Maternal Phenylketonuria (PKU) <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	
MHH.40. Hypothyroidism <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	
MHH.41. High Blood Pressure or Hypertension <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	
MHH.42. Other underlying illness(es): <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	
MHH.43. If yes, specify: _____	
Pregnancy Information	
MHH.44. Last menstrual period (LMP): _____	MHH.45. Estimated delivery date (EDD): _____
MHH.46. Estimated delivery date based on (<i>check all that apply</i>): <input type="checkbox"/> LMP <input type="checkbox"/> 1 st trimester ultrasound <input type="checkbox"/> 2 nd trimester ultrasound <input type="checkbox"/> 3 rd trimester ultrasound <input type="checkbox"/> Other, specify _____	

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

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

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

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

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