

| U.S. Zika Pregnancy Registry and Birth Defects Surveillance — IntegratedMaternal Health History FormThese data are considered confidential and will be stored in a secure database at the Centers for Disease Control and Prevention. | | | | | | | | | | | | | | | | | | | |
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| Please return completed form via SAMS or secure FTP—request access from [ZIKApregnancy@cdc.gov](mailto:ZIKApregnancy@cdc.gov)The form can also be sent by encrypted email to this address or by secure fax to 404-718-1013 or 404-718-2200 | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |
| MHH.1. State/Territory ID:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | MHH.2. Maternal Age at Diagnosis: \_\_\_\_\_ | | | | | | MHH.3. State/Territory reporting: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **MHH.4. County reporting:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
| MHH.5. Ethnicity: 🞎 Hispanic or Latino 🞎 Not Hispanic or Latino | | | | | | | | | | | | | | | | | | | |
| MHH.6. Race *(check all that apply)*:  🞎 American Indian or Alaskan Native 🞎 Asian 🞎 Black or African-American 🞎 Unknown/Not Specified  🞎 Native Hawaiian or other Pacific Islander 🞎 White 🞎 Other, specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | |
| MHH.**7. Indication for maternal Zika virus testing:** 🞎 Exposure history only, no known fetal abnormalities  🞎 Exposure history and fetal abnormalities  🞎 No known exposure (*skip to MHH.38*) | | | | | | | | | | | | | | | | | | | |
| **Maternal Zika Virus History** | | | | | | | | | | | | | | | | | | | |
| MHH.8. Date of Zika virus symptom onset: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **OR** MHH.9. 🞎 Asymptomatic  **MHH.10.** If symptomatic, gestational age at onset: \_\_\_\_\_\_\_\_\_\_\_\_(weeks)\_\_\_\_\_\_\_\_\_\_\_\_(days)  **MHH.11.** If gestational age or date not known, trimester of symptom onset \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (1st, 2nd, 3rd) | | | | | | | | | | | | | | | | | | | |
| **MHH.12. Symptoms of mother’s Zika virus disease:** *(check all that apply)*  🞎 Fever *(if measured)* \_\_\_\_\_oF or \_\_\_\_\_oC 🞎 Arthralgia 🞎 Conjunctivitis 🞎 Rash  🞎 Other clinical presentation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  MHH.13. If rash, check all that apply🞎 Maculopapular 🞎 Petechial 🞎 Purpuric 🞎 Pruritic  Describe rash distribution\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | |
| **MHH.**14. Hospitalized for Zika virus disease 🞎 No 🞎 Yes 🞎 Unknown | | | | | | | | | | | | | | | | | | | |
| **MHH.**15. Maternal Death 🞎 No 🞎 Yes 🞎 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?**  🞎 Human-mosquito-human (vector) 🞎 Sexual 🞎 Other, please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎 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>)  🞎 No 🞎 Yes 🞎 Unknown (*If ‘no’ or ‘unknown’, skip to MHH 27)*  **MHH.20. *If yes*, please characterize the type of travel:**  🞎 Incoming travel (one way travel to US states from an area with active Zika virus transmission)  🞎 Incoming travel (one way travel to US territories from an area with active Zika virus transmission)  🞎 Outgoing and incoming travel (roundtrip from US states to an area with active Zika virus transmission)  🞎 Outgoing and incoming travel (roundtrip from US territories to an area with active Zika virus transmission) | | | | | | | | | | | | | | | | | | | | |
| **If incoming or outgoing travel, please list location and dates of travel:** | | | | | | | | | | | | | | | | | | | |
| **MHH.21.** Country of exposure (1)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | **MHH.22.** Start Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_  🞎 Start date is same as LMP | | | | | | | | End Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **MHH.23.** Country of exposure (2)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | **MHH.24.** Start Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_  🞎 Start date is same as LMP | | | | | | | | End Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **MHH.25.** Country of exposure (3)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | **MHH.26.** Start Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_  🞎 Start date is same as LMP | | | | | | | | End Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **MHH.27.** **Was the** **Zika virus** **exposure within the 50 states, DC, or territories?** 🞎 No 🞎 Yes 🞎 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  🞎 Start date is same as LMP | | | | | | | | End Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  🞎 Still at location | | | |
| **MHH.30*.* State or territory 2**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | **MHH.31.**Start Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  🞎 Start date is same as LMP | | | | | | | | End Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  🞎 Still at location | | | |
| **MHH.32*.* State or territory 3**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | **MHH.33.**Start Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  🞎 Start date is same as LMP | | | | | | | | End Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  🞎 Still at location | | | |
| **MHH.34.** **If suspected mode of transmission is sexual, was the pregnant woman’s sexual partner(s):**  🞎 Male 🞎 Female *Please check all that apply* | | | | | | | | | | | | | | | | | | | |
| **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 spending any time in an area with active Zika virus transmission?**  🞎 No 🞎 Yes 🞎 Unknown | | | | | | | | | | | | | | | | | | | |
| **MHH.36.If yes, was there unprotected sexual contact while partner(s) had this illness?**  🞎 No 🞎 Yes 🞎 Unknown | | | | | | | | | | | | | | | | | | | |
| **MHH.37. Did partner have a test that demonstrated laboratory evidence of Zika virus infection?**  🞎 No 🞎 Yes 🞎 Unknown | | | | | | | | | | | | | | | | | | | |
| **Maternal Health History *(Underlying maternal illness)*** | | | | | | | | | | | | | | | | | | | |
| **MHH.38. Diabetes** 🞎 No 🞎 Yes 🞎 Unknown  **MHH.39.** **Maternal Phenylketonuria (PKU)** 🞎 No 🞎 Yes 🞎 Unknown  **MHH.40.** **Hypothyroidism**  🞎 No 🞎 Yes 🞎 Unknown  **MHH.41.** **High Blood Pressure or Hypertension** 🞎 No 🞎 Yes 🞎 Unknown MHH.42. Other underlying illness(es): 🞎 No 🞎 Yes 🞎 UnknownMHH.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** (*check all that apply*):  🞎 LMP 🞎 1st trimester ultrasound 🞎 2nd trimester ultrasound 🞎 3rd trimester ultrasound  🞎 Other, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | |
| **OB History:** | **MHH.47.** # pregnancies (including current pregnancy) \_\_\_\_\_ **MHH.49**. # miscarriages \_\_\_\_\_ | | | | | | | | | | | | | | **MHH.48.** # living children \_\_\_\_\_  **MHH.50**. # elective terminations \_\_\_\_\_ | | | | |
| MHH.51. Prior fetus/infant with microcephaly: 🞎 No 🞎 Yes 🞎 Unknown  MHH.52. If yes, cause genetic?: 🞎 No 🞎 Yes 🞎 Unknown | | | | | | | | | | | | | | | | | | | |
| **MHH.53. Gestation:** 🞎 Single🞎 Twins 🞎 Triplets+ | | | | | | | | | | | | | | | | | | | |
| **Substance use during this pregnancy:** | | | | **MHH.54.** Alcohol use:  **MHH.55.**Cocaine use:  **MHH.56.** Smoking: | | | | | | 🞎 No 🞎 Yes 🞎 Unknown  🞎 No 🞎 Yes 🞎 Unknown  🞎 No 🞎 Yes 🞎Unknown | | | | | | | | | |
| **Complications during current pregnancy** | | | | | | | | | | | | | | | | | | | |
| **MHH.57.** | | Toxoplasmosis infection: | | | | | | | | 🞎 No 🞎 Yes 🞎 Unknown | | | | | | | | | |
| **MHH.58.** | | Cytomegalovirus infection: | | | | | | | | 🞎 No 🞎 Yes 🞎 Unknown | | | | | | | | | |
| **MHH.59.** | | Herpes Simplex infection: | | | | | | | | 🞎 No 🞎 Yes 🞎 Unknown | | | | | | | | | |
| **MHH.60.** | | Rubella infection: | | | | | | | | 🞎 No 🞎 Yes 🞎 Unknown | | | | | | | | | |
| **MHH.61.** | | Lymphocytic choriomeningitis virus infection: | | | | | | | | 🞎 No 🞎 Yes 🞎 Unknown | | | | | | | | | |
| **MHH.62.** | | Syphilis infection: | | | | | | | | 🞎 No 🞎 Yes 🞎 Unknown | | | | | | | | | |
| MHH.63. If yes for infection testing during current pregnancy, please describe results: | | | | | | | | | | | | | | | | | | | |
| **MHH.64.** | | Fetal genetic abnormality: | | | | | | | | 🞎 No 🞎 Yes, describe \_\_\_\_\_\_\_\_\_\_  🞎Unknown | | | | | | | | | |
| **MHH.65.** | | Gestational diabetes: | | | | | | | | 🞎 No 🞎 Yes 🞎Unknown | | | | | | | | | |
| **MHH.66.** | | Pregnancy-related hypertension: | | | | | | | | 🞎 No 🞎 Yes 🞎Unknown | | | | | | | | | |
| **MHH.67.** | | Intrauterine death of a twin: | | | | | | | | 🞎 No 🞎 Yes 🞎Unknown | | | | | | | | | |
| **MHH.68.** | | Other: 🞎 No 🞎 Yes 🞎Unknown  **MHH.69.** If yes, please *s*pecify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | |
| **MHH.70. Medications during pregnancy:** 🞎 No 🞎 Yes 🞎Unknown  **MHH.71.** If yes, specify (*please specify type and see guide for further instructions):* | | | | | | | | | | | | | | | | | | | |
| **Pregnancy Losses:**  *Please also complete pertinent sections of neonatal assessment form* | | | | | | | | | | | | | | | | | | | |
| MHH.72. Did this pregnancy end in miscarriage **(<20 weeks of gestation)?**  🞎 No 🞎 Yes🞎UnknownMHH.73. Date: *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* ORgestational age*\_\_\_\_\_\_\_* weeks  MHH.74. Please describe any abnormalities noted \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | |
| MHH.75. Did this pregnancy end in **stillbirth (intrauterine fetal demise) (≥20 weeks of gestation)?**  🞎 No 🞎 Yes🞎UnknownMHH.76.Date: *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  ORgestational age*\_\_\_\_\_\_\_* weeks  MHH.77. Please describe any abnormalities noted\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | |
| MHH.78. Was this pregnancy terminated?  🞎 No 🞎 Yes 🞎Unknown MHH.79. Date: *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  OR gestational age *\_\_\_\_\_\_* weeks  MHH.80. Please describe any abnormalities noted\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | |
| **Maternal Prenatal Imaging and Diagnostics** | | | | | | | | | | | | | | | | | | | |
| **MHH.81. Date(s) of ultrasound(s):**  *\_\_\_\_\_\_\_\_\_*  🞎 **MHH.82.** *Check if date approximated*  **MHH.83***. If date not known,* Gestational age  *\_\_\_\_\_ \_\_\_\_\_* (weeks) (days) | | | **MHH.84. Overall fetal ultrasound results:** 🞎 Normal 🞎 Abnormal | | | | | | | | | | | | | | | | |
| **MHH.85.** 🞎 Reported by patient/healthcare provider 🞎 Ultrasound report | | | | | | | | | | | | | | | | |
| **MHH.86.** Head circumference (HC) \_\_\_\_\_\_\_cm  **MHH.87.** 🞎 Normal 🞎 Abnormal (*by physician report*) | | | | | | | | | | | | | | | | |
| **MHH.88.** Biparietal diameter (BPD) \_\_\_\_\_\_cm  **MHH.89.** Femur length (FL) \_\_\_\_\_cm  **MHH.90.** Abdominal circumference (AC) \_\_\_\_\_cm | | | | | | | | | | | | | | | | |
| **MHH.91.** 🞎 Symmetric intrauterine growth restriction (IUGR)  🞎 Asymmetric IUGR (HC%>AC% or HC%>FL%) | | | | | | | | | | | | | | | | |
| **MHH.92.** Microcephaly | | | | | | | 🞎 No 🞎 Yes | | | | **MHH.93.** Intracranial calcifications | | | | | 🞎 No 🞎 Yes |
| **MHH.94.** Cerebral /cortical atrophy | | | | | | | 🞎 No 🞎 Yes | | | | **MHH.95.** Abnormal cortical gyral patterns (e.g., polymicrogyria, lissencephaly, pachygyria, schizencephaly, gray matter heterotopia) | | | | | 🞎 No 🞎 Yes |
| **MHH.96.** Corpus callosum abnormalities | | | | | | | 🞎 No 🞎 Yes | | | | **MHH.97.** Cerebellar abnormalities | | | | | 🞎 No 🞎 Yes |
| **MHH.98.** Porencephaly | | | | | | | 🞎 No 🞎 Yes | | | | **MHH.99.** Hydranencephaly | | | | | 🞎 No 🞎 Yes |
| **MHH.100.** Moderate or severeventriculomegaly /  hydrocephaly | | | | | | | 🞎 No 🞎 Yes | | | | **MHH.101.** Fetal brain disruption sequence (collapsed skull, overlapping sutures, prominent occipital bone, scalp rugae) | | | | | 🞎 No 🞎 Yes |
| **MHH.102.** Other major brain abnormalities | | | | | | | 🞎 No 🞎 Yes | | | | **MHH.103.** Anencephaly / acrania | | | | | 🞎 No 🞎 Yes |
| **MHH.104.** Encephalocele | | | | | | | 🞎 No 🞎 Yes | | | | **MHH.105.** Spina bifida | | | | | 🞎 No 🞎 Yes |
| **MHH.106.** Holoprosencephaly /  arhinencephaly | | | | | | | 🞎 No 🞎 Yes | | | | **MHH.107.** Structural eye abnormalities / dysplasia | | | | | 🞎 No 🞎 Yes |
| **MHH.108.** Arthrogryposis | | | | | | | 🞎 No 🞎 Yes | | | | **MHH.109.** Clubfoot | | | | | 🞎 No 🞎 Yes |
| **MHH.110.** Hydrops | | | | | | | 🞎 No 🞎 Yes | | | | **MHH.111.** Ascites | | | | | 🞎 No 🞎 Yes |
| **MHH.112.** Other | | | | | | | 🞎 No 🞎 Yes If yes, describe: | | | | | | | | | |
| **MHH.113. Description of abnormal ultrasound findings:** | | | | | | | | | | | | | | | | | | | |
| **MHH.114. Date(s) of Ultrasound(s):**  *\_\_\_\_\_\_\_\_\_\_\_\_*  🞎 **MHH.115.** *check*  *if date approximated*  **MHH.116.**  *if date not known,* gestational age  *\_\_\_\_\_ \_\_\_\_\_* (weeks) (days) | | | **MHH.117. Overall fetal ultrasound results:** 🞎 Normal 🞎 Abnormal | | | | | | | | | | | | | | | | |
| **MHH.118.** 🞎 Reported by patient/healthcare provider  🞎 Ultrasound report | | | | | | | | | | | | | | | | |
| **MHH.119.** Head circumference (HC) \_\_\_\_\_\_\_cm  **MHH.120.** 🞎 Normal 🞎 Abnormal (*by physician report*) | | | | | | | | | | | | | | | | |
| **MHH.121.** Biparietal diameter (BPD) \_\_\_\_\_\_cm  **MHH.122.** Femur length (FL) \_\_\_\_\_cm  **MHH.123.** Abdominal circumference (AC) \_\_\_\_\_cm | | | | | | | | | | | | | | | | |
| **MHH.124.** 🞎 Symmetric IUGR 🞎 Asymmetric IUGR (HC%>AC% or HC%>FL%) | | | | | | | | | | | | | | | | |
| **MHH.125.** Microcephaly | | | | | | | 🞎 No 🞎 Yes | | | | **MHH.126.** Intracranial calcifications | | | | | 🞎 No 🞎 Yes |
| **MHH.127.** Cerebral / cortical atrophy | | | | | | | 🞎 No 🞎 Yes | | | | **MHH.128.** Abnormal cortical gyral patterns (e.g., polymicrogyria, lissencephaly, pachygyria, schizencephaly, gray matter heterotopia) | | | | | 🞎 No 🞎 Yes |
| **MHH.129.** Corpus callosum abnormalities | | | | | | | 🞎 No 🞎 Yes | | | | **MHH.130.** Cerebellar abnormalities | | | | | 🞎 No 🞎 Yes |
| **MHH.131.** Porencephaly | | | | | | | 🞎 No 🞎 Yes | | | | **MHH.132.** Hydranencephaly | | | | | 🞎 No 🞎 Yes |
| **MHH.133.** Moderate or severeventriculomegaly /  hydrocephaly | | | | | | | 🞎 No 🞎 Yes | | | | **MHH.134.** Fetal brain disruption sequence (collapsed skull, overlapping sutures, prominent occipital bone, scalp rugae) | | | | | 🞎 No 🞎 Yes |
| **MHH.135.** Other major brain abnormalities | | | | | | | 🞎 No 🞎 Yes | | | | **MHH.136.** Anencephaly / acrania | | | | | 🞎 No 🞎 Yes |
| **MHH.137.** Encephalocele | | | | | | | 🞎 No 🞎 Yes | | | | **MHH.138.** Spina bifida | | | | | 🞎 No 🞎 Yes |
| **MHH.139.** Holoprosencephaly /  arhinencephaly | | | | | | | 🞎 No 🞎 Yes | | | | **MHH.140.** Structural eye abnormalities / dysplasia | | | | | 🞎 No 🞎 Yes |
| **MHH.141.** Arthrogryposis | | | | | | | 🞎 No 🞎 Yes | | | | **MHH.142.** Clubfoot | | | | | 🞎 No 🞎 Yes |
| **MHH.143.** Hydrops | | | | | | | 🞎 No 🞎 Yes | | | | **MHH.144.** Ascites | | | | | 🞎 No 🞎 Yes |
| **MHH.145.** Other | | | | | | | 🞎 No 🞎 Yes If yes, describe: | | | | | | | | | |
| **MHH.146. Description of abnormal ultrasound findings:** | | | | | | | | | | | | | | | | | | | |
| **MHH.147. Date(s) of Ultrasound(s):**  *\_\_\_\_\_\_\_\_\_\_\_\_*    🞎 **MHH.148.** *check if date approximated*  **MHH.149.** *if date not known,* gestational age  *\_\_\_\_\_ \_\_\_\_\_* (weeks) (days) | | | **MHH.150. Overall fetal ultrasound results:** 🞎 Normal 🞎 Abnormal | | | | | | | | | | | | | | | | |
| **MHH.151.** 🞎 Reported by patient/healthcare provider 🞎 Ultrasound report | | | | | | | | | | | | | | | | |
| **MHH.152.** Head circumference (HC)\_\_\_\_\_\_\_cm  **MHH.153.** 🞎 Normal 🞎 Abnormal (*by physician report*) | | | | | | | | | | | | | | | | |
| **MHH.154.** Biparietal diameter (BPD) \_\_\_\_\_\_cm  **MHH.155.** Femur length (FL) \_\_\_\_\_cm  **MHH.156.**Abdominal circumference (AC) \_\_\_\_\_cm | | | | | | | | | | | | | | | | |
| **MHH.157.** 🞎 Symmetric IUGR 🞎 Asymmetric IUGR (HC%>AC% or HC%>FL%) | | | | | | | | | | | | | | | | |
| **MHH.158.** Microcephaly | | | | | | | 🞎 No 🞎 Yes | | | | **MHH.159.** Intracranial calcifications | | | | | 🞎 No 🞎 Yes |
| **MHH.160.** Cerebral / cortical atrophy | | | | | | | 🞎 No 🞎 Yes | | | | **MHH.161.** Abnormal cortical gyral patterns (e.g., polymicrogyria, lissencephaly, pachygyria, schizencephaly, gray matter heterotopia) | | | | | 🞎 No 🞎 Yes |
| **MHH.162.** Corpus callosum abnormalities | | | | | | | 🞎 No 🞎 Yes | | | | **MHH.163.** Cerebellar abnormalities | | | | | 🞎 No 🞎 Yes |
| **MHH.164.** Porencephaly | | | | | | | 🞎 No 🞎 Yes | | | | **MHH.165.** Hydranencephaly | | | | | 🞎 No 🞎 Yes |
| **MHH.166.** Moderate or severeventriculomegaly /  hydrocephaly | | | | | | | 🞎 No 🞎 Yes | | | | **MHH.167.** Fetal brain disruption sequence (collapsed skull, overlapping sutures, prominent occipital bone, scalp rugae) | | | | | 🞎 No 🞎 Yes |
| **MHH.168.** Other major brain abnormalities | | | | | | | 🞎 No 🞎 Yes | | | | **MHH.169.** Anencephaly / Acrania | | | | | 🞎 No 🞎 Yes |
| **MHH.170.** Encephalocele | | | | | | | 🞎 No 🞎 Yes | | | | **MHH.171.** Spina bifida | | | | | 🞎 No 🞎 Yes |
| **MHH.172.** Holoprosencephaly /  arhinencephaly | | | | | | | 🞎 No 🞎 Yes | | | | **MHH.173.** Structural eye abnormalities / dysplasia | | | | | 🞎 No 🞎 Yes |
| **MHH.174.** Arthrogryposis | | | | | | | 🞎 No 🞎 Yes | | | | **MHH.175.** Clubfoot | | | | | 🞎 No 🞎 Yes |
| **MHH.176.** Hydrops | | | | | | | 🞎 No 🞎 Yes | | | | **MHH.177.** Ascites | | | | | 🞎 No 🞎 Yes |
|  | | | **MHH.178.** Other | | | | | | | 🞎 No 🞎 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:**  🞎 No 🞎 Yes (If yes, please answer questions below) | | | | | | | | | | | | | | | | | | | |
| **MHH.181. Date(s) of MRI(s):**  *\_\_\_\_\_\_\_\_\_*  🞎 **MHH.182.** *check if date is approximated* | | | **MHH.184. Overall fetal MRI results:** 🞎 Normal 🞎 Abnormal | | | | | | | | | | | | | | | | |
| **MHH.185.** 🞎 Reported by patient/healthcare provider🞎 MRI report | | | | | | | | | | | | | | | | |
| **MHH.186.** Head circumference (HC) \_\_\_cm  **MHH.187.** 🞎 Normal 🞎 Abnormal (*by physician report*) | | | | | | | | | | | | | | | | |
| **MHH.188.** Biparietal diameter (BPD) \_\_\_\_\_cm  **MHH.189.** Femur length (FL) \_\_\_\_\_cm  **MHH.190.** Abdominal circumference (AC) \_\_\_\_\_cm | | | | | | | | | | | | | | | | |
| **MHH.191.** 🞎 Symmetric IUGR 🞎 Asymmetric IUGR (HC%>AC% or HC%>FL%) | | | | | | | | | | | | | | | | |
| **MHH.183.** *if date not known,* gestational age  *\_\_\_\_\_ \_\_\_\_\_* (weeks) (days) | | | **MHH.192.** Microcephaly | | | | | | | 🞎 No 🞎 Yes | | | | **MHH.193.** Intracranial calcifications | | | | | 🞎 No 🞎 Yes |
| **MHH.194.** Cerebral / cortical atrophy | | | | | | | 🞎 No 🞎 Yes | | | | **MHH.195.** Abnormal cortical gyral patterns (e.g., polymicrogyria, lissencephaly, pachygyria, schizencephaly, gray matter heterotopia) | | | | | 🞎 No 🞎 Yes |
| **MHH.196.** Corpus callosum abnormalities | | | | | | | 🞎 No 🞎 Yes | | | | **MHH.197.** Cerebellar abnormalities | | | | | 🞎 No 🞎 Yes |
| **MHH.198.** Porencephaly | | | | | | | 🞎 No 🞎 Yes | | | | **MHH.199.** Hydranencephaly | | | | | 🞎 No 🞎 Yes |
| **MHH.200.** Moderate or severeventriculomegaly /  hydrocephaly | | | | | | | 🞎 No 🞎 Yes | | | | **MHH.201.** Fetal brain disruption sequence (collapsed skull, overlapping sutures, prominent occipital bone, scalp rugae) | | | | | 🞎 No 🞎 Yes |
| **MHH.202.** Other major brain abnormalities | | | | | | | 🞎 No 🞎 Yes | | | | **MHH.203.** Anencephaly / acrania | | | | | 🞎 No 🞎 Yes |
| **MHH.204.** Encephalocele | | | | | | | 🞎 No 🞎 Yes | | | | **MHH.205.** Spina bifida | | | | | 🞎 No 🞎 Yes |
| **MHH.206.** Holoprosencephaly /  arhinencephaly | | | | | | | 🞎 No 🞎 Yes | | | | **MHH.207.** Structural eye abnormalities / dysplasia | | | | | 🞎 No 🞎 Yes |
| **MHH.208.** Arthrogryposis | | | | | | | 🞎 No 🞎 Yes | | | | **MHH.209.** Clubfoot | | | | | 🞎 No 🞎 Yes |
| **MHH.210.** Hydrops | | | | | | | 🞎 No 🞎 Yes | | | | **MHH.211.** Ascites | | | | | 🞎 No 🞎 Yes |
|  | | | **MHH.212.** Other | | | | | | | 🞎 No 🞎 Yes If yes, describe: | | | | | | | | | |
| **MHH.213. Description of abnormal MRI findings:** | | | | | | | | | | | | | | | | | | | |
| **MHH.214. Amniocentesis performed:**  🞎 No 🞎 Yes  *If Zika virus testing performed on amniotic fluid, please enter in Laboratory Results Form.*  *If cytogenetic testing performed on amniotic fluid, please enter below.* | | | | | | | | | | | | | | | | | | | |
| **Prenatal (Fetal) Cytogenetic Testing** | | | | | | | | | | | | | | | | | | | |
| **MHH.215.**  **Prenatal (fetal) cytogenetic testing performed:** 🞎 No 🞎 Yes (If yes, please answer questions below) | | | | | | | | | | | | | | | | | | | |
| **MHH.216. Cytogenetic Tests**  🞎 Karyotype  🞎 FISH  🞎 CGH microarray  🞎 Cell-free DNA  🞎 Other, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | **MHH.217. Date of test:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **MHH.218. Gestational Age:** \_\_\_\_\_(weeks)\_\_\_\_\_ (days) or  **Trimester:** 🞎1st 🞎2nd 🞎3rd | | | | | | | **MHH.219. Specimen type:**  🞎 Amniocentesis  🞎 Chorionic Villus Sampling (CVS)  🞎 Maternal Serum  🞎 Other, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | **MHH.220. Test Result**  🞎 Normal  🞎 Abnormal  🞎 Unknown | |
| **MHH.221. Description of abnormal cytogenetic testing findings:** | | | | | | | | | | | | | | | | | | | |
| **Prenatal (Fetal) Cytogenetic Testing** | | | | | | | | | | | | | | | | | | | |
| **MHH.222.**  **Prenatal (fetal) cytogenetic testing performed:** 🞎 No 🞎 Yes (If yes, please answer questions below) | | | | | | | | | | | | | | | | | | | |
| **MHH.223. Cytogenetic Tests**  🞎 Karyotype  🞎 FISH  🞎 CGH microarray  🞎 Cell-free DNA  🞎 Other, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | **MHH.224. Date of test**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **MHH.225. Gestational Age:** \_\_\_\_\_(weeks)\_\_\_\_\_ (days) or  **Trimester:** 🞎1st 🞎2nd 🞎3rd | | | | | | | **MHH.226. Specimen type:**  🞎 Amniocentesis  🞎 Chorionic Villus Sampling (CVS)  🞎 Maternal Serum  🞎 Other, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | **MHH.227. Test Result**  🞎 Normal  🞎 Abnormal  🞎 Unknown | |
| **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). | | | | | | | | | | | | | | | | | | | |