Visit Code ☐☐.☐ 1

MTN-011 (135) PR-1 (440)

Participant ID

☐☐☐ ☐☐☐☐ - ☐ - 0

Protocol PTID Chk Cohort

Pregnancy Report and History

Report

1. First day of last menstrual period: ☐☐ *dd* ☐☐☐ *MMM* ☐☐ *yy* OR ☐ *amenorrheic for past 6 months*

2. Estimated date of delivery: ☐☐ *dd* ☐☐☐ *MMM* ☐☐ *yy*

3. What information was used to estimate the date of delivery?

	yes	*no*
3a. last menstrual period	☐	☐
3b. initial ultrasound < 20 weeks	☐	☐
3c. initial ultrasound ≥ 20 weeks	☐	☐
3d. physical examination	☐	☐
3e. conception date by assisted reproduction	☐	☐
3f. other, specify: _____	☐	☐

History

	yes	*no*	
4. Has the participant ever been pregnant before?	☐	☐	→ *If no, end of form.*
4a. Is this the participant's first pregnancy since enrollment in this study?	☐	☐	→ *If no, go to item 5.*
4b. Number of full term live births (≥ 37 weeks)	☐☐		
4c. Number of premature live births (< 37 weeks)	☐☐		
4d. Number of spontaneous fetal deaths and/or still births (≥ 20 weeks)	☐☐		
4e. Number of spontaneous abortions (< 20 weeks)	☐☐		
4f. Number of therapeutic/elective abortions	☐☐		
4g. Number of ectopic pregnancies	☐☐		

	yes	*no*	
5. Does the participant have a history of pregnancy complications or fetal/infant congenital anomalies?	☐	☐	→ *If no, end of form.*

5a. If yes, specify: _____

_____

_____

Pregnancy Report and History (PR-1)	
Purpose:	Complete this form when reporting a pregnancy of a study participant post enrollment through termination.
General Information/ Instructions:	A Pregnancy Report and History form is required for each new pregnancy that the participant experiences during the study. • Visit Code: Record the visit code of the visit at which study staff became aware that the participant is/was pregnant.
Item-specific Instructions:	
Item 1:	A complete date is required. Record best estimate if date not known.
Item 2:	A complete date is required.
Item 3d:	Physical examination includes fundal height, uterine size by pelvic exam, and/or fetal heart rate.
Item 5:	Include information on pregnancy complications and fetal/infant congenital anomalies experienced prior to enrolling in the study as well as any conditions experienced/reported during the study.