DALLAS COUNTY HEALTH AND HUMAN SERVICES
Epidemiology

Registry ID _____

ZIKA PREGNANCY SURVEILLANCE FORM: MATERNAL HEALTH HISTORY

These data are considered confidential and will be stored in a secure database at the Centers for Disease Control and Prevention and ***Dallas County Health and Human Services***

Please return completed form by sending an encrypted email to Epidemiology@dallascounty.org or by secure fax to: (214) 819-1933. For assistance with completing these forms, contact DCHHS at (214) 235-1799 or CDC at (770) 488-7100

Mothers Zika Virus Infection

Mother's Name:_____ **Maiden Name:**_____ **DOB:**____/____/____
Last **First** **MI**

MHH.1. State ID_____ **MHH.2. Maternal Age at Diagnosis:**____ **MHH.3. State 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 ☐ Native Hawaiian or other Pacific Islander ☐ White

MHH.7. Indication for maternal Zika virus testing: ☐ Exposure history only, no known fetal abnormalities ☐ Exposure history and fetal abnormalities

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 _____ (1^{st}, 2^{nd}, 3^{rd})

MHH.12. Symptoms of mother's Zika virus disease: *(check all that apply)*

☐ Fever*(if measured)* _____°F **or** _____°C ☐ 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 **If yes, describe**_____
MHH.16. If yes, date of death _____/_____/_____ _____

History of Exposure

MHH.17. What was the suspected mode of Zika virus transmission?

☐ Human-mosquito-human (vector) ☐ Sexual ☐ Other, please specify_____ ☐ Unknown

MHH.18. 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 question 26)*

MHH.19. ***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: _____

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MHH.20. Country of exposure (1) _____	**MHH.21**. Start Date ____/_____/_____ ☐ Start date is same as LMP	End Date ____/_____/_____
MHH.22. Country of exposure (2) _____	**MHH.23**. Start Date ____/_____/_____ ☐ Start date is same as LMP	End Date ____/_____/_____
MHH.24. Country of exposure (3) _____	**MHH.25**. Start Date ____/_____/_____ ☐ Start date is same as LMP	End Date ____/_____/_____

MHH.26. 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.27. State _____	**MHH.28**. Start Date_____/_____/_____ ☐ Start date is same as LMP	End Date _____/_____/_____ ☐ Still at location
MHH.29. State _____	**MHH.30**. Start Date_____/_____/_____ ☐ Start date is same as LMP	End Date _____/_____/_____ ☐ Still at location
MHH.31. State _____	**MHH.32**. Start Date_____/_____/_____ ☐ Start date is same as LMP	End Date _____/_____/_____ ☐ Still at location

MHH.33. If suspected mode of transmission is sexual, was the pregnant woman's sexual partner(s):
☐ Male ☐ Female *Please check all that apply*

MHH.34. 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.35. If yes, was there unprotected sexual contact while partner(s) had this illness?
☐ No ☐ Yes ☐ Unknown

MHH.36. Did partner have a test that demonstrated laboratory evidence of Zika virus infection? ☐ No ☐ Yes ☐ Unknown

Maternal Health History *(Underlying maternal illness)*

MHH.37. Diabetes ☐ No ☐ Yes ☐ Unknown
MHH.38. Maternal Phenylketonuria (PKU) ☐ No ☐ Yes ☐ Unknown
MHH.39. Hypothyroidism ☐ No ☐ Yes ☐ Unknown
MHH.40. High Blood Pressure or Hypertension ☐ No ☐ Yes ☐ Unknown
MHH.41. Other underlying illness (es): ☐ No ☐ Yes ☐ Unknown
MHH.42. If yes, specify: _____

Pregnancy Information

MHH.43. Last menstrual period (LMP): ____/____/____ **MHH.44. Estimated delivery date (EDD):** ____/____/____

MHH.45. Estimated delivery date based on (*check all that apply*):
☐ LMP ☐ U/S (1st trimester) ☐ U/S (2nd trimester) ☐ U/S (3rd trimester)
☐ Other, specify _____

OB **MHH.46.** # pregnancies (including current pregnancy) _____ **MHH.47.** # living children _____

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History: **MHH.48.** # miscarriages _____ **MHH.49.** # elective terminations _____

MHH.50. Prior fetus/infant with microcephaly: ☐ No ☐ Yes ☐ Unknown
MHH.51. If yes, cause genetic?: ☐ No ☐ Yes ☐ Unknown

MHH.52. Gestation: ☐ Single ☐ Twins ☐ Triplets+

Substance use during this pregnancy:	**MHH.53.** Alcohol use:	☐ No ☐ Yes ☐ Unknown
	MHH.54. Cocaine use:	☐ No ☐ Yes ☐ Unknown
	MHH.55. Smoking:	☐ No ☐ Yes ☐ Unknown

Complications during current pregnancy

MHH.56.	Toxoplasmosis infection:	☐ No ☐ Yes ☐ Unknown
MHH.57.	Cytomegalovirus infection:	☐ No ☐ Yes ☐ Unknown
MHH.58.	Herpes Simplex infection:	☐ No ☐ Yes ☐ Unknown
MHH.59.	Rubella infection:	☐ No ☐ Yes ☐ Unknown
MHH.60.	Syphilis infection:	☐ No ☐ Yes ☐ Unknown
MHH.61.	Fetal genetic abnormality:	☐ No ☐ Yes, **MHH.62.** Diagnosis _____ ☐ Unknown
MHH.63.	Gestational diabetes:	☐ No ☐ Yes ☐ Unknown
MHH.64.	Pregnancy-related hypertension:	☐ No ☐ Yes ☐ Unknown
MHH.65.	Intrauterine death of a twin:	☐ No ☐ Yes ☐ Unknown
MHH.66.	Other: ☐ No ☐ Yes ☐ Unknown **MHH.67.** If yes, please specify _____	

MHH.68. Medications during pregnancy: ☐ No ☐ Yes ☐ Unknown
MHH.69. If yes, specify (*please specify type and see guide for further instructions):*

Pregnancy Losses: *Please also complete pertinent sections of neonatal assessment form*

MHH.70. Did this pregnancy end in miscarriage (<20 weeks of gestation)?
☐ No ☐ Yes ☐ Unknown **MHH.71.** Date: _____/_____/_____ *or* gestational age_____ *weeks*
MHH.72. Please describe any abnormalities noted _____

MHH.73. Did this pregnancy end in stillbirth (intrauterine fetal demise) (≥20 weeks of gestation)?
☐ No ☐ Yes ☐ Unknown **MHH.74.** Date: _____/_____/_____ *or* gestational age_____ *weeks*
MHH.75. Please describe any abnormalities noted_____

MHH.76. Was this pregnancy terminated?
☐ No ☐ Yes ☐ Unknown **MHH.77.** Date: _____/_____/_____ *or* gestational age _____ *weeks*
MHH.78. Please describe any abnormalities noted _____

Maternal Prenatal Imaging and Diagnostics

MHH.79. Date(s) of	**MHH.82. Overall fetal ultrasound results:** ☐ Normal ☐ Abnormal
	MHH.83. ☐ Reported by patient/healthcare provider **MHH.84.** ☐ Ultrasound report

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ultrasound(s): ___/___/___ ☐ **MHH.80.** *Check if date approximated* **MHH.81.** *If date not known,* Gestational age _____ *(weeks, days)*	**MHH.85.** Head Circumference (HC) _____cm **MHH.86.** ☐ Normal ☐ Abnormal (*by physician report*)			
	MHH.87. Biparietal diameter (BPD) _____cm **MHH.88.** Femur length (FL) _____cm **MHH.89.** Abdominal circumference (AC) _____cm			
	MHH.90. ☐ Symmetrical intrauterine growth restriction (IUGR) (<5% EFW) ☐ Asymmetrical IUGR (HC<FL or HC <AC)			
	MHH.91. Microcephaly	☐ No ☐ Yes	**MHH.92.** Intracranial calcifications	☐ No ☐ Yes
	MHH.93. Encephalocele	☐ No ☐ Yes	**MHH.94.** Ventriculomegaly	☐ No ☐ Yes
	MHH.95. Cerebral atrophy	☐ No ☐ Yes	**MHH.96.** Ocular anomalies	☐ No ☐ Yes
	MHH.97. Cerebellar abnormalities	☐ No ☐ Yes	**MHH.98.** Corpus callosum abnormalities	☐ No ☐ Yes
	MHH.99. Arthrogryposis	☐ No ☐ Yes	**MHH.100.** Lissencephaly	☐ No ☐ Yes
	MHH.101. Pachygyria	☐ No ☐ Yes	**MHH.102.**Hydranencephaly	☐ No ☐ Yes
	MHH.103. Porencephaly	☐ No ☐ Yes	**MHH.104.**Hydrops	☐ No ☐ Yes
	MHH.105. Ascites	☐ No ☐ Yes		
	MHH.106. Other	☐ No ☐ Yes If yes, describe:		
MHH.107. Description of abnormal ultrasound findings:				
MHH.108. Date(s) of Ultrasound(s): ____/____/____ ☐ **MHH.109.** *check if date approximated*	**MHH.111. Overall fetal ultrasound results:** ☐ Normal ☐ Abnormal			
	MHH.112. ☐ Reported by patient/healthcare provider *or* **MHH.113.** ☐ Ultrasound report			
	MHH.114. Head Circumference (HC) _____cm **MHH.115.** ☐ Normal ☐ Abnormal (*by physician report*)			
	MHH.116. Biparietal diameter (BPD) _____cm **MHH.117.** Femur length (FL) _____cm **MHH.118.** Abdominal circumference (AC) _____cm			
	MHH.119. ☐ Symmetrical IUGR (<5% EFW) ☐ Asymmetrical IUGR (HC<FL or HC <AC)			
	MHH.120. Microcephaly	☐ No ☐ Yes	**MHH.121.** Intracranial calcifications	☐ No ☐ Yes
	MHH.122. Encephalocele	☐ No ☐ Yes	**MHH.123.** Ventriculomegaly	☐ No ☐ Yes
	MHH.124. Cerebral atrophy	☐ No ☐ Yes	**MHH.125.** Ocular anomalies	☐ No ☐ Yes
MHH.110. *if date not known,* gestational age _____ *(weeks, days)*	**MHH.126.** Cerebellar abnormalities	☐ No ☐ Yes	**MHH.127.** Corpus callosum abnormalities	☐ No ☐ Yes
	MHH.128. Arthrogryposis	☐ No ☐ Yes	**MHH.129.** Lissencephaly	☐ No ☐ Yes
	MHH.130. Pachygyria	☐ No ☐ Yes	**MHH.131.** Hydranencephaly	☐ No ☐ Yes
	MHH.132. Porencephaly	☐ No ☐ Yes	**MHH.133.** Hydrops	☐ No ☐ Yes
	MHH.134. Ascites	☐ No ☐ Yes		
	MHH.135. Other	☐ No ☐ Yes If yes, describe:		

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MHH.136. Description of abnormal ultrasound findings:				
MHH.137. Date(s) of Ultrasound(s): ___/___/___ ☐ **MHH.138.** *check if date approximated* **MHH.139.** *if date not known,* gestational age _____ *(weeks, days)*	**MHH.140. Overall fetal ultrasound results:** ☐ Normal ☐ Abnormal			
	MHH.141. ☐ Reported by patient/healthcare provider **MHH.142.** ☐ Ultrasound report			
	MHH.143. Head Circumference (HC)_____cm **MHH.144.** ☐ Normal ☐ Abnormal (*by physician report*)			
	MHH.145. Biparietal diameter (BPD) _____cm **MHH.146.** Femur length (FL) _____cm **MHH.147.**Abdominal circumference (AC) _____cm			
	MHH.148. ☐ Symmetrical IUGR (<5% EFW) ☐ Asymmetrical IUGR (HC<FL or HC <AC)			
	MHH.149. Microcephaly	☐ No ☐ Yes	**MHH.150** Intracranial calcification	☐ No ☐ Yes
	MHH.151. Encephalocele	☐ No ☐ Yes	**MHH.152.** Ventriculomegaly	☐ No ☐ Yes
	MHH.153. Cerebral atrophy	☐ No ☐ Yes	**MHH.154.** Ocular anomalies	☐ No ☐ Yes
	MHH.155. Cerebellar abnormalities	☐ No ☐ Yes	**MHH.156.** Corpus callosum abnormalities	☐ No ☐ Yes
	MHH.157. Arthrogryposis	☐ No ☐ Yes	**MHH.158.** Lissencephaly	☐ No ☐ Yes
	MHH.159. Pachygyria	☐ No ☐ Yes	**MHH.160.** Hydranencephaly	☐ No ☐ Yes
	MHH.161. Porencephaly	☐ No ☐ Yes	**MHH.162.** Hydrops	☐ No ☐ Yes
	MHH.163. Ascites	☐ No ☐ Yes		
	MHH.164. Other	☐ No ☐ Yes If yes, describe:		
MHH.165. Description of abnormal ultrasound findings:				
****For additional ultrasounds or MRIs, please request a supplementary imaging form****				
MHH.166. Fetal MRI performed: ☐ No ☐ Yes (If yes, please answer questions below)				
MHH.167. Date(s) of MRI(s): ___/___/___ ☐ **MHH.168.** *check if date is approximated*	**MHH.170. Overall fetal MRI results:** ☐ Normal ☐ Abnormal Describe:_____			
	MHH.171. ☐ Reported by patient/healthcare provider **MHH.172.** ☐ MRI report			
	MHH.173. Head Circumference (HC) ___cm **MHH.174.** ☐ Normal ☐ Abnormal (*by physician report*)			
	MHH.175. Biparietal diameter (BPD) _____cm **MHH.176.** Femur Length (FL) _____cm **MHH.177.** Abdominal circumference (AC) _____cm			
	MHH.178. ☐ Symmetrical IUGR (<5% EFW) ☐ Asymmetrical IUGR (HC<FL or HC<AC)			
MHH.169. *if date not known,* gestational age _____	**MHH.179.** Encephalocele	☐ No ☐ Yes	**MHH.180.** Intracranial calcifications	☐ No ☐ Yes
	MHH.181. Ventriculomegaly	☐ No ☐ Yes	**MHH.182.** Cerebral atrophy	☐ No ☐ Yes
	MHH.183. Ocular anomalies	☐ No ☐ Yes	**MHH.184.** Cerebellar abnormalities	☐ No ☐ Yes

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(weeks, days)	**MHH.185.** Arthrogryposis	☐ No ☐ Yes	**MHH.186.** Corpus callosum abnormalities	☐ No ☐ Yes
	MHH.187. Lissencephaly	☐ No ☐ Yes	**MHH.188**. Pachygyria	☐ No ☐ Yes
	MHH.189. Hydranencephaly	☐ No ☐ Yes	**MHH.190.** Porencephaly	☐ No ☐ Yes
	MHH.191. Hydrops	☐ No ☐ Yes	**MHH.192.** Ascites	☐ No ☐ Yes
	MHH.193. Other	☐ No ☐ Yes	**MHH. 194.** If yes, describe:	

MHH.195. Description of abnormal MRI findings:

MHH.196. Amniocentesis performed: ☐ No ☐ Yes **MHH.197**. I*f yes,* date performed: _____/_____/_____

MHH.198. If date unknown, gestational age at time of amniocentesis _____(weeks, days)

MHH.199. Amniotic fluid Zika virus testing: ☐ Not performed ☐ Yes

MHH. 200. If yes, test results: ☐ Negative for Zika ☐ PCR+ Zika

MHH.201. Non-Zika infection detected: ☐ No ☐ Yes

MHH. 202. If yes, what infection(s) detected_____

MHH.203. Genetic abnormality detected: ☐ No ☐ Yes

MHH.204. If yes, please describe: _____

For reporting additional lab results, please use lab form

Healthcare Provider Information

Provider name: ☐ Dr. ☐ PA ☐ RN ☐ Other (Last)_____(First)_____

Hospital/Facility: _____Phone: _____ Email: _____

Name of person completing form (if different from provider): _____ Date of form completion:_____/_____/_____

Health Department Information

MHH.205. Name of person completing form: _____**MHH.206. Phone:** _____
MHH.207. Email: _____**MHH.208. Date form completed** _____/_____/_____

Internal use only

Date entered____/_____/_____	***Mother infection type:*** ☐ ***Confirmed*** ☐ ***Probable*** ☐ ***Possible***
Data Entry POC Initials: _____	***Data Entry Notes***: