Pregnancy Follow-up

Study Subject Number 0 1 – 0 0 0 1 **Visit Date** D D — M M — Y Y

Study Antenatal Clinic Code **Date of Birth** D D — M M — Y Y

Antenatal Record Number

Section 1: Pregnancy status

1. Weight (at this visit)
   - 1st measurement . kg
   - 2nd measurement . kg
2. Father's Height (if it can be obtained at this visit) . cm
3. Proteinuria (by dipstick). Cross one box only
   - 0 + ++ ++ ++++ no urine test available since last visit
   - and/or actual result received from laboratory mg/dl
4. Urine culture (please cross one box only)
   - Positive
   - Negative
   - No urine culture available
5. If positive, was antibiotic treatment given? yes no
6. Haemoglobin level (if available) g/dl
7. Blood pressure
   - Systolic mmHg
   - Diastolic mmHg

Since her last visit has she;

8. Smoked? yes no
9. If yes, how many cigarettes a day?
10. Lived with someone who smokes heavily at home? yes no
11. Taken any recreational drugs? yes no
12. Had more than 5 units of alcohol per week? (1 unit = small (125ml) glass of wine or a bottle/can (330ml) of beer) yes no
13. Been involved in a high risk occupation or taken part in a vigorous/contact sport? (see table) yes no
14. Followed any special diets? (vegetarian with no animal products, weight loss programme, malabsorption treatment, gluten free diet) yes no

Section 2: Current health

Since her last visit has she been diagnosed with or treated for any of the following conditions?

15. Cardiac disease yes no
16. Chronic respiratory disease (including chronic asthma) yes no
17. Malaria yes no
18. Mental illness e.g. depression yes no
19. Epilepsy yes no
20. Thyroid disease or any other endocrinological condition yes no
21. Lower urinary tract infection requiring antibiotic treatment yes no
22. Pyelonephritis yes no
23. Respiratory tract infection requiring antibiotic/antiviral treatment yes no
24. Any other infection requiring antibiotic/antiviral treatment yes no
25. HIV or AIDS yes no
26. Any type of malignancy or cancer (if yes, please complete an **adverse event form**) yes no
27. Any sexually transmitted infection yes no
28. Any other medical/surgical condition requiring treatment (if yes, please complete an **adverse event form**) yes no

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Section 3: Current health (continued)

Since her last visit has she been diagnosed with or treated for any of the following pregnancy-related conditions?

29. Severe vomiting requiring hospitalisation — yes / no
30. Gestational diabetes — yes / no
31. Vaginal bleeding — yes / no
32. Pregnancy-induced hypertension — yes / no
33. Preeclampsia — yes / no
34. Severe Preeclampsia/ Eclampsia/HELLP Syndrome — yes / no
35. Rhesus disease — yes / no
36. Preterm labour without delivery — yes / no
37. Prelabour rupture of membranes (PROM) — yes / no
38. Fetal distress — yes / no
39. Suspected impaired fetal growth or small for gestational age — yes / no
40. Any other pregnancy related condition requiring treatment (if yes, please complete an **adverse event form**) — yes / no

Section 4: Nutritional supplements / Medications

Since her last visit, has she routinely taken any of the following?

41. Iron — yes / no
42. Folic acid — yes / no
43. Calcium — yes / no
44. Food supplements — yes / no
45. Multi-vitamins/minerals — yes / no

Since her last visit, has she been given any of the following?

46. Aspirin — yes / no
47. Non-steroidal anti-inflammatories — yes / no
48. Antibiotics or Antivirals — yes / no
49. Insulin — yes / no
50. Any other treatment — yes / no

Section 5: Referral

51. Since her last visit, has the woman been referred to another level of care, been admitted to a hospital or is she being referred or admitted at this visit? — yes / no

If yes, please complete a **maternal referral form**. If she has delivered please complete a **pregnancy and delivery form**

Section 6: Next appointment

If not already done, please now arrange the next ultrasound appointment for within 5 weeks (± 1 week) of today

52. Date of the next ultrasound appointment D D — M M — Y Y

Name of Researcher	
Signature	
Researcher Code	