Items included on the U.S. Standard Certificate of Live Birth, by year revised

Item	1900	1910	1915	1918	1930	1939	1949	1956	1968	1978	1989	2003
Birth information												
Name of child	X	X	X	X	X	X	X	X	X	X	X	X
Sex	X	X	X	X	X	X	X	X	X	X	X	X
Date of birth	X	X	X	X	X	X	X	X	X	X	X	X
Time of birth	X	X	X	X	X	X	–	–	–	X	X	X
Place of birth:	X	X	X	X	X	X	X	X	X	X	X	X
Place of delivery	–	–	–	–	–	–	X	X	X	X	X	–
Name of facility	–	–	–	–	–	–	–	–	–	–	–	X
Street and number	X	X	X	–	–	–	–	–	–	–	–	–
If birth occurred in hospital or institution, give its name instead of street number	–	–	–	X	X	–	–	–	–	–	–	–
Place where birth occurred (check one)												
Checkbox for “Hospital”	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for “Freestanding birthing center”	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for “Clinic/doctor’s office”	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for “Residence”	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for “Home birth”	–	–	–	–	–	–	–	–	–	–	–	X
Planned to deliver at home? Checkbox for “yes” or “no”	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for “Other (specify)”	–	–	–	–	–	–	–	–	–	–	–	X
Street and number if not in hospital	–	–	–	–	–	–	X	X	X	X	X	X
Township of, or	X	X	X	X	X	X	–	–	–	–	–	–
Village of, or	X	X	X	X	X	X	–	–	–	–	–	–
City	X	X	X	X	X	X	–	–	–	–	–	–
City, town, or location of birth	–	–	–	–	–	–	X	X	X	X	X	X
Inside city limits	–	–	–	–	–	–	–	–	X	X	–	–
If outside city or town limits, write rural	–	–	–	–	–	X	X	–	–	–	–	–
County	X	X	X	X	X	X	X	X	X	X	X	X
Ward	X	X	X	X	X	X	–	–	–	–	–	–
Birth weight	–	–	–	–	–	–	–	X	X	X	X	X
Birth weight, checkbox for “grams” and “lb./oz.”	–	–	–	–	–	–	–	–	–	–	–	X
Single, twin, triplet, etc.	X	X	X	X	X	X	X	X	X	X	X	X
Plurality–Single, twin, triplet, etc. (specify)	–	–	–	–	–	–	–	–	–	–	–	X
Birth order if not single birth	X	X	X	X	X	X	X	X	X	X	X	X
If not single birth–Born first, second, third, etc. (specify)	–	–	–	–	–	–	–	–	–	–	–	X
Apgar Score:												
1 minute	–	–	–	–	–	–	–	–	–	–	X	–
5 minutes	–	–	–	–	–	–	–	–	–	–	–	X
If 5-minute score is less that 6, score at 10 minutes	–	–	–	–	–	–	–	–	–	–	–	X
Mother transferred prior to delivery	–	–	–	–	–	–	–	–	–	–	X	X
Mother transferred for maternal medical or fetal indications for delivery? Checkbox for “yes” or “no”	–	–	–	–	–	–	–	–	–	–	–	X
If yes, enter name of facility mother transferred from:	–	–	–	–	–	–	–	–	–	–	–	X
Infant transferred	–	–	–	–	–	–	–	–	–	–	X	–
Was infant transferred within 24 hours of delivery? Checkbox for “yes” or “no”	–	–	–	–	–	–	–	–	–	–	–	X
If yes, name of facility infant transferred to:	–	–	–	–	–	–	–	–	–	–	–	X
Is infant living at time of report? Checkbox for “yes,” “no,” and “infant transferred, status unknown”	–	–	–	–	–	–	–	–	–	–	–	X
Is the infant being breastfed at discharge? Checkbox for “yes” or “no”	–	–	–	–	–	–	–	–	–	–	–	X
Newborn medical record number	–	–	–	–	–	–	–	–	–	–	–	X
Mother information												
Maiden name	–	X	X	X	X	X	X	X	X	X	–	–
Maiden surname	–	–	–	–	–	–	–	–	–	–	X	–
Full name	X	–	–	–	–	–	–	–	–	–	X	–
Mother’s name prior to first marriage	–	–	–	–	–	–	–	–	–	–	–	X
Mother’s current legal name	–	–	–	–	–	–	–	–	–	–	–	X
Age	X	X	X	X	X	X	X	X	X	X	–	–
Date of birth	–	–	–	–	–	–	–	–	–	–	X	X
Birthplace	X	X	X	–	–	–	–	–	–	–	–	–
Birthplace (state or country)	–	–	–	X	X	X	X	X	X	X	X	X
Birthplace (city or place)	–	–	–	X	X	X	–	–	–	–	–	–
Mother’s stay before delivery: In hospital or institution	–	–	–	X	–	–	–	–	–	–	–	–
In this community	–	–	–	–	–	X	–	–	–	–	–	–
Residence	X	X	X	X	X	–	–	–	–	–	–	–
State	–	–	–	–	–	X	X	X	X	X	X	X
County	–	–	–	X	X	X	X	X	X	X	X	X
City, town, or location	–	–	–	–	–	X	X	X	X	X	X	X

See footnotes at end of table.

Items included on the U.S. Standard Certificate of Live Birth, by year revised—Con.

Item	1900	1910	1915	1918	1930	1939	1949	1956	1968	1978	1989	2003
Mother information—Con.												
Street and number	–	–	–	–	–	X	X	X	X	X	X	X
Inside city limits	–	–	–	–	–	–	–	X	X	X	X	X
If rural, give location	–	–	–	–	–	X	X	–	–	–	–	–
Is residence on a farm?	–	–	–	–	–	–	–	X	–	–	–	–
Apartment No.	–	–	–	–	–	–	–	–	–	–	–	X
Mother's mailing address	–	–	–	–	–	X	–	X	–	X	X	X
Mother's mailing address–checkbox for "Same as residence" or state, city, town, or location, street and number, apartment, zip code	–	–	–	–	–	–	–	–	–	–	–	X
Education–Specify highest grade completed	–	–	–	–	–	–	–	–	X	X	X	–
Elementary (0,1,2,3,4,…or 8)	–	–	–	–	–	–	–	–	X	–	–	–
Elementary/secondary (0–12)	–	–	–	–	–	–	–	–	–	X	X	–
High school (1,2,3, or 4)	–	–	–	–	–	–	–	–	X	–	–	–
College (1,2,3,4, or 5+)	–	–	–	–	–	–	–	–	X	–	–	–
College (1–4 or 5+)	–	–	–	–	–	–	–	–	–	X	X	–
Education (Check the box that best describes the highest degree or level of school completed at the time of delivery):	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "8th grade or less"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "9th–12th grade, no diploma"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "High school graduate or GED completed"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Some college credit but no degree"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Associate degree (e.g., AA, AS)"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Bachelor's degree (e.g., BA, AB, BS)"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA)"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)"	–	–	–	–	–	–	–	–	–	–	–	X
Of Hispanic origin? (Specify "no" or "yes"–If yes, specify Cuban, Mexican, Puerto Rican, etc.) Checkbox for "yes" or "no" (specify)__	–	–	–	–	–	–	–	–	–	–	X	–
Mother of Hispanic origin (Check the box that best describes whether the mother is Spanish/Hispanic/Latina. Check the "no" box if mother is not Spanish/Hispanic/Latina.)	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "No, not Spanish/Hispanic/Latina"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Yes, Mexican, Mexican American, Chicana"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Yes, Puerto Rican"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Yes, Cuban"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Yes, other Spanish/Hispanic/Latina (specify)"	–	–	–	–	–	–	–	–	–	–	–	X
Race–American Indian, black, white, etc. (specify below)	X	X	X	X	X	X	X	X	X	X	X	–
Race (Check one or more races to indicate what the mother considers herself to be)												
Checkbox for "White"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Black or African American"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "American Indian or Alaska Native (Name of the enrolled or principal tribe)"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Asian Indian"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Chinese"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Filipino"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Japanese"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Korean"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Vietnamese"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Other Asian (specify)"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Native Hawaiian"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Guamanian or Chamorro"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Samoan"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Other Pacific Islander (specify)"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Other (specify)"	–	–	–	–	–	–	–	–	–	–	–	X
Legitimate	X	X	X	X	X	–	X	X	X	–	–	–
Mother married?	–	–	–	–	–	X	–	–	–	X	X	–
Mother married? (At birth, conception, or any time between) Checkbox for "yes" or "no"	–	–	–	–	–	–	–	–	–	–	–	X
If no, has paternity acknowledgement been signed in the hospital? (Checkbox for "yes" or "no")	–	–	–	–	–	–	–	–	–	–	–	X
Facility ID (National Provider Identifier)	–	–	–	–	–	–	–	–	–	–	–	X
Social security number (mother)	–	–	–	–	–	–	–	–	–	–	–	X
Social security number requested for child? Checkbox for "yes" and "no"	–	–	–	–	–	–	–	–	–	–	–	X
Occupation	X	X	X	X	X	–	–	–	–	–	–	–
Usual occupation	–	–	–	–	–	X	–	–	–	–	–	–

See footnotes at end of table.

Items included on the U.S. Standard Certificate of Live Birth, by year revised—Con.

Item	1900	1910	1915	1918	1930	1939	1949	1956	1968	1978	1989	2003
Mother information—Con.												
Nature of industry	–	–	–	X	X	X	–	–	–	–	–	–
Date (month and year) last engaged in this work	–	–	–	–	X	–	–	–	–	–	–	–
Total time (years) spent in this work	–	–	–	–	X	–	–	–	–	–	–	–
Father information												
Name	X	X	X	X	X	X	X	X	X	X	X	X
Age	X	X	X	X	X	X	X	X	X	X	–	–
Date of birth	–	–	–	–	–	–	–	–	–	–	X	X
Birthplace	X	X	X	–	–	–	–	–	–	–	–	–
Birthplace (state or country)	–	–	–	X	X	X	X	X	X	X	X	X
Birthplace (city or place)	–	–	–	X	X	X	X	X	X	X	X	X
Education–Specify highest grade completed	–	–	–	–	–	–	–	–	X	X	X	–
Elementary (0,1,2,3,4,…or 8)	–	–	–	–	–	–	–	–	X	–	–	–
Elementary/secondary (0–12)	–	–	–	–	–	–	–	–	–	X	X	–
High school (1,2,3, or 4)	–	–	–	–	–	–	–	–	X	–	–	–
College (1,2,3,4, or 5+)	–	–	–	–	–	–	–	–	X	–	–	–
College (1–4 or 5+)	–	–	–	–	–	–	–	–	–	X	X	–
Education (Check the box that best describes the highest degree or level of school completed at the time of delivery):	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for “8th grade or less”	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for “9th–12th grade, no diploma”	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for “High school graduate or GED completed”	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for “Some college credit but no degree”	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for “Associate degree (e.g., AA, AS)”	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for “Bachelor’s degree (e.g., BA, AB, BS)”	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for “Master’s degree (e.g., MA, MS, MEng, MEd, MSW, MBA)”	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for “Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)”	–	–	–	–	–	–	–	–	–	–	–	X
Of Hispanic origin? (Specify no or yes–If yes, specify Cuban, Mexican, Puerto Rican, etc.) Checkbox for “yes” or “no” (specify)__	–	–	–	–	–	–	–	–	–	–	X	–
Father of Hispanic origin (Check the box that best describes whether the father is Spanish/Hispanic/Latino. Check the “no” box if father is not Spanish/Hispanic/Latino.)	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for “No, not Spanish/Hispanic/Latino”	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for “Yes, Mexican, Mexican American, Chicano”	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for “Yes, Puerto Rican”	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for “Yes, Cuban”	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for “Yes, other Spanish/Hispanic/Latino (specify)”	–	–	–	–	–	–	–	–	–	–	–	X
Race	X	X	X	X	X	X	X	X	X	X	X	–
Race (Check one or more races to indicate what the father considers himself to be)	–	–	–	–	–	–	–	–	–	–	X	X
Checkbox for “White”	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for “Black or African American”	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for “American Indian or Alaska Native (Name of the enrolled or principal tribe)”	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for “Asian Indian”	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for “Chinese”	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for “Filipino”	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for “Japanese”	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for “Korean”	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for “Vietnamese”	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for “Other Asian (specify)”	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for “Native Hawaiian”	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for “Guamanian or Chamorro”	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for “Samoan”	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for “Other Pacific Islander (specify)”	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for “Other (specify)”	–	–	–	–	–	–	–	–	–	–	–	X
Residence	X	X	X	X	X	–	–	–	–	–	–	–
Social security number (father)	–	–	–	–	–	–	–	–	–	–	–	X
Occupation	X	X	X	X	X	–	–	–	–	–	–	–
Usual occupation	–	–	–	–	–	X	X	X	–	–	–	–
Nature of industry	–	–	–	X	X	X	X	X	–	–	–	–
Date (month and year) last engaged in this work	–	–	–	–	X	–	–	–	–	–	–	–
Total time (years) spent in this work	–	–	–	–	X	–	–	–	–	–	–	–

See footnotes at end of table.

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Item	1900	1910	1915	1918	1930	1939	1949	1956	1968	1978	1989	2003
Medical and health information												
Did mother get Women, Infants, and Children (WIC) food for herself during this pregnancy? Checkbox for "yes" or "no"	–	–	–	–	–	–	–	–	–	–	–	X
Children born to this mother	–	–	–	–	–	X	–	–	–	–	–	–
Children previously born to this mother (Do not include this child.)	–	–	–	–	–	–	X	–	–	–	–	–
How many other children of this mother are now living?	–	–	–	–	–	X	X	X	–	–	–	–
How many other children were born alive but are now dead?	–	–	–	–	–	X	X	X	–	–	–	–
How many children were born dead?	–	–	–	–	–	X	–	–	–	–	–	–
Previous deliveries to mother (Do not include this birth.)	–	–	–	–	–	–	–	X	–	–	–	–
Previous deliveries–How many other children…	–	–	–	–	–	–	–	–	X	–	–	–
Are now living	–	–	–	–	–	–	X	X	–	–	–	–
Were born alive–Now dead	–	–	–	–	–	–	X	X	–	–	–	–
Were born dead (fetal death at any time after conception)	–	–	–	–	–	–	–	–	X	–	–	–
How many children were stillborn (born dead after 20 weeks of pregnancy)?	–	–	–	–	–	–	X	–	–	–	–	–
How many fetal deaths (fetuses born dead at any time after conception)?	–	–	–	–	–	–	–	X	–	–	–	–
Pregnancy history (complete each section)	–	–	–	–	–	–	–	–	–	X	X	–
Live births (Do not include this child.)	–	–	–	–	–	–	–	–	–	X	X	–
Live births, Number___, checkbox for "None"	–	–	–	–	–	–	–	–	–	–	–	X
Live births, now dead	–	–	–	X	X	X	X	X	X	X	X	X
Born dead (stillborn, fetal death)	–	–	–	X	X	X	–	X	X	–	–	–
Born dead after 20 weeks of pregnancy	–	–	–	–	–	–	X	–	–	–	–	–
Other terminations (spontaneous and induced):	–											
Under 20 weeks	–	–	–	–	–	–	–	–	–	X	–	–
Over 20 weeks	–	–	–	–	–	–	–	–	–	X	–	–
Other terminations (spontaneous and induced at any time after conception):	–	–	–	–	–	–	–	–	–	–	X	X
Number of other pregnancy outcomes (spontaneous or induced losses or ectopic pregnancies)	–	–	–	–	–	–	–	–	–	–	–	X
Other outcomes–Number____, checkbox for "none"	–	–	–	–	–	–	–	–	–	–	–	X
Date of last other pregnancy outcome	–	–	–	–	–	–	–	–	–	–	–	X
Date of last live birth	–	–	–	–	–	–	–	–	X	X	X	X
Date of last fetal death	–	–	–	–	–	–	–	–	X	–	–	–
Date of last other termination	–	–	–	–	–	–	–	–	–	X	X	X
Whether born alive or stillborn	X	X	X	X	X	–	–	–	–	–	–	–
Cause of stillbirth	–	–	–	–	X	–	–	–	–	–	–	–
Stillbirth–Before labor or during labor	–	–	–	–	X	–	–	–	–	–	–	–
If stillborn, period of gestation	–	–	–	–	X	–	–	–	–	–	–	–
Clinical estimate of gestation	–	–	–	–	–	–	–	–	–	–	X	–
Obstetric estimate of gestation	–	–	–	–	–	–	–	–	–	–	–	X
Date last normal menses began	–	–	–	–	–	–	–	–	X	X	X	X
Mother's medical record number	–	–	–	–	–	–	–	–	–	–	–	X
Length of pregnancy (completed weeks)	–	–	–	–	–	–	X	X	–	–	–	–
Months of pregnancy	–	–	–	–	–	X	–	–	–	–	–	–
Premature or full term	–	–	–	–	X	–	–	–	–	–	–	–
Month of pregnancy prenatal care began	–	–	–	–	–	–	–	–	X	X	X	X
Number of prenatal visits	–	–	–	–	–	–	–	–	X	X	X	X
Date of first prenatal care visit	–	–	–	–	–	–	–	–	–	–	–	X
Date of last prenatal care visit	–	–	–	–	–	–	–	–	–	–	–	X
Total number of prenatal visits for this pregnancy	–	–	–	–	–	–	–	–	–	–	–	X
Other risk factors for this pregnancy	–	–	–	–	–	–	–	–	–	–	X	–
Tobacco use during pregnancy–Checkbox for "yes" or "no"	–	–	–	–	–	–	–	–	–	–	X	–
Average number of cigarettes per day	–	–	–	–	–	–	–	–	–	–	X	–
Alcohol use during pregnancy–Checkbox for "yes" or "no"	–	–	–	–	–	–	–	–	–	–	X	–
Average number drinks per week	–	–	–	–	–	–	–	–	–	–	X	–
Weight gained during pregnancy: ___lbs.	–	–	–	–	–	–	–	–	–	–	X	–
Mother's height	–	–	–	–	–	–	–	–	–	–	–	X
Mother's prepregnancy weight	–	–	–	–	–	–	–	–	–	–	–	X
Mother's weight at delivery	–	–	–	–	–	–	–	–	–	–	–	X
Cigarette smoking before and during pregnancy. For each time period, enter either the number of cigarettes or the number of packs of cigarettes smoked. If none, enter "0."	–	–	–	–	–	–	–	–	–	–	–	X
Average number of cigarettes or packs of cigarettes smoked per day	–	–	–	–	–	–	–	–	–	–	–	X
Three months before pregnancy: ____# of cigarettes or ____# of packs	–	–	–	–	–	–	–	–	–	–	–	X
First three months of pregnancy: ____# of cigarettes or ____# of packs	–	–	–	–	–	–	–	–	–	–	–	X

See footnotes at end of table.

Items included on the U.S. Standard Certificate of Live Birth, by year revised—Con.

Item	1900	1910	1915	1918	1930	1939	1949	1956	1968	1978	1989	2003
Medical and health information—Con.												
Second three months of pregnancy: ____# of cigarettes or ____# of packs	–	–	–	–	–	–	–	–	–	–	–	X
Third trimester of pregnancy: ____# of cigarettes or ____# of packs	–	–	–	–	–	–	–	–	–	–	–	X
Medical risk factors for this pregnancy (check all that apply)	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Anemia (Hct. < 30/Hgb. < 10)"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Cardiac disease"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Acute or chronic lung disease"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Diabetes"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Genital herpes"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Hydramnios/oligohydramnios"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Hemoglobinopathy"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Hypertension, chronic"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Hypertension, pregnancy-associated"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Eclampsia"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Incompetent cervix"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Previous infant 4,000+ grams"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Previous preterm or small-for-gestational age infant"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Renal disease"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Rh sensitization"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Uterine bleeding"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "None"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Other (specify)"	–	–	–	–	–	–	–	–	–	–	X	–
Risk factors in this pregnancy (check all that apply)												
Diabetes:	–	–	–	–	–	–	–	–	–	–	X	X
Checkbox for "Prepregnancy (diagnosis prior to this pregnancy)"	–	–	–	–	–	–	–	–	–	–	X	X
Checkbox for "Gestational (diagnosis in this pregnancy)"	–	–	–	–	–	–	–	–	–	–	–	X
Hypertension:	–	–	–	–	–	–	–	–	–	–	–	–
Checkbox for "Prepregnancy (chronic)"	–	–	–	–	–	–	–	–	–	–	X	X
Checkbox for "Gestational (Pregnancy-induced hypertension, preeclampsia)"	–	–	–	–	–	–	–	–	–	–	X	X
Checkbox for "Eclampsia"	–	–	–	–	–	–	–	–	–	–	X	X
Checkbox for "Previous preterm birth"	–	–	–	–	–	–	–	–	–	–	X	X
Checkbox for "Other previous poor pregnancy outcome (includes perinatal death, small-for-gestational age/ intrauterine growth restricted birth)"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Pregnancy resulted from infertility treatment– If yes, check all that apply"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Fertility-enhancing drugs, artificial insemination, or intrauterine insemination"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Assisted reproductive technology [e.g., in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT)]"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Mother had a previous cesarean delivery"	–	–	–	–	–	–	–	–	–	–	–	X
If yes, how many? _____	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "None of the above"	–	–	–	–	–	–	–	–	–	–	–	X
Infections present and/or treated during this pregnancy (check all that apply)	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Gonorrhea"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Syphilis"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Chlamydia"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Hepatitis B"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Hepatitis C"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "None of the above"	–	–	–	–	–	–	–	–	–	–	–	X
Principal source of payment for this delivery	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Private Insurance"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Medicaid"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Self-pay"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Other (specify)___"	–	–	–	–	–	–	–	–	–	–	–	X
Concurrent illnesses or conditions affecting the pregnancy	–	–	–	–	–	–	–	–	–	X	–	–
Complications not related to pregnancy	–	–	–	–	–	–	–	–	X	–	–	–
Complications of pregnancy	–	–	–	–	–	–	–	–	–	X	–	–
Complications related to pregnancy	–	–	–	–	–	–	–	–	X	–	–	–
Complications of labor	–	–	–	–	–	–	–	–	X	–	–	–
Complications of labor and/or delivery (check all that apply)	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Febrile (>100°F or 38°C)"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Meconium, moderate/heavy"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Premature rupture of membranes (>12 hours)"	–	–	–	–	–	–	–	–	–	–	X	–

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Item	1900	1910	1915	1918	1930	1939	1949	1956	1968	1978	1989	2003
Medical and health information—Con.												
Checkbox for "Abruptio placenta"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Placenta previa"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Other excessive bleeding"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Seizures during labor"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Precipitous labor (<3 hours)"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Prolonged labor (>20 hours)"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Dysfunctional labor"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Breech/malpresentation"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Cephalopelvic disproportion"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Cord prolapsed"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Anesthetic complications"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Fetal distress"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "None"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Other, specify"	–	–	–	–	–	–	–	–	–	–	X	–
Onset of labor (check all that apply)	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Premature rupture of the membranes (prolonged, ≥12 hrs.)"	–	–	–	–	–	–	–	–	–	–	X	X
Checkbox for "Precipitous labor (<3 hrs.)"	–	–	–	–	–	–	–	–	–	–	X	X
Checkbox for "Prolonged labor (≥20 hrs.)"	–	–	–	–	–	–	–	–	–	–	X	X
Checkbox for "None of the above"	–	–	–	–	–	–	–	–	–	–	X	X
Characteristics of labor and delivery (check all that apply)	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Induction of labor"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Augmentation of labor"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Non-vertex presentation"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Antibiotics received by the mother during labor"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Clinical chorioamnionitis diagnosed during labor or maternal temperature > 38°C (100.4°F)"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Moderate/heavy meconium staining of the amniotic fluid"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Fetal intolerance of labor such that one or more of the following actions were taken: In-utero resuscitative measures, further fetal assessment, or operative delivery"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Epidural or spinal anesthesia during labor"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "None of the above"	–	–	–	–	–	–	–	–	–	–	–	X
Obstetric procedures (check all that apply)	–	–	–	–	–	–	–	–	–	–	X	X
Checkbox for "Amniocentesis"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Electronic fetal monitoring"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Induction of labor"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Stimulation of labor"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Tocolysis"	–	–	–	–	–	–	–	–	–	–	X	X
Checkbox for "Ultrasound"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "None"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Other"	–	–	–	–	–	–	–	–	–	–	X	X
Checkbox for "Cervical cerclage"	–	–	–	–	–	–	–	–	–	–	–	X
External cephalic version	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Successful"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Failed"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "None of the above"	–	–	–	–	–	–	–	–	–	–	–	X
Method of delivery (check all that apply)	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Vaginal"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Vaginal birth after previous C-section"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Primary C-section"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Repeat C-section"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Forceps"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Vacuum"	–	–	–	–	–	–	–	–	–	–	X	–
Method of delivery	–	–	–	–	–	–	–	–	–	–	–	X
Was delivery with forceps attempted but unsuccessful? Checkbox for "yes" or "no"	–	–	–	–	–	–	–	–	–	–	–	X
Was delivery with vacuum extraction attempted but unsuccessful? Checkbox for "yes" or "no"	–	–	–	–	–	–	–	–	–	–	–	X
Fetal presentation at birth	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Cephalic"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Breech"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Other"	–	–	–	–	–	–	–	–	–	–	–	X
Final route and method of delivery (check one)	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Vaginal/spontaneous"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Vaginal/forceps"	–	–	–	–	–	–	–	–	–	–	–	X

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Item	1900	1910	1915	1918	1930	1939	1949	1956	1968	1978	1989	2003
Medical and health information—Con.												
Checkbox for "Vaginal/vacuum"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Cesarean"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "If cesarean, was a trial of labor attempted? Checkbox for "yes" or "no"	–	–	–	–	–	–	–	–	–	–	–	X
Maternal morbidity (check all that apply) (complications associated with labor and delivery)	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Maternal transfusion"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Third or fourth degree perineal laceration"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Ruptured uterus"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Unplanned hysterectomy"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Admission to intensive care unit"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Unplanned operating room procedure following delivery"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "None of the above"	–	–	–	–	–	–	–	–	–	–	X	X
Abnormal conditions of the newborn (check all that apply)	–	–	–	–	–	–	–	–	–	–	X	X
Checkbox for "Anemia (Hct. < 38/Hgb. < 13)"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Birth injury"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Fetal alcohol syndrome"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Hyaline membrane dresses/respiratory distress syndrome"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Meconium aspiration syndrome"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Assisted ventilation ≤ 30 min"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Assisted ventilation ≥ 30 min"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Seizures"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "None"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Other (specify)"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Assisted ventilation required immediately following delivery"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Assisted ventilation required for more than six hours"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "NICU admission"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Newborn given surfactant replacement therapy"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Antibiotics received by the newborn for suspected neonatal sepsis"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Seizure or serious neurologic dysfunction"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Significant birth injury (skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention)"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "None of the above"	–	–	–	–	–	–	–	–	–	–	X	X
Congenital malformations or anomalies of child	–	–	–	–	–	–	–	–	X	X	–	–
Congenital anomalies of child (check all that apply)	–	–	–	–	–	–	–	–	–	–	X	X
Checkbox for "Hydrocephalus"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Microcephalus"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Other central nervous system anomalies (specify)"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Heart malformations"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Other circulatory/respiratory anomalies (specify)"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Rectal atresia/stenosis"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Tracheo-esophageal fistula/esophageal atresia"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Other gastrointestinal anomalies (specify)"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Malformed genitalia"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Renal agenesis"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Other urogenital anomalies (specify)"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Cleft lip/palate"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Polydactyly/syndactyly/adactyly"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Club foot"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Other musculoskeletal/integumental anomalies (specify)"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Other chromosomal anomalies (specify)"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "None"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Other (specify)"	–	–	–	–	–	–	–	–	–	–	X	–
Checkbox for "Anencephaly"	–	–	–	–	–	–	–	–	–	–	X	X
Checkbox for "Meningomyelocele/spina bifida"	–	–	–	–	–	–	–	–	–	–	X	X
Checkbox for "Cyanotic congenital heart disease"	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for "Congenital diaphragmatic hernia"	–	–	–	–	–	–	–	–	–	–	X	X
Checkbox for "Omphalocele"	–	–	–	–	–	–	–	–	–	–	X	X
Checkbox for "Gastroschisis"	–	–	–	–	–	–	–	–	–	–	X	X
Checkbox for "Limb reduction defect (excluding congenital amputation and dwarfing syndromes)"	–	–	–	–	–	–	–	–	–	–	–	X

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Item	1900	1910	1915	1918	1930	1939	1949	1956	1968	1978	1989	2003
Medical and health information—Con.												
Checkbox for “Cleft lip with or without cleft palate”	–	–	–	–	–	–	–	–	–	–	X	X
Checkbox for “Cleft palate alone”	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for “Down syndrome”	–	–	–	–	–	–	–	–	–	–	X	X
Checkbox for “Karyotype confirmed”	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for “Karyotype pending”	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for “Suspected chromosomal disorder”	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for “Karyotype confirmed”	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for “Karyotype pending”	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for “Hypospadias”	–	–	–	–	–	–	–	–	–	–	–	X
Checkbox for “None of the anomalies listed above”	–	–	–	–	–	–	–	–	–	–	X	X
Birth injuries to child	–	–	–	–	–	–	–	–	X	–	–	–
Certification information												
Signature of certifier	–	–	–	–	–	–	–	–	–	–	X	X
Type of attendant	–	–	–	–	–	–	–	–	–	–	X	X
Date signed	–	–	–	–	–	–	–	–	–	–	X	X
Date on which given name was added	X	X	X	X	X	X	X	X	–	–	–	–
Certificate of attending physician or midwife	–	–	–	–	–	–	–	–	–	–	–	–
I hereby certify that I attended the birth of this child, and that it occurred on_____, 190_, at ___m.	–	–	–	–	–	–	–	–	–	–	–	–
When there was no attending physician or midwife, then the father, householder, etc., should make this return	X	X	–	–	–	–	–	–	–	–	–	–
Signature	X	X	–	–	–	–	–	–	–	–	–	–
Address	X	X	–	–	–	–	–	–	–	–	–	–
Filed___190_,	X	X	–	–	–	–	–	–	–	–	–	–
Registrar	X	X	–	–	–	–	–	–	–	–	–	–
Christian name added from supplemental report, 190_	X	–	–	–	–	–	–	–	–	–	–	–
Given name added from supplemental report, (date of)_	X	X	X	X	X	–	–	–	–	–	–	–
Name of registrar adding given name	X	X	X	X	X	X	X	X	–	–	–	–
Name and title of attendant at birth if other than certifier	–	–	–	–	–	–	–	–	–	X	–	–
Name and title of attendant if other than certifier (checkboxes)	–	–	–	–	–	–	–	–	–	–	X	X
Mailing address of attendant	–	–	–	–	–	–	–	–	–	–	X	X
Name and title of certifier	–	–	–	–	–	–	–	–	–	X	–	–
Name and title of certifier (checkboxes)	–	–	–	–	–	–	–	–	–	–	X	X
Name of certifier	–	–	–	–	–	–	–	–	X	–	–	–
Mailing address of certifier	–	–	–	–	–	–	–	–	X	X	–	–
Address of certifier	X	X	X	X	X	X	X	X	–	–	–	–
Signature of registrar	X	–	–	–	–	X	X	X	X	X	X	X
Registrar	X	X	X	X	X	–	–	–	–	–	–	–
Date received by registrar	X	–	–	–	–	–	–	–	–	X	–	–
Date received by local registrar	X	–	–	–	–	X	X	X	X	–	–	–
Date filed	X	X	X	X	X	–	–	–	–	–	X	X
Signature of parent or other informant	–	–	–	–	–	–	–	–	–	X	X	–
Informant	–	–	–	–	–	X	X	X	X	–	–	–
Relation to child	–	–	–	–	–	X	–	–	X	X	–	–
Information for Administrative Use Section	–	–	–	–	–	–	–	–	–	–	–	X
Information for Medical and Health Purposes Only Section	–	–	–	–	–	–	–	–	–	–	–	X
Newborn Information Section	–	–	–	–	–	–	–	–	–	–	–	X

X Indicates item included on standard certificate.

– Indicates item not included on standard certificate.