Medical Record Abstraction

Study ID

_____

Quality Assurance: Interview

Interviewer's Name

_____
(First and last name)

Date of Interview

_____

Result of Interview

◯ Complete
◯ Incomplete

If complete, specify

_____

Reviewed by

_____
(First and last name)

Date of Review

_____

Result of review

◯ Complete
◯ Incomplete

Recommendations

_____

Quality Assurance: Abstract

Abstractor Name

_____
(First and last name)

Abstraction Date

_____

Reviewed by

_____
(First and last name)

Date of Review

_____

Result of review

◯ Complete
◯ Incomplete

Recommendations

_____

1. Prenatal Care	◯ No Prenatal Care ◯ Prenatal Care Outside BMC ◯ Prenatal Care at BMC ◯ Prenatal Care Both Outside and at BMC
Starts at week at BMC	_____
# of Documented Visits at BMC	_____
Rec. avail from week at BMC	_____
Starts at Week Outside BMC	_____
# Documented Visits Outside BMC	_____
Rec avail from week Outside BMC	_____
Starts at Week at BMC	_____
# Documented Visits BMC	_____
Rec avail from wk BMC	_____
Starts at week Outside BMC	_____
# Documented Visits Outside BMC	_____
Rec Avail from Wk Outside BMC	_____
2. Date of Last Menstrual Period	◯ Certain ◯ Uncertain ◯ Unknown
Please Specify LMP Date	_____
3a. Gravidity	_____
3b. Parity	_____
3c. TAB	_____

3d. SAB

_____

4a. Gestational Age By LMP

_____
(Decimal weeks by LMP)

4a. EDC by LMP

_____

4b. Gestational Age by Ultrasound

_____
(Decimal Weeks by Ultrasound)

4b. EDC by Ultrasound

_____

4c. Gestational Age by Dubowitz at birth

_____
(Decimal weeks by Dubowitz at birth)

4c. Dubowitz Total score

_____

4d. Gestational Age by New Ballard Score

_____
(Decimal weeks by New Ballard Score)

4d. New Ballard Score: Total score

_____

5a. Apgars at 1 Minute

_____

5b. Apgars at 5 Min

_____

5c. Apgars at 10 Min

_____

6. Birth Weight

_____

6a. Type of Delivery

◯ Vaginal
◯ C/S

6b. Length of Ruptured of Membranes

◯ Known
◯ Unknown

Hours

_____
(hours)

Minutes

_____
(minutes)

6c. Clinical Presentation Before Delivery	◯ Uterine contraction as first sign of labor ◯ Rupture of Membrane without uterine contraction as first sign of labor: Water broke noted by mom ◯ Rupture of Membrane without uterine contraction as first sign of labor: Fern test positive ◯ Rupture of Membrane without uterine contraction as first sign of labor: Both by mom and fern test ◯ Both uterine contraction and rupture of membrane as first sign of labor ◯ Medical Induction(no Contraction, no ROM, to end pregnancy due to medical reasons)
Medical Induction	◯ Artificial Initiation of Labor ◯ No artificial Initiation of Labor
Artificial Initiation of Labor	☐ Postdate (>40 Weeks) ☐ Maternal Complications (eg, PIH) ☐ Fetal Distress/IUGR ☐ Other
Artificial Initiation of labor if Other	_____
C/S: No artificial initiation of labor	☐ Elective C/S ☐ Repeat C/S ☐ Postdate (>40 weeks) ☐ Breech Presentation ☐ Pelvic-fetal Disproportion ☐ Maternal Complications (eg, PIH) ☐ Fetal Distress / IUGR ☐ Other
CS: No Artificial Initiation of Labor if other	_____

8. Complications of the Index Pregnancy

8a. Preeclampsia	◯ No ◯ Mild ◯ Severe
8b. Eclampsia	◯ Yes ◯ No
8c. Chronic Hypertension	◯ Yes ◯ No
8d. Gestational Hypertension	◯ Yes ◯ No
8e. Placental Abruption	◯ Yes ◯ No
8f. Placenta Previa	◯ Yes ◯ No
8f. Incompetent Cervix	◯ Yes ◯ No

If yes, Suture placed	◯ Yes ◯ No
At week	_____
8h. Diabetes	◯ No ◯ GDM ◯ DM
8i. Genital Tract Infections	◯ Yes ◯ No
8j. Urinary Tract Infections	◯ Yes ◯ No
8k. HEELP Syndrome	◯ Yes ◯ No
8l. Oligohydramnios	◯ Yes ◯ No
If yes, the lowest amniotic fluid level(< =5cm)	_____
8m. Polyhydramnios	◯ Yes ◯ No
If yes, the highest amniotic fluid level (>=25)	_____
8n. Meconium in Amniotic Fluid	◯ Yes ◯ No
8o. Any documented preterm non Braxton-Hicks contractions	◯ Yes ◯ No
8p. First Documented preterm contractions at	_____ (weeks)
8q. Number of Documented Preterm Contraction Episodes	_____
8r. Bed Rest	◯ Yes ◯ No
8r. Tocolysis	☐ None ☐ Magnesium Sulfate ☐ Beta2-adrenergic agents ☐ other
8r. Betamethazone	◯ None ◯ 1 Dose ◯ 2 or more doses

8r. IV Fluids	◯ Yes ◯ No
8r. Other	◯ Yes ◯ No
Specify Other	_____
8s. Fetal Fibronectin 1	_____
Fetal Fibronectin 1 Results	◯ Positive ◯ Negative ◯ Unknown
Fetal Fibronectin 2	_____
Fetal Fibronectin 2 Results	◯ Positive ◯ Negative ◯ Unknown
8t. Vaginal Bleeding	◯ Yes ◯ No
During first trimester	◯ Yes ◯ No
During 2nd trimester	◯ Yes ◯ No
During 3rd trimester	◯ Yes ◯ No
Preceding onset of labor	◯ Yes ◯ No
8u. Signs of Chorioamnionitis	◯ Yes ◯ No
Maternal Temperature >38c	◯ Yes ◯ No
Uterine tenderness	◯ Yes ◯ No
Foul smelling vaginal discharge or amniotic fluid	◯ Yes ◯ No
Maternal tarchycardia	◯ Yes ◯ No
Fetal tachycardia	◯ Yes ◯ No

Maternal white blood cell count >15,000
◯ Yes
◯ No

8v. Were any intrapartum antibiotics administered
◯ Yes
◯ No

If yes, specify intrapartum antibiotic administration: Check all that apply
If none administered check "None"

	None	One dose < 4 hours prior to delivery	One does >=4 hours prior to delivery	2 or more doses	Given, but time unknown
Ampicillin	◯	◯	◯	◯	◯
Clindamycin	◯	◯	◯	◯	◯
Gentamicin	◯	◯	◯	◯	◯
Penicillin	◯	◯	◯	◯	◯
Other Antibiotic 1	◯	◯	◯	◯	◯
Other Antibiotic 2	◯	◯	◯	◯	◯

If other, specify antibiotic 1
_____

If other, specify antibiotic 2
_____

9. Amniocentesis
◯ Yes
◯ No

If yes, what was the result
◯ Normal
◯ Abnormal
◯ Unknown

If Abnormal, specify
_____

10. Number of Prenatal Ultrasounds
_____

Please specify any abnormal results
_____

U/S gestational week at which the FIRST U/S was performed
_____
(2 decimal places)

LMP gestational week at which the FIRST U/S was performed
_____
(2 Decimal places)

11. Placenta Sent for Pathology
◯ Yes
◯ No

12. Does the mother smoke or drink or take drug	◯ Yes ◯ No
Pre pregnancy Smoking	◯ Yes ◯ No
Type of cigarette	☐ Cigarette ☐ E-Cigarette
Number of cigs per day	_____
Pre pregnancy Alcohol	◯ Yes ◯ No
Number drinks/week	_____
Pre pregnancy Drug Type 1	_____
#use/wk	_____
Pre pregnancy Drug Type 2	_____
#use/wk	_____
Pre pregnancy Drug Type 3	_____
#use/wk	_____
Pre pregnancy Drug Type 4	_____
#use/wk	_____
1st Trimester Smoking	◯ Yes ◯ No
Type of cigarette	☐ Cigarette ☐ E-Cigarette
Number of sigs per day	_____
1st Trimester Alcohol	◯ Yes ◯ No

Number drinks/week	_____
1st Trimester Drug type 1	_____
#use/wk	_____
1st Trimester Drug type 2	_____
#use/wk	_____
1st Trimester Drug type 3	_____
#use/wk	_____
1st Trimester Drug type 4	_____
#use/wk	_____
2nd trimester Smoking	◯ Yes ◯ No
Type of cigarette	☐ Cigarette ☐ E-Cigarette
#cigs/day	_____
2nd Trimester Alcohol	◯ Yes ◯ No
#drinks/week	_____
2nd trimester drug type 1	_____
#use/wk 1	_____
2nd trimester drug type 2	_____
#use/wk 2	_____

2nd trimester drug type 3	_____
#use/wk 3	_____
2nd trimester drug type 4	_____
#use/wk 4	_____
3rd trimester smoking	◯ Yes ◯ No
Type of cigarette	☐ Cigarette ☐ E-Cigarette
#cigs/days	_____
3rd trimester alcohol	◯ Yes ◯ No
#drinks/wk	_____
3rd trimester Drug Type 1	_____
#use/wk	_____
3rd trimester Drug Type 2	_____
#use/wk	_____
3rd trimester Drug Type 3	_____
#use/wk	_____
3rd trimester Drug Type 4	_____
#use/wk	_____
15. Mother Received anesthesia	◯ Yes ◯ No

17. CBC	◯ Yes ◯ No
18. Mother Transfused	◯ Yes ◯ No
If yes, Date Transfused:	_____
Transfusion Time: 24 Hour Clock	_____
Transfusion, number of units	_____
19. Amniotic Fluid Culture	◯ Yes ◯ No
If Yes, specify pathogen	_____
20. Urine Culture	◯ Yes ◯ No
21a. Urinary Tract Infection during 1st and 2nd trimester (< 27 weeks gestation)	◯ 1. Neither Reported or indicated by labs ◯ 2. Pt Report Only ◯ 3. (+) urine Culture only or chart mentioned in problem list ◯ 4. Both 2 and 3 ◯ 5. (+) urine culture but < 50,000 colonies ◯ 6. Unable to determine
21b. Urinary Tract Infection during 3rd trimester (>= 27 weeks gestation)	◯ 1. Neither Reported or indicated by labs ◯ 2. Pt Report Only ◯ 3. (+) urine Culture only or chart mentioned in problem list ◯ 4. Both 2 and 3 ◯ 5. (+) urine culture but < 50,000 colonies ◯ 6. Unable to determine

Any significant past medical history: USE MEDICAL RECORD INFO ONLY

Asthma	◯ Yes ◯ No
If Yes	◯ During Pregnancy ◯ Before Pregnancy ◯ Both
Hyperthyroidism	◯ Yes ◯ No
If Yes	◯ During Pregnancy ◯ Before Pregnancy ◯ Both

Hypothyroidism	◯ Yes ◯ No
If Yes:	◯ During Pregnancy ◯ Before Pregnancy ◯ Both
Endometriosis	◯ Yes ◯ No
If yes:	◯ During Pregnancy ◯ Before Pregnancy ◯ Both
Uterine Myoma	◯ Yes ◯ No
If yes	◯ During Pregnancy ◯ Before Pregnancy ◯ Both
Uterine Malformation	◯ Yes ◯ No
If yes:	◯ During Pregnancy ◯ Before Pregnancy ◯ Both
Pelvic Inflammatory Disease	◯ Yes ◯ No
If yes	◯ During Pregnancy ◯ Before Pregnancy ◯ Both
Abnormal PAP Smear	◯ Yes ◯ No
If yes	◯ During Pregnancy ◯ Before Pregnancy ◯ Both
Polycystic Ovaries	◯ Yes ◯ No
If yes	◯ During Pregnancy ◯ Before Pregnancy ◯ Both
Abdominal Operation	◯ Yes ◯ No
If yes	◯ During Pregnancy ◯ Before Pregnancy ◯ Both

Anemia	◯ Yes ◯ No
If yes	◯ During Pregnancy ◯ Before Pregnancy ◯ Both
Malignant Tumor	◯ Yes ◯ No
If yes	◯ During Pregnancy ◯ Before Pregnancy ◯ Both
Tuberculosis	◯ Yes ◯ No
If yes	◯ During Pregnancy ◯ Before Pregnancy ◯ Both
Cardiovascular Disease	◯ Yes ◯ No
If yes	◯ During Pregnancy ◯ Before Pregnancy ◯ Both
High Blood Pressure	◯ Yes ◯ No
If Yes	◯ During Pregnancy ◯ Before Pregnancy ◯ Both
Auto-immune Disease	◯ Yes ◯ No
If Yes	◯ During Pregnancy ◯ Before Pregnancy ◯ Both
Drug Allergy	◯ Yes ◯ No
If yes	◯ During Pregnancy ◯ Before Pregnancy ◯ Both
Seizure Disorder	◯ Yes ◯ No
If yes	◯ During Pregnancy ◯ Before Pregnancy ◯ Both

Gestational Diabetes	◯ Yes ◯ No
If yes	◯ During Pregnancy ◯ Before Pregnancy ◯ Both
Diabetes Mellitus	◯ Yes ◯ No
If yes	◯ During Pregnancy ◯ Before Pregnancy ◯ Both
Infertility (Unable to get pregnant after one year of unprotected intercourse)	◯ Yes ◯ No
Age Diagnosed	_____
Any Treatment:(check all that apply)	☐ Medications ☐ Intrauterine Insemination(IUI) ☐ In-vitro-Fertilization ☐ Others
If Other	_____
Mother is allergic to food or environmental allergens	◯ Yes ◯ No
Cow's Milk	◯ Yes ◯ No
Egg	◯ Yes ◯ No
Peanut	◯ Yes ◯ No
Walnut	◯ Yes ◯ No
sesame	◯ Yes ◯ No
Shellfish	◯ Yes ◯ No
Fish	◯ Yes ◯ No
Soy	◯ Yes ◯ No

Wheat	◯ Yes ◯ No
Cat	◯ Yes ◯ No
Dog	◯ Yes ◯ No
Cockroach	◯ Yes ◯ No
Dust Mites	◯ Yes ◯ No
Molds	◯ Yes ◯ No
Others	◯ Yes ◯ No
If others, specify	_____
Eczema	◯ Yes ◯ No
Seasonal Allergy (or Hay Fever)	◯ Yes ◯ No
If Others, specify	_____

BABY INFORMATION

Date of Delivery	_____ (Month and Year only)
Time of delivery	_____
Baby Gender	◯ Male ◯ Female
Length	_____ (cm)
Head Circumference	_____ (cm)
Birth Defect Present	◯ Yes ◯ No

Was birth defect diagnosed	◯ Prenatally ◯ Perinatally ◯ Unknown
Type of Birth Defect	☐ Anecephalus ☐ Cleft lib/palate ☐ Club foot ☐ congenital hip dislocation ☐ Diaphragmatic hernia ☐ Down Syndrome ☐ Gastroschisis ☐ Hydrocephalus ☐ Hypospadius ☐ Microcephalus ☐ Omphalocele ☐ Other Cardiac ☐ Other chromosomal ☐ Other CNS ☐ Other GI ☐ Other musculoskeletal ☐ Other urogenital ☐ Other(specify) ☐ Patent ductus ateriosus ☐ Polydactyly ☐ Rectal atresia/stenosis ☐ Renal agenesis ☐ Spina bifida ☐ Syndactyly ☐ Unknown
If Other, specify	_____