

**INFLUENZA A/H1N1v
IN PREGNANCY STUDY**

PRIVATE & CONFIDENTIAL

SWINE FLU IN PREGNANCY STUDY: INITIAL INFORMATION COLLECTION - PARTICIPANTS

Thank you for taking part in our 'Swine Flu in Pregnancy' study. We would be grateful if you could please provide us with the following information about yourself. If anything on this form is unclear, or if you need help with filling it in please contact us on 0191 260 6197 and a member of our team will be glad to help.

YOUR DETAILS

Please provide the following information about yourself:

Your name

Your date of birth ____/____/____

Your NHS number (if known).....

Your address.....
.....

Postcode

Telephone number.....

What is your occupation?.....

What is your ethnic group?..... (please use the codes provided in the box)

Do you smoke? Yes Number of cigarettes a day:.....
 No (never)
 I used to smoke but stopped before I became pregnant
 I stopped smoking atweeks of this pregnancy

How many units of alcohol do you drink per week?

Do you use illicit/recreational drugs? Yes No Don't know

If yes, please detail

UK census coding for ethnic group

WHITE

- 01. British
- 02. Irish
- 03. Any other white background

MIXED

- 04. White and black Caribbean
- 05. White and black African
- 06. White and Asian
- 07. Any other mixed background

ASIAN OR ASIAN BRITISH

- 08. Indian
- 09. Pakistani
- 10. Bangladeshi
- 11. Any other Asian background

BLACK OR BLACK BRITISH

- 12. Caribbean
- 13. African
- 14. Any other black background

CHINESE OR OTHER ETHNIC GROUP

- 15. Chinese
- 16. Any other ethnic group

PREGNANCY DETAILS

What was the first day of your last menstrual period? ____/____/____

When is your baby due? ____/____/____

What was your weight before you were pregnant? _____

How tall are you? _____

Have you had any complications during your pregnancy so far? Please detail below including when in your pregnancy they occurred:
.....

This study has been reviewed and approved by an ethics committee.

For help completing this form please telephone 0191 260 6197.

For advice on how to get information about medications in pregnancy please visit our website: www.uktis.org.

Have you had any antenatal screening during this pregnancy? Yes No Don't know

If yes, were any of your antenatal screening tests abnormal? Please include information on blood tests and ultrasound scans.

.....

Did you take folic acid before pregnancy? Yes No Don't know

Are you currently taking folic acid during pregnancy? Yes No Don't know Dose (if known).....

If yes, how many weeks pregnant were you when you started taking folic acid? _____weeks

If you have stopped taking folic acid, how many weeks pregnant were you when you stopped? _____weeks

MEDICAL HISTORY

Do you have any of the following medical conditions? (Please tick any that apply)

Asthma (requiring medication) Hypertension
in the past three years

Longstanding lung disease Hypercholesterolemia

Longstanding heart disease Epilepsy

Longstanding kidney disease Psychiatric illness

Longstanding liver disease Obesity

Longstanding neurological disease Diabetes mellitus

Immunosuppression (caused by disease or treatment)

Any other significant medical condition (please detail).....

.....

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VACCINATION (INJECTION)

Have you been offered vaccination for Swine Flu? Yes No

Did you have the vaccine? Yes No

If yes, please give the dates of when you were vaccinated (dd/mm/yy)

____/____/____ and ____/____/____

And the name of the vaccine if known.....

If 'no', what was the reason for not having the vaccine?

Vaccine not available yet

Other please specify

If 'no', what was the reason for not having the vaccine?

Vaccine not available yet Other please specify.....

Did you experience any side effects from the vaccination ? Yes No

If yes, please select from the list below:

headache

arthralgia (joint pain)

myalgia (muscle pain)

reactions at the site of the injection (hardening, swelling, pain and redness)

fever and fatigue (tiredness)

other (please detail).....

Have you had the seasonal flu vaccine this year? Yes No Date.....

INFLUENZA

Have you been in close contact with someone with suspected / confirmed Swine Flu? Yes No

If 'yes', - please state your relationship to this person (eg. husband / neighbour).....

Do you live in the same home? Yes No

Do you work together? Yes No

Was this person diagnosed with swine flu on clinical symptoms?
Yes No Don't know

Did this person have a swab (nose or throat) to test for swine flu?
Yes No Don't know

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Have **you** had any flu-like symptoms? Yes No If 'yes', please fill in the table below

Symptom	Tick if Yes	Date symptom started	Symptom	Tick if Yes	Date symptom started
Fever (temperature $\geq 38^{\circ}\text{C}/100.4^{\circ}\text{F}$)			Chills		
Cough			Aching muscles		
Sore throat			Limb or joint pain		
Runny nose			Headache		
Loss of appetite			Vomiting		
Diarrhoea			Sneezing		
Tiredness			Shortness of breath		
Other:					

Have you been diagnosed with swine flu? Yes No Don't know

If yes, was this diagnosis made on clinical symptoms alone (i.e. without a swab test)? Yes No Don't know

How was the swine flu diagnosed?

By the GP at the surgery

By the GP over the telephone

Other (e.g. flu line, walk in centre, internet) Please provide details

On what date were you diagnosed with swine flu? ___/___/___ Not applicable

Have you been swabbed or tested for H1N1 influenza? Yes No* Don't know*

- If you have any flu-like symptoms and **have not already been tested** for Swine Flu (H1N1) PLEASE telephone us or submit this form immediately by FAX to UKTIS TO ENABLE A SELF SWAB KIT TO BE POSTED OUT TO YOU (for research purposes) Fax: 0191 260 6193 ☎ 0191 260 6197
- Please note that we do **not** need to collect a swab sample from you if you have only been in contact with someone with Swine Flu, and you yourself do not have any flu-like symptoms.

If you have already been swabbed for swine flu, what was the result?

Swine flu confirmed Swab did not detect swine flu I am still waiting for the result

How long had you felt unwell when the swab was taken?.....

What type of swab was taken? (e.g. nose, throat).....

Were you hospitalised because of the flu? Yes No If yes, what was the hospital name?
.....

ANTIVIRAL MEDICATION

Were you prescribed antiviral medication? (Please tick):

Tamiflu® No Yes Start date ___/___/___ Stop date ___/___/___ for Treatment Prevention Don't know

Relenza® No Yes Start date ___/___/___ Stop date ___/___/___ for Treatment Prevention Don't know

Did you experience any side effects / abnormal reactions to the antiviral medication? No Yes

Please describe.....

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YOUR FAMILY

Does the baby's father have any medical conditions? Yes No Don't know

If yes, please detail.....

Does the baby's father take any medication or been exposed to any chemicals? Yes No Don't know

If yes, please detail.....

Did any of your blood relatives have a birth defect (e.g. Missing fingers, heart abnormalities)? Yes No Don't know

Are any of your relatives affected with a genetic condition? Yes No

If so, please tell us more about the defect or condition and how this person is related to you.....

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YOUR PAST PREGNANCIES

Is this your first pregnancy? Yes No

If no, can you complete the following about your previous pregnancies

Infant	Outcome*	Sex (M/F)	Date of birth (dd/mm/yy)	Gestational age	Birth weight (kg)	Neonatal problems	Congenital malformations (birth defects)
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

Outcome e.g. miscarriage, elective termination, IUD, live-born baby, stillborn, neonatal death

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Is there anything else that you think might be important to tell us?

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Please provide your GP and/or midwife's name, address and telephone number below

GP's name

Address.....

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Postcode

GP's ☎

Midwife's name.....

Address.....

.....

Postcode

Midwife's ☎.....

Hospital Doctors details (name, hospital, specialty)

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Thank you for completing this form – please return this form using the FREEPOST envelope or using the FREEPOST address: UK Teratology Information Service, Regional Drug & Therapeutics Centre, FREEPOST NEA1573, Newcastle upon Tyne. NE2 1BR.
☎ 0191 260 6197 Fax: 0191 260 6193

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