
THE NATIONAL ARCHIVES OF THE UNITED STATES
LITTERA
SCRIPTA
MANET
★ 1934 ★

OB-4 Gynecological History

Form OB-4 was used to record information about the gravida's menstrual history, including unusual features, pain and sterility. The form was first implemented in January 1959; revisions to the form occurred once in November 1959. Revision affected the form by altering itemization only.

TABLE OB-4.1 Cards and Data Records by Revision for Form OB-4

Card Name	Card Number	Rev. No.	Number Records
OB-4: Gynecological History	0304	1	56,798
	total for form		56,798

Data Items Referencing Form OB-4, Gynecological History

DATA ITEM TD	ITEM IN FORM	CARD NUM	FROM	TO	DATA ITEM NAME
268.....		0304	1	5	Card number (sequence, form type, form number, revision number)
269.....		0304	6	14	NINDB case number
270...OB-4	4	0304	15	16	Form OB-4 date (mo)
271...OB-4	4	0304	17	18	Form OB-4 date (day)
272...OB-4	4	0304	19	20	Form OB-4 date (yr)
273...OB-4	6	0304	21	22	Menarche; age at onset of menstruation
274...OB-4	7	0304	23	24	Menstrual period duration
275...OB-4	8	0304	25	26	Menstrual period usual interval, minimum
276...OB-4	8	0304	27	28	Menstrual period usual interval, maximum
277...OB-4	9	0304	29	29	Menstrual period, amount of flow
278...OB-4	10	0304	30	30	Menstrual history, unusual features
279...OB-4	11	0304	31	31	Menstrual history; LMP, type of entry
280...OB-4	11	0304	32	33	Menstrual history; LMP, first day (mo)
281...OB-4	11	0304	34	35	Menstrual history; LMP, first day (day)
282...OB-4	11	0304	36	37	Menstrual history; LMP, first day (yr)
283...OB-4	12	0304	38	39	Menstrual history; PMP, first day (mo)
284...OB-4	12	0304	40	41	Menstrual history; PMP, first day (day)
285...OB-4	12	0304	42	43	Menstrual history; PMP, first day (yr)
286...OB-4	12	0304	44	44	Menstrual history; PMP, type of entry
287...OB-4	14	0304	45	45	Dysmenorrhea
288...OB-4	16	0304	46	46	Fertility, patient trying to become pregnant
289...OB-4	17	0304	47	48	Fertility, months to become pregnant
290...OB-4	18	0304	49	49	Fertility; contraceptive use, usual
291...OB-4	19	0304	50	50	Fertility; contraceptive use at conception
292...OB-4	20	0304	51	51	Fertility; contraceptive type used, diaphragm
293...OB-4	20	0304	52	52	Fertility; contraceptive type used, condom
294...OB-4	20	0304	53	53	Fertility; contraceptive type used, jelly
295...OB-4	20	0304	54	54	Fertility; contraceptive type used, vaginal suppository
296...OB-4	20	0304	55	55	Fertility; contraceptive type used, coitus interruptus
297...OB-4	20	0304	56	56	Fertility; contraceptive type used, douche
298...OB-4	20	0304	57	57	Fertility; contraceptive type used, rhythm
299...OB-4	20	0304	58	58	Fertility; contraceptive type used, oral contraceptives
300...OB-4	20	0304	59	59	Fertility; contraceptive type used, intrauterine ring
301...OB-4	20	0304	60	60	Fertility; contraceptive type used, other contraceptives
302...OB-4	21	0304	61	61	Fertility; sterility investigation
303.....		0304	62	80	Blank
4989....VAR	11		59	64	Menstrual period; LMP, first day (mo/day/yr)
4990....VAR	12		65	70	Menstrual period; PMP, first day (mo/day/yr)
4991....VAR	17		71	72	Fertility, length of time to become pregnant
4992....VAR	21		73	73	Sterility investigation
5203....VAR	14		311	311	Dysmenorrhea
5204....VAR	6		312	313	Menarche; age at onset of menstruation (yrs)

Data Items Referencing Form OB-4, Gynecological History

DATA ITEM TO	ITEM ON FORM	CARD NUM	FROM	TO	DATA ITEM NAME
5205....VAR			314	314	Menstrual cycle, unusual interval
5920....VAR	0		1101	1102	Gestation at delivery (wks)

COLR—3663-4
REV. 11-69
2

GYNECOLOGICAL HISTORY

(Interviewer)

2. HISTORY TAKEN BY

3. TITLE OR POSITION

4. DATE — Mo. / Day / Year

1. PATIENT IDENTIFICATION

5. MENSTRUAL HISTORY

6. AGE AT ONSET _____

7. DURATION _____

8. USUAL INTERVAL _____

9. AMOUNT AS DESCRIBED BY GRAVIDA

- ☐ HEAVY 1
- ☐ MEDIUM 2
- ☐ LIGHT 3

10. UNUSUAL FEATURES OF MENSTRUAL PERIOD

- ☐ NONE 0
- ☐ YES *(Describe)* 1

11. FIRST DAY OF LAST NORMAL MENSTRUAL PERIOD _____

12. FIRST DAY OF PREVIOUS MENSTRUAL PERIOD _____

13. EXPECTED DATE OF CONFINEMENT _____

14. DYSMENORRHEA

- ☐ NONE *(If no discomfort noted)* 0
- ☐ SLIGHT *(If discomfort noted but no medication is required)* 1
- ☐ MODERATE *(If discomfort requires medication but patient continues with usual activities)* 2
- ☐ SEVERE *(If patient has to be in bed or away from gainful employment for one day)* 3

15. FERTILITY

16. HAVE YOU BEEN TRYING TO BECOME PREGNANT?

- ☐ NO
- ☐ YES

17. IF YES, HOW LONG DID IT TAKE YOU TO BECOME PREGNANT?

_____ MONTHS

18. IF NO, DO YOU USUALLY USE A CONTRACEPTIVE?

- ☐ NO 0
- ☐ YES 1

19. WERE YOU USING A CONTRACEPTIVE AT THE TIME YOU BECAME PREGNANT?

- ☐ NO 0
- ☐ YES 1

20. IF YES, WHAT CONTRACEPTIVE WERE YOU USING? *(Check all applicable)*

- ☐ DIAPHRAGM 1
- ☐ CONDOM 2
- ☐ JELLY 3
- ☐ VAGINAL SUPPOSITORY 4
- ☐ COITUS INTERRUPTUS (Withdrawal) 5
- ☐ OTHER *(Describe)* 6

21. STERILITY INVESTIGATION

- ☐ NONE 0
- ☐ YES (Describe) 1

COLLABORATIVE RESEARCH
PERINATAL RESEARCH BRANCH, NINDS, NIH
BETHESDA 14, MD.

(REV. 11-69)

OB-4

Form Item Numbers linked to Data Items on OB-4, Gynecological History

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
	5205....VAR		314	314	Menstrual cycle, unusual interval
0	5920....VAR		1101	1102	Gestation at delivery (wks)
4	271...OB-4	0304	17	18	Form OB-4 date (day)
4	270...OB-4	0304	15	16	Form OB-4 date (mo)
4	272...OB-4	0304	19	20	Form OB-4 date (yr)
6	273...OB-4	0304	21	22	Menarche; age at onset of menstruation
6	5204....VAR		312	313	Menarche; age at onset of menstruation (yrs)
7	274...OB-4	0304	23	24	Menstrual period duration
8	276...OB-4	0304	27	28	Menstrual period usual interval, maximum
8	275...OB-4	0304	25	26	Menstrual period usual interval, minimum
9	277...OB-4	0304	29	29	Menstrual period, amount of flow
10	278...OB-4	0304	30	30	Menstrual history, unusual features
11	281...OB-4	0304	34	35	Menstrual history; LMP, first day (day)
11	280...OB-4	0304	32	33	Menstrual history; LMP, first day (mo)
11	282...OB-4	0304	36	37	Menstrual history; LMP, first day (yr)
11	279...OB-4	0304	31	31	Menstrual history; LMP, type of entry
11	4989....VAR		59	64	Menstrual period; LMP, first day (mo/day/yr)
12	284...OB-4	0304	40	41	Menstrual history; PMP, first day (day)
12	283...OB-4	0304	38	39	Menstrual history; PMP, first day (mo)
12	285...OB-4	0304	42	43	Menstrual history; PMP, first day (yr)
12	286...OB-4	0304	44	44	Menstrual history; PMP, type of entry
12	4990....VAR		65	70	Menstrual period; PMP, first day (mo/day/yr)
14	287...OB-4	0304	45	45	Dysmenorrhea
14	5203....VAR		311	311	Dysmenorrhea
16	288...OB-4	0304	46	46	Fertility, patient trying to become pregnant
17	4991....VAR		71	72	Fertility, length of time to become pregnant
17	289...OB-4	0304	47	48	Fertility, months to become pregnant
18	290...OB-4	0304	49	49	Fertility; contraceptive use, usual
19	291...OB-4	0304	50	50	Fertility; contraceptive use at conception
20	296...OB-4	0304	55	55	Fertility; contraceptive type used, coitus interruptus
20	293...OB-4	0304	52	52	Fertility; contraceptive type used, condom
20	292...OB-4	0304	51	51	Fertility; contraceptive type used, diaphragm
20	297...OB-4	0304	56	56	Fertility; contraceptive type used, douche
20	300...OB-4	0304	59	59	Fertility; contraceptive type used, intrauterine ring
20	294...OB-4	0304	53	53	Fertility; contraceptive type used, jelly
20	299...OB-4	0304	58	58	Fertility; contraceptive type used, oral contraceptives
20	301...OB-4	0304	60	60	Fertility; contraceptive type used, other contraceptives
20	298...OB-4	0304	57	57	Fertility; contraceptive type used, rhythm
20	295...OB-4	0304	54	54	Fertility; contraceptive type used, vaginal suppository
21	302...OB-4	0304	61	61	Fertility; sterility investigation
21	4992....VAR		73	73	Sterility investigation

DEFINITION OF CODES
GYNECOLOGICAL HISTORY
FORM OB-4 CARD 03041

FIELD		CARD COLUMN
1.	**Card Number** Code: 0	1
2.	**Form Number** Code: 304	2-4
3.	**Revision Number*** Code: 1 - Form Dated: 1/59 or Rev. 11/59	5
4.	**NINDB Number** Nine-digit number for Patient Identification Code: As given	6-14
5.	**Date Form Completed** Item 4 Six-digit code for month (cols. 15-16), day (cols. 17-18) and year (cols. 19-20) Code: As given 99 - Month, day and/or year unknown	15-20
6.	**Age At Onset** Item 6 Code: **00 - Never menstruated 08-25 - As given 99 - Unknown **Additional codes reviewed and approved: 04-07, 26	21-22
7.	**Duration of Menses** Item 7 Two-digit code for Lowest (col. 23) and Highest (col. 24) Code for each column: 0 - Never menstruated 1-7 - Number of days as given 8 - 8 or more days, irregular 9 - Unknown	23-24

Note: 00 - Never menstruated; 89 - Irregular; 99 - Unknown

* Item numbers refer to Form Dated 11/59

FIELD		CARD COLUMN
8.	**Usual Interval** Item 8 Four-digit code for Lowest (cols. 25-26) and Highest (cols. 27-28) Code for each column: 00 - Never menstruated 01-86 - Number of days as given 87 - 87 days or more 88 - Irregular 99 - Unknown	25-28
9.	**Amount of Flow** Item 9 Code: 1 - Heavy 2 - Medium 3 - Light 8 - Irregular 9 - Unknown	29
10.	**Unusual Features** Item 10 Code: 0 - None 1 - More than one period a month 2 - Skipped or missed one or more menstrual periods regularly 3 - Combination of codes 1 and 2 4 - Irregular 5 - Combination of codes 1 and 4 6 - Combination of codes 2 and 4 7 - Amenorrhea 8 - Spotting or staining between menstrual periods 9 - Unknown	30
11.	**Type of Entry: LMP** Code: 0 - One specific day reported for LMP 1 - Day of LMP reported as a range of 7 days or less 2 - Day of LMP reported as a range of 8 or more days 3 - Any portion of or entire date questioned 4 - Two LMP dates reported by gravida 5 - Two LMP dates reported - one by gravida and one by hospital editor 6 - Non-numerical entries 7 - Termination of last pregnancy 9 - Unknown	31

DEFINITION OF CODES (Continued)

FORM OB-4
Card 03041

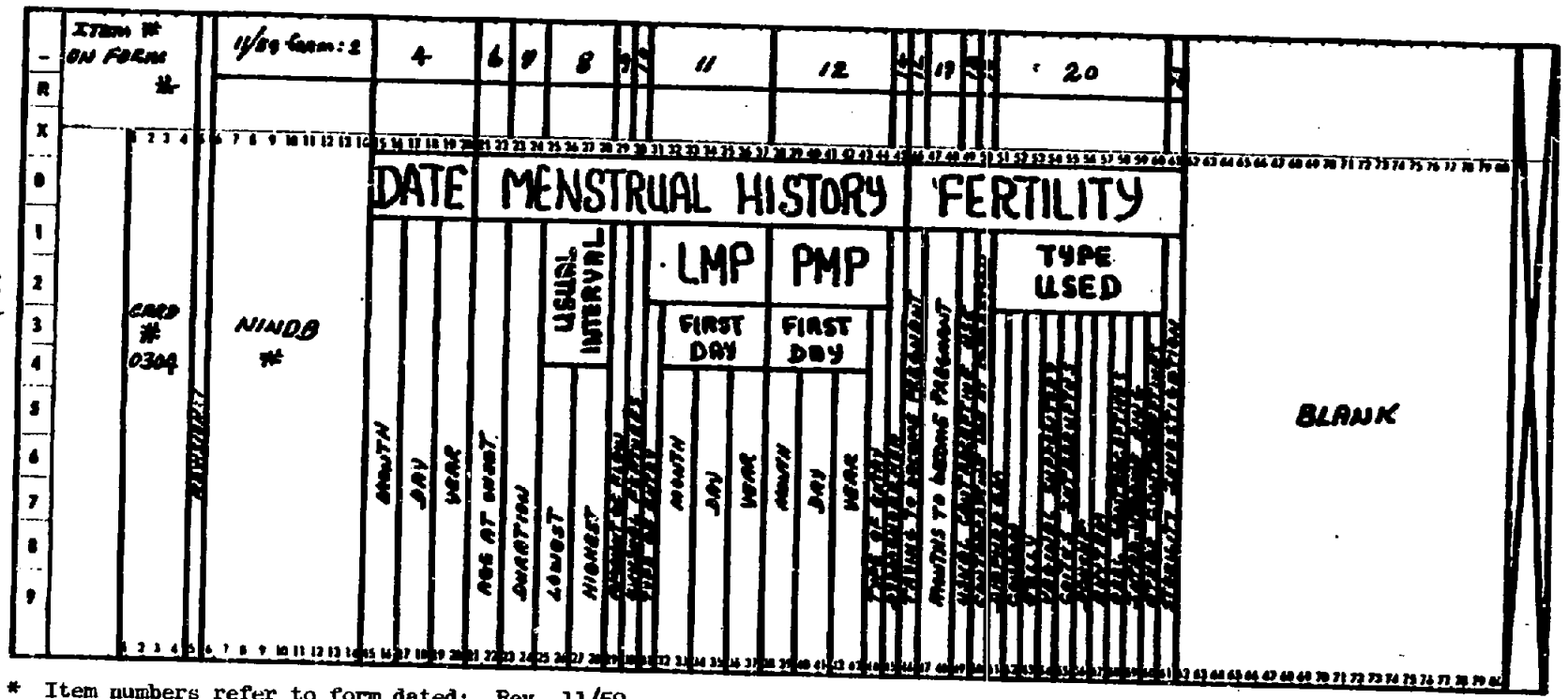
FIELD		CARD COLUMN
12.	LMP, First Day Item 11 Six-digit code for Month (cols. 32-33), Day (cols. 34-35) and Year (cols. 36-37) Code: As given 000000 - Never Menstruated 777777 - None since last delivery 99 - Month, day and/or year unknown Supplemental code for day: 04 - Early, beginning of month, first week 11 - Second week 16 - Middle 20 - Third week 27 - Last week, end of month, late	32-37
13.	PMP, First Day Item 12 Six-digit code for Month (cols. 38-39), Day (cols. 40-41) and Year (cols. 42-43) Code: Same as in Field 12	38-43
14.	Type of Entry: PMP Code: Same as in Field 11	44
15.	Dysmenorrhea Item 14 Code: 0 - None 1 - Slight 2 - Moderate 3 - Severe 8 - Irregular 9 - Unknown	45
16.	Trying to Become Pregnant Item 16 Code: 0 - No 1 - Yes 2 - Unconcerned 9 - Unknown	46
17.	Months to Become Pregnant Item 17 Code: 00 - Not applicable, not trying 01-97 - As given 98 - 98 months or more 99 - Unknown	47-48

DEFINITION OF CODES (Continued)

FORM OB-4
Card 03041

FIELD		CARD COLUMN
18.	Usual Contraceptive Use Item 18 Code: 0 - No 1 - Yes 2 - Occasionally 9 - Unknown	49
19.	Contraceptive Used at Conception Item 19 Code: 0 - No, not applicable 1 - Yes 9 - Unknown	50
20.	Type of Contraceptive Item 20 Ten-digit code for: Diaphragm (col. 51) Condom (col. 52) Jelly (col. 53) Vaginal Suppository (col. 54) Coitus Interruptus (col. 55) Douche (col. 56) Rhythm (col. 57) Oral Contraceptive (col. 58) Intra-Uterine Ring (col. 59) Other (col. 60) Code for each column: 0 - Not used 1 - Used 9 - Unknown	51-60
21.	Sterility Investigation Item 21 Code: Same as in Field 19	61

GYNECOLOGICAL HISTORY
FORM OB-4



* Item numbers refer to form dated: Rev. 11/59

GYNECOLOGICAL HISTORY
(For Form OB-4, Revised 11-59)

Instructions for Interviewer

In Item #2 "History Taken By", record your first and last name. Do not write in the small box following. In Item #3 "Title or Position" record your official title, such as "lay interviewer", "Nurse interviewer", "social worker", etc. In Item #4 labeled "Date", record the date this information was obtained in the manner designated: month, day, and year (11/22/59).

Item #5 MENSTRUAL HISTORY

Item #6 "Age at Onset"

Record the age (at her last birthday) at which the patient's menstrual periods began.

Item #7 "Duration"

Record the average number of days the patient's menstrual periods usually last.

Item #8 "Usual Interval"

Record the average number of days from the first day of one menstrual period to the first day of the next period.

Item #9 "Amount as Described by Gravida"

It is assumed that most women are aware whether the amount of their menstrual bleeding is greater or less than that of most other women. Ask the patient whether in her opinion she bleeds more than most other women at the time of her periods, less than other women, or about the same. If she states she bleeds more, record as "heavy"; if she bleeds about the same, record as "medium"; if she bleeds less, record "light".

Item #10 "Unusual Features of Menstrual Period"

Do not include dysmenorrhea (pain or discomfort with the menstrual period) under unusual features. This will be considered under Item #14. Unusual features of the menstrual period should include gross variations in the duration of flow and in the interval between periods, or any other feature which the patient thinks is unusual.

Item #11 "First Day of Last Normal Menstrual Period"

Record the first day of the last normal period in the order month, day, and year (9/22/59).

Item #12 "First Day of Previous Menstrual Period"

Record the first day of the menstrual period prior to the last normal period in the order month, day, and year (9/22/59).

February 1959
(For Forms in Use April 1961)

Item #13 "Expected Date of Confinement"

Record the expected date of confinement (in the order month, day, and year) obtained by adding seven days to the first day of the last normal menstrual period, adding one year, and counting back three months. If this is obviously not correct, record the obstetrician's estimate instead.

Item #14 "Dysmenorrhea"

Ask the patient if she has any discomfort with her periods. If she has none, check "None". If the patient notes some discomfort, but takes no medication (not even aspirin), check "Slight". If the patient has discomfort which requires medication but is able to continue with her usual activities, check "Moderate". If the patient's discomfort is such that she must remain in bed or away from gainful employment for at least one day, check "Severe".

Item #15 FERTILITY

Item #16 "Have you been Trying to Become Pregnant?"

Ask the patient if she has been trying to become pregnant. If she says "yes", ask question #17, "How long did it take you to become pregnant?" The answer is to be determined in months. If the patient says "no" to Item #16, ask Item #18, "If no, do you usually use a contraceptive?" Record "yes" or "no".

Item #19 "Were you Using a Contraceptive at the Time You Became Pregnant?"

This must be asked of all patients. This refers to the actual exposure at which the patient believes she conceived. Record "yes" or "no". If the patient does not know whether a contraceptive was used at the actual time she conceived, write "UNK" in the space to the right. If the patient answers "no", omit Item #20. If the answer is "yes" ask what contraceptive the patient was using, and check more than one contraceptive if more than one was used at the same time.

Item #21 "Sterility Investigation"

Inquire whether the patient has ever been examined to determine why she did not become pregnant. If the patient did not go to the doctor specifically for this, check "no". If she has gone to the doctor to see why she did not become pregnant, check "yes" and obtain all information possible regarding what the doctor did in the way of investigation.

PHS [illegible] 1-60

GYNECOLOGICAL HISTORY

(Interviewer) yellow

superseded by 11-59 rev.

HISTORY TAKEN BY

TITLE OR POSITION | DATE (Mo-Day-Yr)

I. MENSTRUAL HISTORY

1. AGE AT ONSET _____
2. DURATION _____
3. USUAL INTERVAL _____
4. AMOUNT AS DESCRIBED BY GRAVIDA
   - ☐ Heavy
   - ☐ Medium
   - ☐ Light
5. UNUSUAL FEATURES OF MENSTRUAL PERIOD
   - ☐ None
   - ☐ Yes (Describe)

6. FIRST DAY OF LAST NORMAL MENSTRUAL PERIOD _____
7. FIRST DAY OF PREVIOUS MENSTRUAL PERIOD _____
8. EXPECTED DATE OF CONFINEMENT _____
9. DYSMENORRHEA
   - ☐ None (If no discomfort noted)
   - ☐ Slight (If discomfort noted but no medication is required)
   - ☐ Moderate (If discomfort requires medication ... if patient continues with usual activities)
   - ☐ Severe (If patient has to be in bed or away from gainful employment for one day)

II. FERTILITY

1. HAVE YOU BEEN TRYING TO BECOME PREGNANT?
   - ☐ No
   - ☐ Yes
2. IF YES, HOW LONG DID IT TAKE YOU TO BECOME PREGNANT?
   _____ MONTHS
3. IF NO, DO YOU USUALLY USE A CONTRACEPTIVE?
   - ☐ No
   - ☐ Yes
4. WERE YOU USING A CONTRACEPTIVE AT THE TIME YOU BECAME PREGNANT?
   - ☐ No
   - ☐ Yes
5. IF YES, WHAT CONTRACEPTIVE WERE YOU USING? (Check all applicable).
   - ☐ Diaphragm
   - ☐ Condom
   - ☐ Jelly
   - ☐ Vaginal Suppository
   - ☐ Coitus Interruptus (Withdrawal)
   - ☐ Other (Describe)
6. STERILITY INVESTIGATION
   - ☐ None
   - ☐ Yes (Describe)

Department of Health, Education and Welfare
Public Health Service

(OB-4)

OB-5 Recent Medical History

Form OB-5 was used to obtain medical history for the 12 month period preceding the date the history was taken. The form was first used in January 1959; it was revised in November 1959. The revised form was renumbered and the information on medications was made more specific.

Two cards were used in keypunching data records (Table OB-5.1). Cards punched from the January 1959 version of the form contain information on medications taken in columns 66 to 78 of card 2305; this information is found in columns 50 to 65 of card 2305 for the November 1959 revision. All other columns on the cards contain data from both the January 1959 version and the November 1959 revision. Item numbers refer to the November 1959 revision.

TABLE OB-5.1 Cards and Data Records by Revision for Form OB-5

CARD NAME	CARD NUMBER	REV. NO.	NUMBER RECORDS
OB-5: Illness or Disability	1305		
		0	8,676
		1	47,289
			55,965
OB-5: Non-Confining Illness or Disability	2305		
		0	8,654
		1	47,043
			55,697
	total for form		111,662

Data Items Referencing Form DB-5, Recent Medical History

DATA ITEM ID	ITEM IN FORM	CARD NUM	FROM	TO	DATA ITEM NAME
304.....		1305	1	5	Card number (sequence, form type, form number, revision number)
305.....		1305	6	14	NTNDB case number
306...DB-5	5	1305	15	16	Form DB-5 date (mo)
307...DB-5	5	1305	17	18	Form DB-5 date (day)
308...DB-5	5	1305	19	20	Form DB-5 date (yr)
309...DB-5		1305	21	21	Illness or disability, requiring confinement, number
310...DB-5	7	1305	22	23	Illness or disability, requiring confinement, type
311...DB-5	8	1305	24	25	Illness or disability, requiring confinement, days in bed
312...DB-5	9	1305	26	27	Illness or disability, requiring confinement, date onset (mo)
313...DB-5	9	1305	28	29	Illness or disability, requiring confinement, date onset (day)
314...DB-5	9	1305	30	31	Illness or disability, requiring confinement, date onset (yr)
315...DB-5	10	1305	32	32	Illness or disability, requiring confinement; physician consulted or hospitalized
316...DB-5	7	1305	33	34	Illness or disability, requiring confinement, type
317...DB-5	8	1305	35	36	Illness or disability, requiring confinement, days in bed
318...DB-5	9	1305	37	38	Illness or disability, requiring confinement, date onset (mo)
319...DB-5	9	1305	39	40	Illness or disability, requiring confinement, date onset (day)
320...DB-5	9	1305	41	42	Illness or disability, requiring confinement, date onset (yr)
321...DB-5	10	1305	43	43	Illness or disability, requiring confinement; physician consulted or hospitalized
322...DB-5	7	1305	44	45	Illness or disability, requiring confinement, type
323...DB-5	8	1305	46	47	Illness or disability, requiring confinement, days in bed
324...DB-5	9	1305	48	49	Illness or disability, requiring confinement, date onset (mo)
325...DB-5	9	1305	50	51	Illness or disability, requiring confinement, date onset (day)
326...DB-5	9	1305	52	53	Illness or disability, requiring confinement, date onset (yr)
327...DB-5	10	1305	54	54	Illness or disability, requiring confinement; physician consulted or hospitalized
328...DB-5	7	1305	55	56	Illness or disability, requiring confinement, type
329...DB-5	8	1305	57	58	Illness or disability, requiring confinement, days in bed
330...DB-5	8	1305	59	60	Illness or disability, requiring confinement, date onset (mo)
331...DB-5	9	1305	61	62	Illness or disability, requiring confinement, date onset (day)
332...DB-5	9	1305	63	64	Illness or disability, requiring confinement, date onset (yr)
333...DB-5	10	1305	65	65	Illness or disability, requiring confinement; physician consulted or hospitalized
334.....		1305	66	80	Blank
335.....		2305	1	5	Card number
336.....		2305	6	14	NTNDB case number
337...DB-5	5	2305	15	16	Form DB-5 date (mo)
338...DB-5	5	2305	17	18	Form DB-5 date (day)
339...DB-5	5	2305	19	20	Form DB-5 date (yr)
340...DB-5		2305	21	22	Illness or disability, non confining, number
341...DB-5	12	2305	23	24	Illness or disability, non confining, type

Data Items Referencing Form OB-5, Recent Medical History

DATA ITEM ID	ITEM IN FORM	CARD NUM	FROM	TO	DATA ITEM NAME
342...OB-5	13	2305	25	26	Illness or disability, non confining, date onset (mo)
343...OB-5	13	2305	27	28	Illness or disability, non confining, date onset (day)
344...OB-5	13	2305	29	30	Illness or disability, non confining, date onset (yr)
345...OB-5	14	2305	31	31	Illness or disability, non confining; physician consulted
346...OB-5	12	2305	32	33	Illness or disability, non confining, type
347...OB-5	12	2305	34	35	Illness or disability, non confining, date onset (mo)
348...OB-5	12	2305	36	37	Illness or disability, non confining, date onset (day)
349...OB-5	12	2305	38	39	Illness or disability, non confining, date onset (yr)
350...OB-5	12	2305	40	40	Illness or disability, non confining; physician consulted
351...OB-5	12	2305	41	42	Illness or disability, non confining, type
352...OB-5	13	2305	43	44	Illness or disability, non confining, date onset (mo)
353...OB-5	13	2305	45	46	Illness or disability, non confining, date onset (day)
354...OB-5	13	2305	47	48	Illness or disability, non confining, date onset (yr)
355...OB-5	14	2305	49	49	Illness or disability, non confining; physician consulted
356...OB-5	16	2305	50	50	Immunization, pre/post LMP, preceding 12 months
357...OB-5	17	2305	51	51	Antibiotic infection, pre/post LMP, preceding 12 months
358...OB-5	18	2305	52	52	Antibiotics, other, pre/post LMP, preceding 12 months
359...OB-5	29	2305	53	53	Injection, other, pre/post LMP, preceding 12 months
360...OB-5	20	2305	54	54	Injection, unknown, pre/post LMP, preceding 12 months
361...OB-5	21	2305	55	55	Sleeping pills, pre/post LMP, preceding 12 months
362...OB-5	22	2305	56	56	Tranquilizers, pre/post LMP, preceding 12 months
363...OB-5	23	2305	57	57	Diet or "pep" pills, pre/post LMP, preceding 12 months
364...OB-5	24	2305	58	58	Antihistamines, pre/post LMP, preceding 12 months
365...OB-5	25	2305	59	59	Insulin, pre/post LMP, preceding 12 months
366...OB-5	26	2305	60	60	Thyroid or anti-thyroid, pre/post LMP, preceding 12 months
367...OB-5	27	2305	61	61	Cortisone, pre/post LMP, preceding 12 months
368...OB-5	28	2305	62	62	Hormones, other, pre/post LMP, preceding 12 months
369...OB-5	30	2305	63	63	Laxatives, pre/post LMP, preceding 12 months
370...OB-5	31	2305	64	64	Headache pills, powders, pre/post LMP, preceding 12 months
371...OB-5	32	2305	65	65	Medication or injection, other, pre/post LMP, preceding 12 months
372...OB-5		2305	66	66	Immunization, yes/no, preceding 12 months
373...OB-5		2305	67	67	Antibiotics, yes/no, preceding 12 months
374...OB-5		2305	68	68	Injection, yes/no, other, preceding 12 months
375...OB-5		2305	69	69	Injection, yes/no, unknown, preceding 12 months
376...OB-5		2305	70	70	Antibiotics, yes/no, other, preceding 12 months
377...OB-5		2305	71	71	Laxatives, yes/no, preceding 12 months
378...OB-5		2305	72	72	Sleeping pills, yes/no, preceding 12 months
379...OB-5		2305	73	73	Tranquilizers, yes/no, preceding 12 months
380...OB-5		2305	74	74	Diet or "pep" pills, yes/no, preceding 12 months
381...OB-5		2305	75	75	Headache pills, yes/no, powders, preceding 12 months
382...OB-5		2305	76	76	Nose drops; inhalers, yes/no, preceding 12 months
383...OB-5		2305	77	77	Antihistamines, yes/no, preceding 12 months
384...OB-5		2305	78	78	Medication, yes/no, other, preceding 12 months

Data Items Referencing Form OB-5, Recent Medical History

DATA ITEM ID	ITEM ON FORM	CARD NUM	FROM	TO	DATA ITEM NAME
385.....		2305	79	80	Blank
5206....VAR	6		315	315	Illness confining, preceding 12 months, total number

COLR-3963-6
REV. 11-69
2

RECENT MEDICAL HISTORY

(Interviewee)

1. PATIENT IDENTIFICATION

2. HISTORY RECORDED BY | 3.

4. TITLE OR POSITION | 5. DATE Mo. Day Year

6. ILLNESS OR DISABILITY REQUIRING CONFINEMENT TO BED DURING PRECEDING 12 MONTHS

7. ILLNESS OR DISABILITY	8. DAYS IN BED	9. DATE OF ONSET Mo. Day Year	10. PHYSICIAN CONSULTED AND HOSPITAL IF HOSPITALIZED
(1)			☐ HOSP. 1 ☐ PHYS. 2 ☐ NO 0
(2)			☐ HOSP. 1 ☐ PHYS. 2 ☐ NO 0
(3)			☐ HOSP. 1 ☐ PHYS. 2 ☐ NO 0
(4)			☐ HOSP. 1 ☐ PHYS. 2 ☐ NO 0

11. NON-CONFINING ILLNESS OR DISABILITY PRESENT DURING PRECEDING 12 MONTHS

12. ILLNESS OR DISABILITY	13. DATE OF ONSET Mo. Day Year	14. PHYSICIAN CONSULTED
(1)		☐ NONE 0
(2)		☐ NONE 0
(3)		☐ NONE 0

15. MEDICATION OR INJECTIONS TAKEN DURING PRECEDING 12 MONTHS

	NO	YES-BEFORE LMP 1	YES-SINCE LMP 2	UNKNOWN 9
16. IMMUNIZATIONS				
17. ANTIBIOTICS (by injection)				
18. ANTIBIOTICS (other than by injection)				
19. OTHER INJECTION (specify)				
20. UNKNOWN TYPE OF INJECTION				
21. SLEEPING PILLS				
22. TRANQUILIZERS				
23. "PEP" OR DIET PILLS				
24. ANTIHISTAMINES				
25. INSULIN				
26. THYROID OR ANTI-THYROID				
27. CORTISONE				
28. OTHER HORMONES				
29. OTHER TYPE OF MEDICATION Check "YES" on items below only if taken weekly or more often, or if prescribed by a physician.				
30. LAXATIVES				
31. HEADACHE PILLS OR POWDERS				
32. OTHER				

33. LIST BY BOX NUMBER AND DESCRIBE ANY POSITIVE ANSWERS INDICATING SPECIFIC DRUG IF KNOWN, REASON FOR TAKING, AND FREQUENCY OR NUMBER OF TIMES TAKEN. GIVE LATEST DATE PATIENT HAS TAKEN EACH DRUG REPORTED.

COLLABORATIVE RESEARCH
PERINATAL RESEARCH BRANCH, NINDB, NIH
BETHESDA 14, MD.

(REV. 11-69)

OB-5

Form Item Numbers linked to Data Items on OB-5, Recent Medical History

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
	376...OB-5	2305	70	70	Antibiotics, yes/no, other, preceding 12 months
	373...OB-5	2305	67	67	Antibiotics, yes/no, preceding 12 months
	383...OB-5	2305	77	77	Antihistamines, yes/no, preceding 12 months
	380...OB-5	2305	74	74	Diet or "pep" pills, yes/no, preceding 12 months
	381...OB-5	2305	75	75	Headache pills, yes/no, powders, preceding 12 months
	340...OB-5	2305	21	22	Illness or disability, non confining, number
	309...OB-5	1305	21	21	Illness or disability, requiring confinement, number
	372...OB-5	2305	66	66	Immunization, yes/no, preceding 12 months
	374...OB-5	2305	68	68	Injection, yes/no, other, preceding 12 months
	375...OB-5	2305	69	69	Injection, yes/no, unknown, preceding 12 months
	377...OB-5	2305	71	71	Laxatives, yes/no, preceding 12 months
	384...OB-5	2305	78	78	Medication, yes/no, other, preceding 12 months
	382...OB-5	2305	76	76	Nose drops; inhalers, yes/no, preceding 12 months
	378...OB-5	2305	72	72	Sleeping pills, yes/no, preceding 12 months
	379...OB-5	2305	73	73	Tranquilizers, yes/no, preceding 12 months
5	338...OB-5	2305	17	18	Form OB-5 date (day)
5	307...OB-5	1305	17	18	Form OB-5 date (day)
5	337...OB-5	2305	15	16	Form OB-5 date (mo)
5	306...OB-5	1305	15	16	Form OB-5 date (mo)
5	308...OB-5	1305	19	20	Form OB-5 date (yr)
5	339...OB-5	2305	19	20	Form OB-5 date (yr)
6	5206....VAR		315	315	Illness confining, preceding 12 months, total number
7	310...OB-5	1305	22	23	Illness or disability, requiring confinement, type
7	328...OB-5	1305	55	56	Illness or disability, requiring confinement, type
7	322...OB-5	1305	44	45	Illness or disability, requiring confinement, type
7	316...OB-5	1305	33	34	Illness or disability, requiring confinement, type
8	330...OB-5	1305	59	60	Illness or disability, requiring confinement, date onset (mo)
8	323...OB-5	1305	46	47	Illness or disability, requiring confinement, days in bed
8	311...OB-5	1305	24	25	Illness or disability, requiring confinement, days in bed
8	329...OB-5	1305	57	58	Illness or disability, requiring confinement, days in bed
8	317...OB-5	1305	35	36	Illness or disability, requiring confinement, days in bed
9	319...OB-5	1305	39	40	Illness or disability, requiring confinement, date onset (day)
9	313...OB-5	1305	28	29	Illness or disability, requiring confinement, date onset (day)
9	325...OB-5	1305	50	51	Illness or disability, requiring confinement, date onset (day)
9	331...OB-5	1305	61	62	Illness or disability, requiring confinement, date onset (day)
9	324...OB-5	1305	48	49	Illness or disability, requiring confinement, date onset (mo)
9	312...OB-5	1305	26	27	Illness or disability, requiring confinement, date onset (mo)
9	318...OB-5	1305	37	38	Illness or disability, requiring confinement, date onset (mo)
9	314...OB-5	1305	30	31	Illness or disability, requiring confinement, date onset (yr)
9	326...OB-5	1305	52	53	Illness or disability, requiring confinement, date onset (yr)
9	332...OB-5	1305	63	64	Illness or disability, requiring confinement, date onset (yr)
9	320...OB-5	1305	41	42	Illness or disability, requiring confinement, date onset (yr)

Form Item Numbers linked to Data Items on OB-5, Recent Medical History

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
10	321...OB-5	1305	43	43	Illness or disability, requiring confinement; physician consulted or hospitalized
10	327...OB-5	1305	54	54	Illness or disability, requiring confinement; physician consulted or hospitalized
10	333...OB-5	1305	65	65	Illness or disability, requiring confinement; physician consulted or hospitalized
10	315...OB-5	1305	32	32	Illness or disability, requiring confinement; physician consulted or hospitalized
12	348...OB-5	2305	36	37	Illness or disability, non confining, date onset (day)
12	347...OB-5	2305	34	35	Illness or disability, non confining, date onset (mo)
12	349...OB-5	2305	38	39	Illness or disability, non confining, date onset (yr)
12	351...OB-5	2305	41	42	Illness or disability, non confining, type
12	346...OB-5	2305	32	33	Illness or disability, non confining, type
12	341...OB-5	2305	23	24	Illness or disability, non confining, type
12	350...OB-5	2305	40	40	Illness or disability, non confining; physician consulted
13	353...OB-5	2305	45	46	Illness or disability, non confining, date onset (day)
13	343...OB-5	2305	27	28	Illness or disability, non confining, date onset (day)
13	352...OB-5	2305	43	44	Illness or disability, non confining, date onset (mo)
13	342...OB-5	2305	25	26	Illness or disability, non confining, date onset (mo)
13	354...OB-5	2305	47	48	Illness or disability, non confining, date onset (yr)
13	344...OB-5	2305	29	30	Illness or disability, non confining, date onset (yr)
14	355...OB-5	2305	49	49	Illness or disability, non confining; physician consulted
14	345...OB-5	2305	31	31	Illness or disability, non confining; physician consulted
16	356...OB-5	2305	50	50	Immunization, pre/post LMP, preceding 12 months
17	357...OB-5	2305	51	51	Antibiotic injection, pre/post LMP, preceding 12 months
18	358...OB-5	2305	52	52	Antibiotics, other, pre/post LMP, preceding 12 months
20	360...OB-5	2305	54	54	Injection, unknown, pre/post LMP, preceding 12 months
21	361...OB-5	2305	55	55	Sleeping pills, pre/post LMP, preceding 12 months
22	362...OB-5	2305	56	56	Tranquilizers, pre/post LMP, preceding 12 months
23	363...OB-5	2305	57	57	Diet or "pep" pills, pre/post LMP, preceding 12 months
24	364...OB-5	2305	58	58	Antihistamines, pre/post LMP, preceding 12 months
25	365...OB-5	2305	59	59	Insulin, pre/post LMP, preceding 12 months
26	366...OB-5	2305	60	60	Thyroid or anti-thyroid, pre/post LMP, preceding 12 months
27	367...OB-5	2305	61	61	Cortisone, pre/post LMP, preceding 12 months
28	368...OB-5	2305	62	62	Hormones, other, pre/post LMP, preceding 12 months
29	359...OB-5	2305	53	53	Injection, other, pre/post LMP, preceding 12 months
30	369...OB-5	2305	63	63	Laxatives, pre/post LMP, preceding 12 months
31	370...OB-5	2305	64	64	Headache pills, powders, pre/post LMP, preceding 12 months
32	371...OB-5	2305	65	65	Medication or injection, other, pre/post LMP, preceding 12 months

DEFINITION OF CODES
RECENT MEDICAL HISTORY
FORM OB-5 CARD 1305

FIELD		CARD COLUMN
1.	Card Number Code: 1	1
2.	Form Number Code: 305	2-4
3.	Revision Number * Code: 0 - Form Dated: 1/59 1 - Form Dated: Rev. 11/59	5
4.	NINDB Number Nine-digit number for Patient Identification. Code: As given	6-14
5.	Date Form Completed Item 5 Six-digit code for month (cols. 15-16), day (cols. 17-18) and year (cols. 19-20) Code: As given 99 - Month, day and/or year unknown	15-20
6.	Number of Illnesses or Disabilities Requiring Confinement to Bed Item 6 Code: 0 - None 1-7 - As reported 8 - 8 or more reported 9 - Unknown	21
7.	ILLNESS OR DISABILITY I. Illness or Disability - Type (cols. 22-23) Item 7 Code: See Attachment, "Illness or Disability Codes" page OB 5-10 Days In Bed (cols. 24-25) Item 8 Code: 00 - Less than one day 01-97 - As reported 98 - 98 or more days 99 - Unknown	22-32

* Item numbers refer to Form Dated: 11/59

DEFINITION OF CODES (Continued)

FORM OB-5
Card 1305

FIELD		CARD COLUMN
7.	ILLNESS OR DISABILITY I (continued) Item 9 Date of Onset (cols. 26-31) Six-digit code for Month (cols. 26-27), Day (cols. 28-29), and Year (cols. 30-31) Code: As given 000000 - None 99 - Month, day and/or year unknown Supplemental code for day: 04 - Early, beginning of month, first week 11 - Second week 16 - Middle 20 - Third week 27 - Last week, end of month, late Physician Consulted or Hospitalized (col. 32) Item 10 Code: 0 - No 1 - Hospitalized 2 - Physician consulted 3 - Hospitalized and physician consulted 9 - Unknown Note: No illness = "0's" for entire field	22-32
8.	ILLNESS OR DISABILITY II Code: Same as in Field 7	33-43
9.	ILLNESS OR DISABILITY III Code: Same as in Field 7	44-54
10.	ILLNESS OR DISABILITY IV Code: Same as in Field 7	55-65

Note: An illness or disability may be recorded in any of the four fields; therefore, all fields must be checked for data.

DEFINITION OF CODES (Continued)

FORM OB-5
Card 2305

FIELD		CARD COLUMN
1.	Card Number Code: 2	1
2.	Basic Data * Code: Same as in columns 2-20 of Card 1	2-20
3.	Non-Confining Illness or Disability During Preceding 12 Months Item 11 Two-digit code for: Total Number Reported (col. 21) Total Illnesses for Which Physician, Hospital or Clinic was Visited (col. 22) Code for each column: 0 - None 1-7 - As given 8 - 8 or more 9 - Unknown	21-22
4.	NON-CONFINING ILLNESS OR DISABILITY I	23-31

Illness or Disability - Type (cols. 23-24)
Item 12
Code: See Attachment "Illness or Disability Codes" page OB 5 - 10-11

Date of Onset (cols. 25-30)
Item 13
Six-digit code for Month (cols. 25-26), Day (cols. 27-28), and Year (cols. 29-30)
Code: As given
000000 - None
99 - Month, day and/or year unknown
Supplemental code for day:
04 - Early, beginning of month, first week
11 - Second week
16 - Middle
20 - Third week
27 - Last week, end of month, late

* Unless specified, Fields, Codes and Card Columns refer to Revisions "0" and "1". Item numbers refer to Form Dated: 11/59.

FIELD		CARD COLUMN
4.	NON-CONFINING ILLNESS OR DISABILITY I * (continued)	23-31
	Physician Consulted (col. 31) Item 14 Code: 0 - No 1 - Yes 9 - Unknown Note: No illness = "0's" for entire field	
5.	NON-CONFINING ILLNESS OR DISABILITY II * Code: Same as in Field 4	32-40
6.	NON-CONFINING ILLNESS OR DISABILITY III* Code: Same as in Field 4	41-49
7.	Immunization (Revision "1" only) Item 16 Code: 0 - No 1 - Yes, before LMP 2 - Yes, since LMP 3 - Combination of codes 1 and 2 8 - Unknown 9 - Not evaluated, not on Rev. "0"	50
8.	Antibiotic Injection (Revision "1" only) Item 17 Code: Same as in Field 7	51
9.	Antibiotics - Other than Injection (Revision "1" only) Item 18 Code: Same as in Field 7	52
10.	Other Injection (Revision "1" only) Item 19 Code: Same as in Field 7	53
11.	Unknown Type of Injection (Revision "1" only) Item 20 Code: Same as in Field 7	54

* An illness or disability may be recorded in any of the three fields (4-6); therefore, all fields must be checked for data.

FIELD		CARD COLUMN
12.	Sleeping Pills (Revision "1" only) Item 21 Code: Same as in Field 7	55
13.	Tranquilizers (Revision "1" only) Item 22 Code: Same as in Field 7	56
14.	"Pep" or Diet Pills (Revision "1" only) Item 23 Code: Same as in Field 7	57
15.	Antihistamines (Revision "1" only) Item 24 Code: Same as in Field 7	58
16.	Insulin (Revision "1" only) Item 25 Code: Same as in Field 7	59
17.	Thyroid or Anti-Thyroid (Revision "1" only) Item 26 Code: Same as in Field 7	60
18.	Cortisone (Revision "1" only) Item 27 Code: Same as in Field 7	61
19.	Other Hormones (Revision "1" only) Item 28 Code: Same as in Field 7	62
20.	Laxatives (Revision "1" only) Item 30 Code: Same as in Field 7	63
21.	Headache Pills or Powders (Revision "1" only) Item 31 Code: Same as in Field 7	64
22.	Other (Revision "1" only) Item 32 Code: Same as in Field 7	65

FIELD		CARD COLUMN
23.	Immunization (Revision "0" only) Item 1, Section III Code: 0 - No 1 - Yes 9 - Unknown Blank - Not on Revision "1"	66
24.	Antibiotics (Revision "0" only) Item 2, Section III Code: Same as in Field 23	67
25.	Other Injection (Revision "0" only) Item 3, Section III Code: Same as in Field 23	68
26.	Unknown Type of Injection (Revision "0" only) Item 4, Section III Code: Same as in Field 23	69
27.	Antibiotic - Other (Revision "0" only) Item 5, Section III Code: Same as in Field 23	70
28.	Laxatives (Revision "0" only) Item 6, Section III Code: Same as in Field 23	71
29.	Sleeping Pills (Revision "0" only) Item 7, Section III Code: Same as in Field 23	72
30.	Tranquilizer (Revision "0" only) Item 8, Section III Code: Same as in Field 23	73
31.	"Pep" or Diet Pills (Revision "0" only) Item 9, Section III Code: Same as in Field 23	74
32.	Headache Pills or Powders (Revision "0" only) Item 10, Section III Code: Same as in Field 23	75

FIELD		CARD COLUMN
33.	Nose Drops or Inhalers (Revision "0" only) Item 11, Section III Code: Same as in Field 23	76
34.	Antihistamines (Revision "0" only) Item 12, Section III Code: Same as in Field 23	77
35.	Other Type of Medication (Revision "0" only) Item 13, Section III Code: Same as in Field 23	78

NOTE: WHEN OCCURRANCE OF CONFINING OR NON-CONFINING IS DUE TO MORE THAN ONE ILLNESS, THE MOST MEDICALLY SIGNIFICANT CAUSE IS NOT CODED. THE HIGHEST NUMERIC CODE FOR THAT OCCURRANCE IS CODED.

ILLNESS OR DISABILITY CODES
OB-5

00 None

Cardiovascular and Blood Systems
01 Cardiovascular (general)
02 Rheumatic Fever
03 Thrombophlebitis
04 Anemia
05 Cardiovascular Surgery
06 Leukemia and Lymphomas
07 Pericarditis
08 Purpura (all types)
09 Combination of codes 01-08

Pulmonary Systems
10 Respiratory Diseases (general)
11 Tuberculosis (all sites and procedures)
12 Pneumona and Pneumonitis
13 Bronchial Asthma
14 Pulmonary Surgery
15 Hemoptysis and Pulmonary Embolism
16 Sarcoidosis (all sites and procedures)
19 Combination of codes 10-16

Metabolic System
20 Metabolic Diseases (general)
21 Glucose Metabolism Disorders
22 Thyroid Diseases
23 Endocrine Surgery
24 Glycosuria (not specified as diabetes)
29 Combination of codes 20-24

Genito-Urinary System
30 Genitourinary (general)
31 Glomerulonephritis
32 Genito-Urinary Infection
33 Genito-Urinary Surgery
34 Hematuria
35 Genito-Urinary Stones
36 Nephrosis
37 Genito-Urinary Tumors
39 Combination of codes 30-37

Gynecological System
40 Gynecological (general)
41 Gynecological Tumors
42 Infertility and Sterility
43 Venereal Diseases
44 Gynecological Surgery
45 Complications of Pregnancy
46 Termination of Pregnancy (except ectopic and mole)
47 Ectopic Pregnancy
48 Trophoblastic Tumors
49 Combination of codes 40-48

Neurological Systems and Psychiatric
50 Neurological (general)
51 Convulsive Disorders
52 CNS Infections and Tumors
53 Neurological Surgery
54 Neuroses and Psychiatric Disorders, n.o.s.
55 Psychoses
56 Alcoholism
57 Drug Addiction
58 Cerebral Palsy
59 Combination of codes 50-58

Gastro-Intestinal Systems
60 Abdominal and Gastrointestinal Diseases (general)
61 Jaundice and Hepatitis
62 Gallbladder and Pancreatic Diseases
63 Gastrointestinal Diseases
64 Hernia (Hiatal only)
65 Abdominal and Gastro-intestinal Tumors (not elsewhere specified)
66 Abdominal and Gastro-intestinal Surgery
67 Hematemesis and Melena
68 Splenic Diseases and Surgery
69 Combination of codes 60-68

ILLNESS OR DISABILITY CODES
(Continued)

Skin, Breast and Appendages

70 Skin Diseases (General)
71 Burns
72 Breast Diseases
73 Diseases of the Head and Neck
74 General Diseases of Extremities (including fractures)
75 Breast Surgery
76 Surgery of skin, head, neck and extremities
77 Bone infections and tumors (any site)
79 Combination of codes 70-77

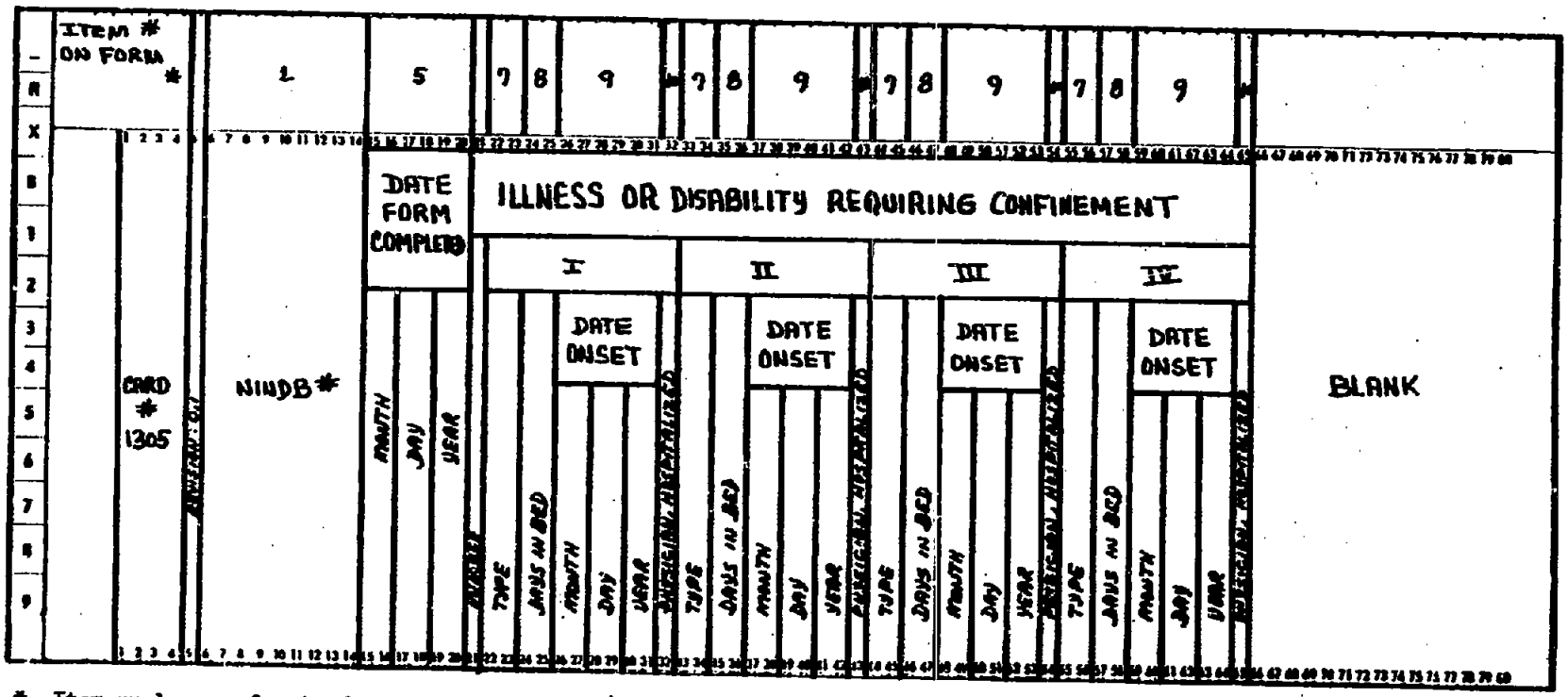
Infectious Diseases

80 Infections (site and type not specified)
81 Viral Infections
82 Bacterial Infections
83 Intestinal Parasitic Infections
84 Fungal Infections
85 Scabies
86 Rickettsial Infections
88 Immunization Procedures and Antitoxin Administration
89 Combination of codes 80-88

Other Diseases and Conditions

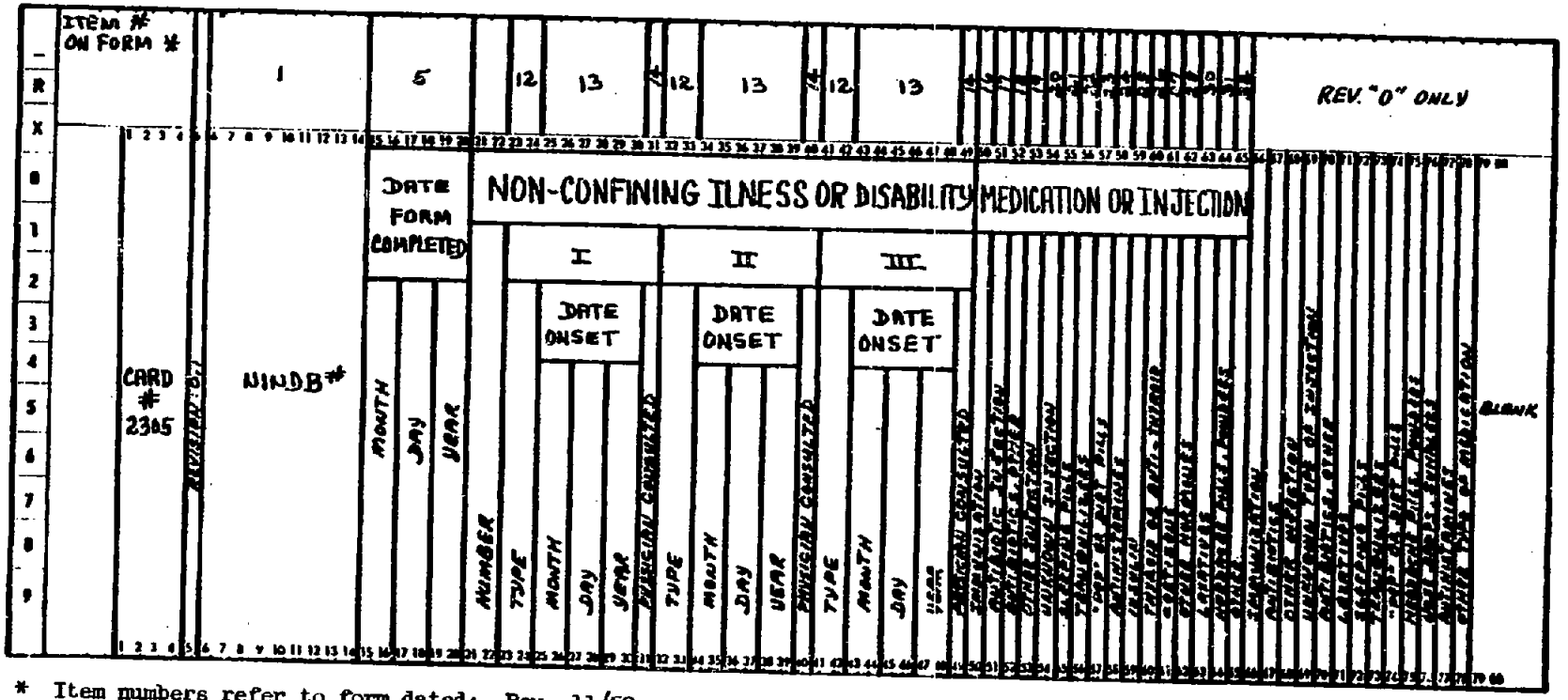
90 Other Diseases and Procedures (General and Unspecified site) not elsewhere specified
91 Observation and Diagnostic Procedures
92 Diseases and Procedures of Back and Side
93 Poisoning, chemical (All types except alcohol)
94 Trauma and Fractures of Pelvis
98 Combination of codes 90-94
99 Unknown

RECENT MEDICAL HISTORY
FORM OB-5



* Item numbers refer to form dated: Rev. 11/59

RECENT MEDICAL HISTORY
FORM OB-5



* Item numbers refer to form dated: Rev. 11/59

RECENT MEDICAL HISTORY
(For Form OB-5, Revised 11-59)

Instructions for Interviewer

Item #2 "History Recorded By"

Record your first and last names.

Item #4 "Title or Position"

Record your official title, such as "lay interviewer", nurse interviewer", "social service interviewer", etc.

Item #5 "Date"

Record the date this history was obtained in the order designated: month, day, and year (9/22/59).

This "Recent Medical History" covers the period of twelve months preceding the date this history was obtained. It is obvious that all items on this page will cover that portion of the pregnancy which the patient has experienced before reporting for prenatal care, as well as a number of months preceding the pregnancy. Therefore, it is especially important to fix dates as accurately as possible.

Item #6 "Illness or Disability Requiring Confinement to Bed During Preceding (12) Twelve Months"

Item #7 "Illness or Disability"

Include any symptom, disorder, illness or disability which resulted in confinement to bed for at least one day, whether or not the patient was attended by a physician.

Item #8 "Days in Bed"

Record the number of days that the patient was confined to bed.

Item #9 "Date of Onset"

Record the dates (month, day, year) of onset of the illness or disability.

Item #10 "Physician Consulted and Hospital if Hospitalized"

If a doctor was consulted, record his full name and address, and if the patient was hospitalized, record the name and address of the hospital.

Have the patient describe the illness or disability and record it as described. If she gives a medical diagnosis in addition, record this also.

Item #11 "Non-Confining Illness or Disability Present During Preceding (12) Twelve Months"

Item #12 "Illness or Disability"

Item #13 "Date of Onset

Record the dates (month, day, year) of onset of the illness or disability.

Item #14 "Physician Consulted"

If a doctor was consulted, record his full name and address.

Items #15 - 32 "Medication or Injections Taken During Preceding Twelve Months"

This is to include any medication or injection which was taken during the twelve months preceding this interview. Since this covers a portion of the early pregnancy, there must be a way to distinguish between drugs taken during pregnancy and those taken before. Therefore, for each positive item check either "Yes"-before "LMP"; or "Yes", since "LMP", and indicate the approximate time in the pregnancy if possible, such as "first month", "third month", etc.

Ask the patient specifically about each item listed and record as "yes" or "no", or "unknown", if the patient doesn't know if she has taken this medication. List each positive answer by box number in item #33 and describe, indicating the specific drug (if known), the reason for taking, and the frequency or number of times taken. If the patient doesn't know the name of the drug, attempt to obtain as detailed a description of the medication as possible.

P.H.S. 6000-6
1-58

RECENT MEDICAL HISTORY (Interviewer) yellow

superseded by 11-59 rev.

HISTORY RECORDED BY

TITLE OR POSITION | DATE (Mo-Day-Yr)

I. ILLNESS OR DISABILITY REQUIRING CONFINEMENT TO BED DURING PRECEDING 12 MONTHS

ILLNESS OR DISABILITY	DAYS IN BED	DATES	PHYSICIAN CONSULTED AND HOSPITAL IF HOSPITALIZED
1.			
2.			
3.			
4.			

II. [illegible] AND DISEASE FOR WHICH [illegible] DURING PRECEDING 12 MONTHS

ILLNESS OR DISABILITY	DATE	PHYSICIAN CONSULTED
1.		
2.		
3.		

III. MEDICATION OR INJECTIONS TAKEN DURING PRECEDING 12 MONTHS

TYPE	YES	NO	UNKNOWN
INJECTIONS OR "SHOTS"			
1. IMMUNIZATIONS			
2. ANTIBIOTICS (Powder Drops)			
3. OTHER INJECTION (Specify)			
4. UNKNOWN TYPE OF INJECTION			
5. ANTIBIOTIC (Other than by injection)			
6. LAXATIVES			
7. SLEEPING PILLS			
8. TRANQUILLIZERS			
9. "PEP" OR DIET PILLS			
10. HEADACHE PILLS OR POWDERS			
11. NOSE DROPS OR INHALERS			
12. ANTIHISTAMINES			
13. OTHER TYPE OF MEDICATION			

21. LIST BY BOX NUMBER AND DESCRIBE ANY POSITIVE ANSWERS INDICATING SPECIFIC DRUG IF KNOWN, REASON FOR TAKING, AND FREQUENCY OR NUMBER OF TIMES TAKEN.

Department of Health, Education and Welfare
Public Health Service

(OB-5)

OB-6 Past Medical History

Form OB-6 was used to record medical history of the gravida from birth until the beginning of the year prior to pregnancy. (See form OB-5 for medical history 12 months prior to registration.) Form OB-6 also recorded any radiological treatments or examinations taken during the last 12 months. Form OB-6 was implemented into the study in January 1959 and revised once in November 1959. In revision, information was itemized; some items were added and items were coded. Two cards were used for keypunching data (Table OB-6.1).

Additional information on past medical history is available on form OB-42. Form OB-42 includes information on childhood diseases, other diseases (respiratory, cardiovascular, digestive, gynecological and venereal, renal, endocrine, psychiatric), blood transfusions and other conditions.

TABLE OB-6.1 Cards and Data Records by Revision for Form OB-6

CARD NAME	CARD NUMBER	REV. NO.	NUMBER RECORDS
OB-6: Hospitalization	1306		
		0	8,310
		1	47,627
			55,937
OB-6: Radiological Exams, Other Exams	2306		
		0	8,303
		1	47,615
			55,918
	total for form		111,855

Data Items Referencing Form DB-6, Past Medical History

DATA ITEM ID	ITEM IN FORM	CARD NUM	FROM	TO	DATA ITEM NAME
386..		1306	1	5	Card number (sequence, form type, form number, revision number)
387.....		1306	6	14	NTNDB case number
388...DB-6	4	1306	15	16	Form DB-6 date (mo)
389...DB-6	4	1306	17	18	Form DB-6 date (day)
390...DB-6	4	1306	19	20	Form DB-6 date (yr)
391...DB-6	5	1306	21	21	Hospitalization, number
392...DB-6	8	1306	22	23	Hospitalization, nth, illness or disability
393...DB-6	6	1306	24	25	Hospitalization, nth, date (mo)
394...DB-6	6	1306	26	27	Hospitalization, nth, date (yr)
395...DB-6	8	1306	28	29	Hospitalization, nth, illness or disability
396...DB-6	6	1306	30	31	Hospitalization, nth, date (mo)
397...DB-6	6	1306	32	33	Hospitalization, nth, date (yr)
398...DB-6	8	1306	34	35	Hospitalization, nth, illness or disability
399...DB-6	6	1306	36	37	Hospitalization, nth, date, (mo)
400...DB-6	6	1306	38	39	Hospitalization, nth, date (yr)
401...DB-6	8	1306	40	41	Hospitalization, nth, illness or disability
402...DB-6	6	1306	42	43	Hospitalization, nth, date (mo)
403...DB-6	6	1306	44	45	Hospitalization, nth, date (yr)
404...DB-6	8	1306	46	47	Hospitalization, nth, illness or disability
405...DB-6	6	1306	48	49	Hospitalization, nth, date (mo)
406...DB-6	6	1306	50	51	Hospitalization, nth, date (yr)
407.....		1306	52	80	Blank
408.....		2306	1	5	Card number (sequence, form type, form number, revision number)
409.....		2306	6	14	NTNDB case number
410...DB-6	4	2306	15	16	Form DB-6 date (mo)
411...DB-6	4	2306	17	18	Form DB-6 date (day)
412...DB-6	4	2306	19	20	Form DB-6 date (yr)
413...DB-6	9	2306	21	21	Radiological exams or treatments, number, preceding 12 months
414...DB-6	12-13	2306	22	22	Radiological exams or treatments, nth, type, preceding 12 months
415...DB-6	10	2306	23	24	Radiological exams or treatments, nth, date, preceding 12 months (mo)
416...DB-6	10	2306	25	26	Radiological exams or treatments, nth, date, preceding 12 months (yr)
417...DB-6	12-13	2306	27	27	Radiological exams or treatments, nth, type, preceding 12 months
418...DB-6	10	2306	28	29	Radiological exams or treatments, nth, date, preceding 12 months (mo)
419...DB-6	10	2306	30	31	Radiological exams or treatments, nth, date, preceding 12 months (yr)
420...DB-6	12-13	2306	32	32	Radiological exams or treatments, nth, type, preceding 12 months
421...DB-6	10	2306	33	34	Radiological exams or treatments, nth, date, preceding 12 months (mo)
422...DB-6	10	2306	35	36	Radiological exams or treatments, nth, date, preceding 12 months (yr)

Data Items Referencing Form OB-6, Past Medical History

DATA ITEM ID	ITEM ON FORM	CARD NUM	FROM	TO	DATA ITEM NAME
423...OB-6	12-13	2306	37	37	Radiological exams or treatments, nth, type, preceding 12 months
424...OB-6	10	2306	38	39	Radiological exams or treatments, nth, date, preceding 12 months (mo)
425...OB-6	10	2306	40	41	Radiological exams or treatments, nth, date, preceding 12 months (yr)
426...OB-6	16	2306	42	43	Radiological exams or treatments, other, number of; chest x-rays
427...OB-6	17	2306	44	45	Radiological exams or treatments, other, number of; dental x-rays
428...OB-6	18	2306	46	46	Extremities, examinations and treatment, number
429...OB-6	20	2306	47	47	Extremities, examinations and treatment, type
430...OB-6	19	2306	48	49	Extremities, examinations and treatment, year
431...OB-6	20	2306	50	50	Extremities, examinations and treatment, type
432...OB-6	19	2306	51	52	Extremities, examinations and treatment, year
433...OB-6	20	2306	53	53	Extremities, examinations and treatment, type
434...OB-6	19	2306	54	55	Extremities, examinations and treatment, year
435...OB-6	22	2306	56	56	Examinations, other, number
436...OB-6	24	2306	57	57	Examinations, other, type
437...OB-6	23	2306	58	59	Examinations, other, year
438...OB-6	24	2306	60	60	Examinations, other, type
439...OB-6	23	2306	61	62	Examinations, other, year
440...OB-6	24	2306	63	63	Examinations, other, type
441...OB-6	23	2306	64	65	Examinations, other, year
442...OB-6	27	2306	66	66	Transfusions
443.....		2306	67	80	Blank
4993....VAR	12-13		74	74	Radiologic examinations during the twelve months prior to registration
5207....VAR	27		316	316	Transfusions
5208....VAR	12-13		317	317	Radiographic exposure total number
5209....VAR	5		319	318	Hospitalizations 12 months or more prior to study, total number

PAST MEDICAL HISTORY

(Interviewer)

2. HISTORY TAKEN BY | 3.

4. DATE — Mo. | Day | Year

5. LIST HOSPITALIZATIONS (NOT LISTED ON OB-5) ☐ NONE 0X

(Include Sanitaria, etc., but do not include hospitalization for previous pregnancy. If admitted for surgery, record specific operation performed.)

	6. DATE Mo.	Year	7. HOSPITAL (Name and Address)	8. REASON
(1)				
(2)				
(3)				
(4)				
(5)				

9. RADIOLOGIC EXAMINATIONS OR TREATMENTS DURING PAST 12 MONTHS *(List each)* ☐ NONE 0X

	10. DATE Mo.	Year	11. SINCE PREGNANCY	12. CHEST X-RAY	13. OTHER TYPE OF EXAMINATION OR TREATMENT (DESCRIBE) GIVE SITE	14. REASON, RESULT IF KNOWN
(1)			☐ NO 0 ☐ YES 1	☐ YES 0	0	
(2)			☐ NO 0 ☐ YES 1	☐ YES 0	0	
(3)			☐ NO 0 ☐ YES 1	☐ YES 0	0	
(4)			☐ NO 0 ☐ YES 1	☐ YES 0	0	

15. OTHER RADIOLOGIC EXAMINATIONS OR TREATMENTS *(Prior to last 12 months)*

16. CHEST X-RAYS
TOTAL NUMBER DURING LIFE (EXCEPT THOSE LISTED ABOVE.) _____

17. DENTAL X-RAYS:
TOTAL NUMBER OF EXAMINATIONS DURING LIFE (EXCEPT THOSE LISTED ABOVE.) _____

(IF UNUSUAL PROCEDURES OR NUMBER, DESCRIBE)

18. EXAMINATIONS AND TREATMENTS OF EXTREMITIES *(List)* ☐ NONE 0

19. YEAR	20. TYPE OR PROCEDURE AND SITE	21. REASON, FINDINGS IF KNOWN

22. ALL OTHER EXAMINATIONS AND TREATMENTS NOT ENUMERATED ABOVE *(List)* ☐ NONE 0

23. YEAR	24. TYPE OR PROCEDURE AND SITE	

[redacted]

REV. 11-88
8

PAST MEDICAL HISTORY

(Interviewer)

[redacted]

27. TRANSFUSIONS ☐ NONE 8X

	28. DATE Mo.	Yr.	29. REASON	30. REACTION
(1)				☐ NONE 9
(2)				☐ NONE 9
(3)				☐ NONE 9

31. BLOOD TESTS TAKEN ☐ NONE 8X

	32. DATE Mo.	Yr.	33. REASON	34. RESULT
(1)				
(2)				
(3)				
(4)				
(5)				
(6)				
(7)				

35. SERIES OF INJECTIONS OR "SHOTS" ☐ NONE 9X

	36. DATE Mo.	Yr.	37. REASON	38. REACTION
(1)				☐ NONE 9
(2)				☐ NONE 9
(3)				☐ NONE 9
(4)				☐ NONE 9
(5)				☐ NONE 9
(6)				☐ NONE 9
(7)				☐ NONE 9

Form Item Numbers linked to Data Items on OB-6, Past Medical History

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
4	389...OB-6	1306	17	18	Form OB-6 date (day)
4	411...OB-6	2306	17	18	Form OB-6 date (day)
4	388...OB-6	1306	15	16	Form OB-6 date (mo)
4	410...OB-6	2306	15	16	Form OB-6 date (mo)
4	390...OB-6	1306	19	20	Form OB-6 date (yr)
4	412...OB-6	2306	19	20	Form OB-6 date (yr)
5	391...OB-6	1306	21	21	Hospitalization, number
5	5209....VAR		318	318	Hospitalizations 12 months or more prior to study, total number
6	405...OB-6	1306	48	49	Hospitalization, nth, date (mo)
6	396...OB-6	1306	30	31	Hospitalization, nth, date (mo)
6	402...OB-6	1306	42	43	Hospitalization, nth, date (mo)
6	393...OB-6	1306	24	25	Hospitalization, nth, date (mo)
6	397...OB-6	1306	32	33	Hospitalization, nth, date (yr)
6	406...OB-6	1306	50	51	Hospitalization, nth, date (yr)
6	403...OB-6	1306	44	45	Hospitalization, nth, date (yr)
6	400...OB-6	1306	38	39	Hospitalization, nth, date (yr)
6	394...OB-6	1306	26	27	Hospitalization, nth, date (yr)
6	399...OB-6	1306	36	37	Hospitalization, nth, date, (mo)
8	404...OB-6	1306	46	47	Hospitalization, nth, illness or disability
8	401...OB-6	1306	40	41	Hospitalization, nth, illness or disability
8	392...OB-6	1306	22	23	Hospitalization, nth, illness or disability
8	398...OB-6	1306	34	35	Hospitalization, nth, illness or disability
8	395...OB-6	1306	28	29	Hospitalization, nth, illness or disability
9	413...OB-6	2306	21	21	Radiological exams or treatments, number, preceding 12 months
10	421...OB-6	2306	33	34	Radiological exams or treatments, nth, date, preceding 12 months (mo)
10	418...OB-6	2306	28	29	Radiological exams or treatments, nth, date, preceding 12 months (mo)
10	415...OB-6	2306	23	24	Radiological exams or treatments, nth, date, preceding 12 months (mo)
10	424...OB-6	2306	38	39	Radiological exams or treatments, nth, date, preceding 12 months (mo)
10	422...OB-6	2306	35	36	Radiological exams or treatments, nth, date, preceding 12 months (yr)
10	416...OB-6	2306	25	26	Radiological exams or treatments, nth, date, preceding 12 months (yr)
10	425...OB-6	2306	40	41	Radiological exams or treatments, nth, date, preceding 12 months (yr)
10	419...OB-6	2306	30	31	Radiological exams or treatments, nth, date, preceding 12 months (yr)
12-13	5208....VAR		317	317	Radiographic exposure total number
12-13	4993....VAR		74	74	Radiologic examinations during the twelve months prior to registration

Form Item Numbers linked to Data Items on 08-6, Past Medical History

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
12-13	417...08-6	2306	27	27	Radiological exams or treatments, nth, type, preceding 12 months
12-13	423...08-6	2306	37	37	Radiological exams or treatments, nth, type, preceding 12 months
12-13	414...08-6	2306	22	22	Radiological exams or treatments, nth, type, preceding 12 months
12-13	420...08-6	2306	32	32	Radiological exams or treatments, nth, type, preceding 12 months
16	426...08-6	2306	42	43	Radiological exams or treatments, other, number of; chest x-rays
17	427...08-6	2306	44	45	Radiological exams or treatments, other, number of; dental x-rays
18	428...08-6	2306	46	46	Extremities, examinations and treatment, number
19	432...08-6	2306	51	52	Extremities, examinations and treatment, year
19	430...08-6	2306	48	49	Extremities, examinations and treatment, year
19	434...08-6	2306	54	55	Extremities, examinations and treatment, year
20	431...08-6	2306	50	50	Extremities, examinations and treatment, type
20	429...08-6	2306	47	47	Extremities, examinations and treatment, type
20	433...08-6	2306	53	53	Extremities, examinations and treatment, type
22	435...08-6	2306	56	56	Examinations, other, number
23	441...08-6	2306	64	65	Examinations, other, year
23	437...08-6	2306	58	59	Examinations, other, year
23	439...08-6	2306	61	62	Examinations, other, year
24	436...08-6	2306	57	57	Examinations, other, type
24	438...08-6	2306	60	60	Examinations, other, type
24	440...08-6	2306	63	63	Examinations, other, type
27	442...08-6	2306	66	66	Transfusions
27	5207....VAR		316	316	Transfusions

DEFINITION OF CODES
PAST MEDICAL HISTORY
FORM OB-6 CARD 1306

FIELD		CARD COLUMN
1.	**Card Number** Code: 1	1
2.	**Form Number** Code: 306	2-4
3.	**Revision Number *** Code: 0 - Form Dated: 1/59 1 - Form Dated: Rev. 11/59	5
4.	**NINDB Number** Item 1 Nine-digit number for Patient Identification Code: As given	6-14
5.	**Date Form Completed** Item 4 Six-digit code for month (cols. 15-16), day (cols. 17-18), and year (cols. 19-20) Code: As given 99 - Month, day and/or year unknown	15-20
6.	**Number of Hospitalizations** Item 5 Code: 0 - None 1-7 - Number reported 8 - 8 or more 9 - Unknown	21
7.	**HOSPITALIZATION - I**	22-27
	Illness or Disability (cols. 22-23) Item 8 Code: See Attachment, "Illness or Disability Codes", page OB 5-10	
	Date (cols. 24-27) Item 6 Four-digit code for mor (cols. 24-25), and year (cols. 26-27) Code: As given 0000 - None 99 - Month and/or year unknown	

Note: 0's in entire field = no hospitalization
* Item numbers refer to Form Dated: 11/59

DEFINITION OF CODES (Continued)

FORM OB-6
Card 1306

FIELD		CARD COLUMN
8.	HOSPITALIZATION - II Code: Same as in Field 7	28-33
9.	HOSPITALIZATION - III Code: Same as in Field 7	34-39
10.	HOSPITALIZATION - IV Code: Same as in Field 7	40-45
11.	HOSPITALIZATION - V Code: Same as in Field 7	46-51

Note: A hospitalization may be recorded in any of the five fields; therefore, all fields must be checked for data.

DEFINITION OF CODES (Continued)

FORM OB-6
Card 2306

FIELD		CARD COLUMN
1.	Card Number Code: 2	1
2.	Basic Data* Code: Same as columns 2-20 of Card 1	2-20
3.	Number of Radiological Examinations or Treatments During the Past 12 Months Reported on Different Dates (Rev. "1" only) or Number of Radiological Examinations or Treatments Reported on Different Dates (Rev. "0" only) Item 9 Code: 0 - None 1-7 - Number reported 8 - 8 or more 9 - Unknown	21
4.	RADIOLOGICAL EXAMINATION OR TREATMENT - I Chest X-Ray and Other Type of Examinations (col. 22) Items 12 and 13 Code: 0 - None 1 - Therapeutic radiation of abdomino-pelvic region with or without chest X-Ray 2 - Diagnostic radiation of abdomino-pelvic region with or without chest X-Ray 3 - Therapeutic radiation of other and unspecified regions with or without chest X-Ray 4 - Diagnostic radiation of other and unspecified regions with or without chest X-Ray, chest X-Ray only 5 - Unknown if diagnostic or therapeutic of abdomino-pelvic region with or without chest X-Ray 6 - Unknown if diagnostic or therapeutic of all other and unspecified regions with or without chest X-Ray 9 - Unknown	22-26

* Unless specified, Fields, Codes and Card Columns refer to Revisions "0" and "1". Item numbers refer to Form Dated: 11/59

DEFINITION OF CODES (Continued)

FORM OB-6
Card 2306

FIELD		CARD COLUMN
	Date of Radiological Examinations or Treatments During the Past 12 Months Item 10 Four-digit code for month (cols. 23-24) and year (cols. 25-26) Code: As given 0000 - None 99 - Month and/or year unknown Note: 0's in entire field = no treatment	
5.	RADIOLOGICAL EXAMINATION OR TREATMENT - II Code: Same as in Field 4	27-31
6.	RADIOLOGICAL EXAMINATION OR TREATMENT - III Code: Same as in Field 4	32-36
7.	RADIOLOGICAL EXAMINATION OR TREATMENT - IV Code: Same as in Field 4	37-41
8.	Number of Chest X-Rays Item 16 Code: 00 - None 01-97 - Number reported 98 - 98 or more 99 - Unknown	42-43
9.	Number of Dental X-Rays Item 17 Code: Same as in Field 8	44-45
10.	Number of Examinations and Treatments of Extremities (Rev. "1" only) Item 18 Code: 0 - None 1-7 - Actual number reported 8 - 8 or more reported 9 - Unknown, not on Revision "0"	46

FIELD

CARD COLUMN

11. EXAMINATION AND TREATMENT OF EXTREMITIES - I (Rev. "1" only) — 47-49

Type or Procedure and Site (col. 47)
Item 20
Code: 0 - None
1 - Therapeutic radiation of abdomino-pelvic region with or without chest X-Ray
2 - Diagnostic radiation of abdomino-pelvic region with or without chest X-Ray
3 - Therapeutic radiation of other and unspecified regions with or without chest X-Ray
4 - Diagnostic radiation of other and unspecified regions with or without chest X-Ray, chest X-Ray only
5 - Unknown if diagnostic or therapeutic of abdomino-pelvic region with or without chest X-Ray
6 - Unknown if diagnostic or therapeutic of other and unspecified regions with or without chest X-Ray
9 - Unknown, not on Rev. "0"

Year - Examination and Treatment of Extremities (columns 48-49)
Item 19
Code: As given
00 - None
99 - Unknown, not on Revision "0"
Note: 0's in entire field = no treatment

12. EXAMINATION AND TREATMENT OF EXTREMITIES - II (Revision "1" only) — 50-52
Code: Same as in Field 11

13. EXAMINATION AND TREATMENT OF EXTREMITIES - III (Rev. "1" only) — 53-55
Code: Same as in Field 11

FIELD		CARD COLUMN
14.	Number of All Other Examinations and Treatments Not Enumerated Above (Rev. "1" only) Item 22 Code: Same as in Field 10	56
15.	Other Examinations and Treatments - I (Rev. "1" only)	57-59

Type of Procedure and Site (col. 57)
Item 24
Code:
- 0 - None
- 1 - Therapeutic radiation of abdomino-pelvic region with or without chest X-Ray
- 2 - Diagnostic radiation of abdomino-pelvic region with or without chest X-Ray
- 3 - Therapeutic radiation of other and unspecified regions with or without chest X-Ray
- 4 - Diagnostic radiation of other and unspecified regions with or without chest X-Ray
- 5 - Unknown if diagnostic or therapeutic of abdomino-pelvic region with or without chest X-Ray
- 6 - Unknown if diagnostic or therapeutic of other and unspecified regions with or without chest X-Ray
- 9 - Unknown, not on Revision "0"

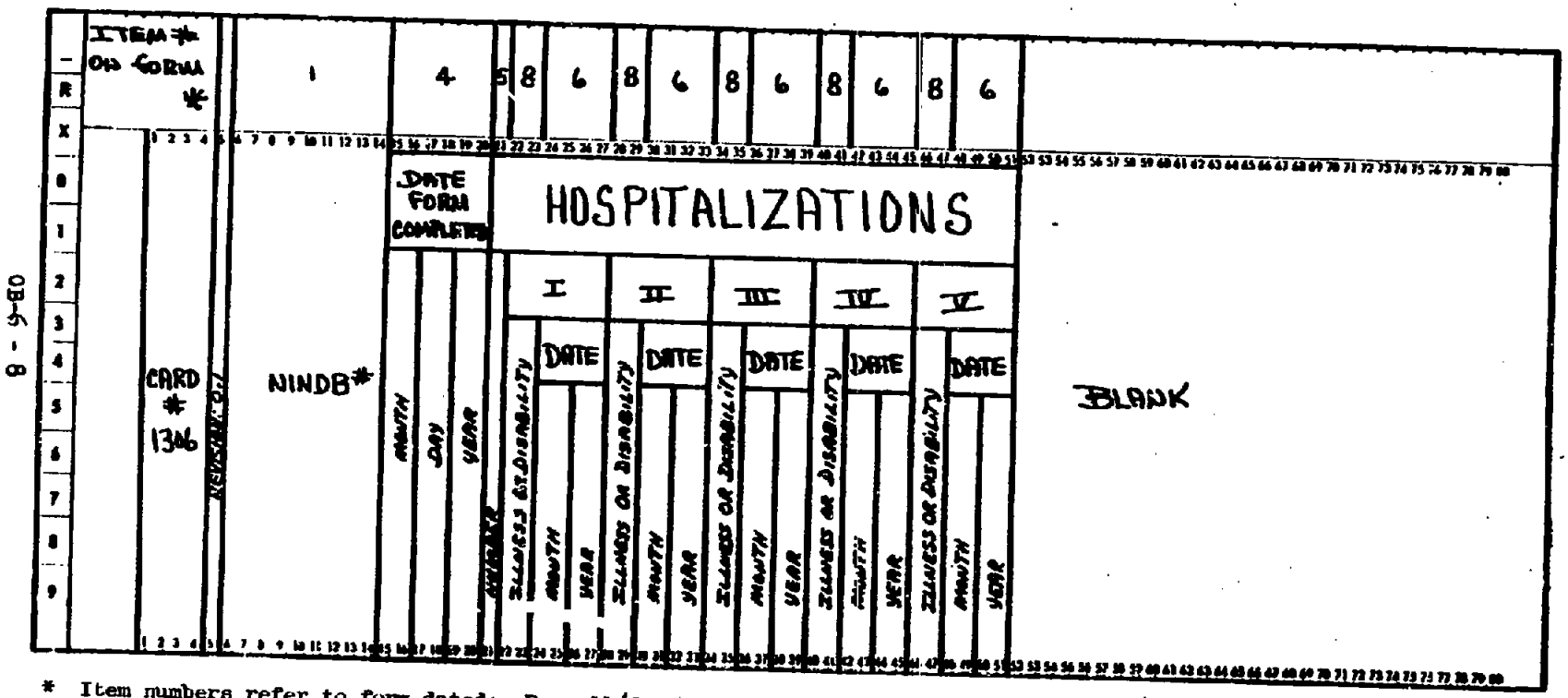
Year - Other Examination and Treatment (cols. 58-59)
Item 23
Code:
- As given
- 00 - None
- 99 - Unknown, not on Rev. "0"

Note: 0's in entire field = no treatment

16.	Other Examinations and Treatments - II (Rev. "1" only) Code: Same as in Field 15	60-62

FIELD		CARD COLUMN
17.	Other Examination and Treatment III (Rev. "1" only) Code: Same as in Field 15	63-65
18.	Transfusions Item 27 Code: 0 - None 1 - One or more transfusions reported 9 - Unknown	66

PAST MEDICAL HISTORY
FORM OB-6



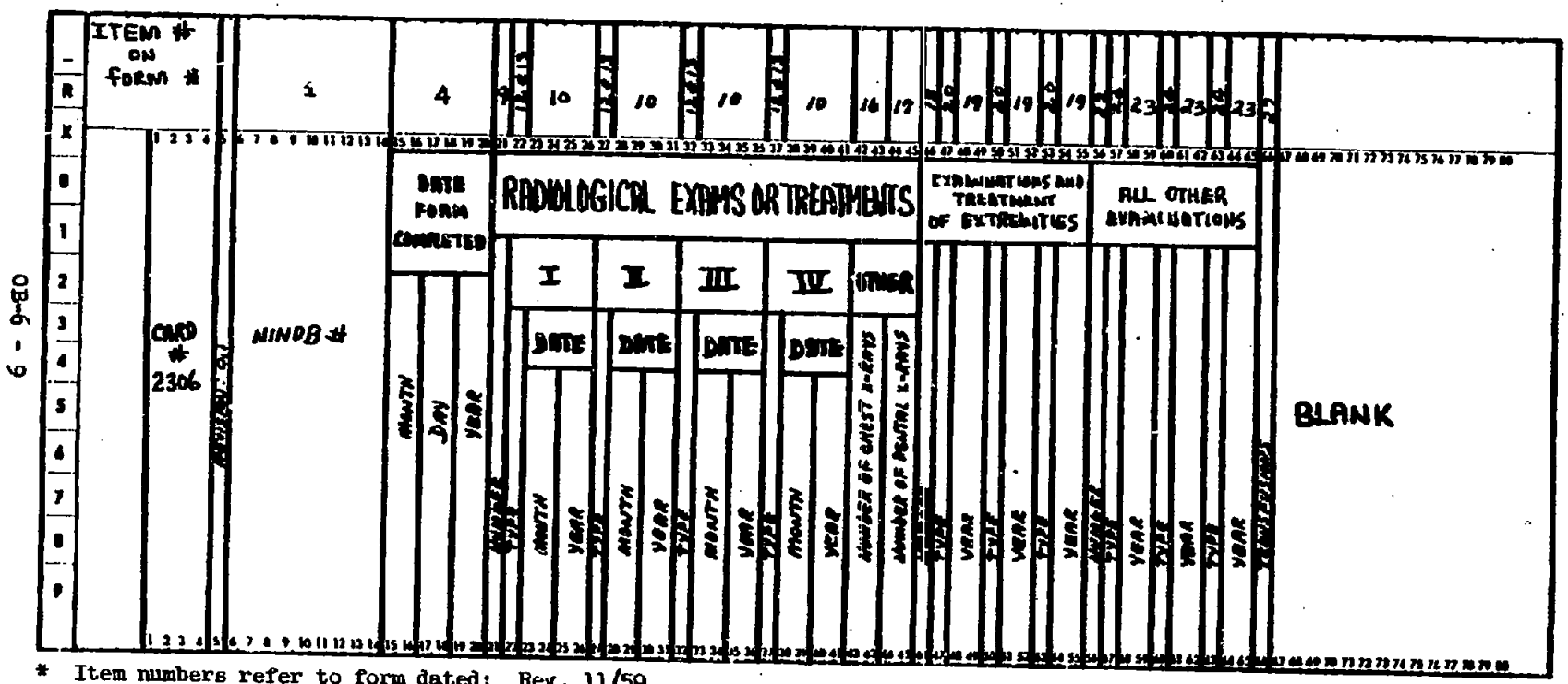
* Item numbers refer to form dated: Rev. 11/59

OB-6 - 8

II.A.106

OB-6

PAST MEDICAL HISTORY
FORM OB-6



* Item numbers refer to form dated: Rev. 11/59

PAST MEDICAL HISTORY
(For Form OB-6, Rev. 11-59)

INSTRUCTIONS FOR INTERVIEWER

Item 2. "History Taken By" Write your first and last name clearly.

Item 3. This space is for Central Office use.

Item 4. "Date" Record the date this history was obtained.

Item 5. "List Hospitalizations" Include here all hospitalizations which were not listed on OB-2 or OB-5. This will include all hospitalizations (not for previous pregnancy) which occurred more than one year ago. Admissions to sanitaria and mental hospitals should be reported here (or on OB-5 if occurring during the past year). If there were no such hospitalizations, mark the box for "None."

Item 6. "Date" Record the patient's best approximation of month and year.

Item 7. "Hospital" Record the name and address or location of the hospital, with sufficient accuracy, if possible, to establish a mailing address. If at this hospital, or any associated hospital using the same record room, record "here."

Item 8. "Reason" Determine the diagnosis or complaint if possible. Inquire specifically about any operation that may have been performed and note the procedure here.

Item 9. "Radiologic Examinations or Treatments During Past 12 Months" This includes the diagnostic use of radioisotopes. A history of X-ray since L.M.P., noted on OB-3, should be reported here also. It need not be described in detail on OB-3, but should always be described here.

X-rays obtained through this obstetric clinic after the patient is registered in the Study should not be reported either here or on OB-3, but only on OB-10, 11, and other appropriate clinical records.

If the patient reports no radiation exposure in the 12 months preceding date of registration in the Study, check the box marked "None."

Item 10. "Date" Record month numerically and year in two digits ('60, '61, etc.).

Item 11. "Since Pregnancy" If the exposure was before LMP (or estimated date of conception if LMP is not related to onset of pregnancy), mark "No." If after LMP, mark "Yes."

Item 12. "Chest X-Ray" Mark "Yes" if the exposure was a routine chest x-ray (either standard or miniature film). In this case items no. 13 and 14 should be left blank.

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Item 12. "Chest X-Ray" (Con't)

For chest X-ray other than a routine plate, mark "Yes" in item no. 12, and complete items 13 and 14.

Item 13. "Other Type of Examination or Treatment" Mark the box in this item if exposure did not consist solely of diagnostic chest films. Describe as fully as possible the type of exposure, number of plates, and site.

Item 14. Reason, Result: Describe these briefly if known to the patient. Note: It is important that the record give the location (for mailing) of the physician or hospital from which X-rays were obtained during the previous year. If this is not specified on OB-3 or OB-5, note it here.

Item 15. "Other Radiologic Examinations or Treatments" The rest of this page of the form summarizes all radiation in the gravida's lifetime, exclusive of the 12 months preceding the interview.

Item 16. "Chest X-Rays" Record the patient's best estimate of the number of examinations. (Not the number of plates.) If none, enter "0."

Item 17. "Dental X-Rays" Record the total number of times the patient has had dental X-rays. An unusual type or amount of dental X-ray should be described in this space.

Item 18. "Examinations and Treatments of Extremities" This includes all diagnostic and therapeutic X-rays of hands, feet, arms, and legs. If for fractures, type or procedure and findings need not be recorded. If this radiation of extremities occurred with radiation of other parts of the body, such as the shoulder, hip, etc., record only in item #22.

Item 22. All Other Examinations and Treatments This includes fluoroscopy, G.I. series, X-rays of head, neck, shoulder, and head of the femur, use of radioisotopes, etc., not done during the past 12 months.

Item 25. Reason, Findings if Known This item number and title does not appear on the form. Describe the reason and findings in the right-hand column under item #22.

Item 27. "Transfusions" Includes any transfusion ever given the gravida. Use one line for each series of transfusions (i.e., those given over a brief span of time for the same season).

Item 30. "Reaction" If the patient reports no acute reaction, such as hives, fever, or shock, mark the box "None."

Item 31. "Blood Tests Taken" Do not record tests given in the prenatal clinic after the patient is registered in the Study.

Item 33. "Reason" If illness was suspected, be as specific as possible and identify the test, if possible. For routine serologies, record simply "marriage," "pregnancy," etc.

Item 34. "Result" List such terms as "negative," "positive," "diabetes," etc.

Item 35. Series of Injections Include any series of injections or "shots" taken up to the time of this interview.

Item 37. "Reason" Record the substance given, if known, such as "triple toxoid," "Salk vaccine," "course of penicillin," etc. Also report reasons in such terms as "routine immunization," "upper respiratory infection," "syphilis," etc.

PAST MEDICAL HISTORY yellow
(Interviewer)

superseded by 11-59 rev.

HISTORY TAKEN BY

DATE (Mo-Day-Yr)

I. LIST HOSPITALIZATIONS (Not listed on OB-5)
(Include Sanitoria, etc., but do not include hospitalization for previous pregnancy. If admitted for surgery, record specific operation performed.)

	DATE	HOSPITAL (Name and Address)	REASON
1.			
2.			
3.			
4.			
5.			

II. X-RAY EXAMINATION OR TREATMENT

	DATE	TYPE OF EXAMINATION OR TREATMENT	REASON
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Department of Health, Education and Welfare
Public Health Service

(OB-6) PAGE 1 OF 2

PHS-0000-0
1-00

PAST MEDICAL HISTORY
(Interviewer)

superseded by 11-54 rev.

I. TRANSFUSIONS

DATE	REASON	REACTION
1.		
2.		
3.		

N. BLOOD TEST TAKEN

DATE	REASON	RESULT
1.		
2.		
3.		
4.		
5.		
6.		
7.		

M. SERIES OF INJECTIONS OR "SHOTS"

DATE	REASON:	REACTION
1.		
2.		
3.		
4.		
5.		
6.		
7.		

OB-7 Infectious Disease and System Review

Form OB-7 was designed to collect data on infectious diseases and other conditions that might affect the body systems. The physician and interviewer worked together to establish as complete a medical history as possible within the limits of the study. First used in February 1959, the form was not revised. Records generated by the form totaled 53,233 and were keypunched on card 0307 of the master file (Table OB-7.1).

TABLE OB-7.1 Cards and Data Records by Revision for Form OB-7

CARD NAME	CARD NUMBER	REV. NO.	NUMBER RECORDS
OB-7: Childhood Disease, Other Infectious Disease and Parasitic Diseases	0307		
		0	53,233
			53,233
	total for form		53,233

Data Items Referencing Form OB-7, Infectious Disease and System Review

DATA ITEM ID	ITEM IN FORM	CARD NUM	FROM	TO	DATA ITEM NAME
444.....		0307	1	5	Card number (sequence, form type, form number, revision number)
445.....		0307	6	14	NINDB case number
446...OB-7		0307	15	16	Form OB-7 date (mo)
447...OB-7		0307	17	18	Form OB-7 date (day)
448...OB-7		0307	19	20	Form OB-7 date (yr)
449...OB-7	1	0307	21	21	Childhood diseases; pertussis
450...OB-7	1	0307	22	23	Childhood diseases; pertussis, age onset
451...OB-7	1	0307	24	24	Childhood diseases; chicken pox
452...OB-7	1	0307	25	26	Childhood diseases; chicken pox, age onset
453...OB-7	1	0307	27	27	Childhood diseases; mumps
454...OB-7	1	0307	28	29	Childhood diseases; mumps, age onset
455...OB-7	1	0307	30	30	Childhood diseases; rubella; German measles
456...OB-7	1	0307	31	32	Childhood diseases; rubella; German measles, age onset
457...OB-7	1	0307	33	33	Childhood diseases; measles
458...OB-7	1	0307	34	35	Childhood diseases; measles, age onset
459...OB-7	1	0307	36	36	Childhood diseases; diphtheria
460...OB-7	1	0307	37	38	Childhood diseases; diphtheria, age onset
461...OB-7	1	0307	39	39	Childhood diseases; scarlet fever
462...OB-7	1	0307	40	41	Childhood diseases; scarlet fever, age onset
463...OB-7	2	0307	42	42	Infectious diseases; poliomyelitis
464...OB-7	2	0307	43	44	Infectious diseases; poliomyelitis, age onset
465...OB-7	2	0307	45	45	Infectious diseases; herpes simplex
466...OB-7	2	0307	46	47	Infectious diseases; herpes simplex, age onset
467...OB-7	2	0307	48	48	Infectious diseases; herpes zoster
468...OB-7	2	0307	49	50	Infectious diseases; herpes zoster, age onset
469...OB-7	2	0307	51	51	Infectious diseases; encephalitis
470...OB-7	2	0307	52	53	Infectious diseases; encephalitis, age onset
471...OB-7	2	0307	54	54	Infectious diseases; meningitis
472...OB-7	2	0307	55	56	Infectious diseases; meningitis, age onset
473...OB-7	2	0307	57	57	Infectious diseases; toxoplasmosis
474...OB-7	2	0307	58	59	Infectious diseases; toxoplasmosis, age onset
475...OB-7	2	0307	60	60	Infectious diseases, 1st other, type
476...OB-7	2	0307	61	62	Infectious diseases, 1st other, age onset
477...OB-7	2	0307	63	63	Infectious diseases, 2nd other, type
478...OB-7	2	0307	64	65	Infectious diseases, 2nd other, age onset
479...OB-7	2	0307	66	66	Infectious diseases, 3rd other, type
480...OB-7	2	0307	67	68	Infectious diseases, 3rd other, age onset
481...OB-7	3	0307	69	69	Infectious diseases; parasitic 1st, type
482...OB-7	3	0307	70	71	Infectious diseases; parasitic 1st, age onset
483...OB-7	3	0307	72	72	Infectious diseases; parasitic 2nd, type
484...OB-7	3	0307	73	74	Infectious diseases; parasitic 2nd, age onset
485...OB-7	3	0307	75	75	Infectious diseases; parasitic 3rd, type

Data Items Referencing Form OB-7, Infectious Disease and System Review

DATA ITEM ID	ITEM ON FORM	CARD NUM	FROM	TO	DATA ITEM NAME
486...OB-7	3	0307	76	77	Infectious diseases: parasitic 3rd, age onset
487.....		0307	78	80	Blank

COLR-00057
1-69

INFECTIOUS DISEASE AND SYSTEM REVIEW

NAME OF PHYSICIAN		NAME OF INTERVIEWER	
TITLE OR POSITION		TITLE OR POSITION	
DATE HISTORY TAKEN		DATE HISTORY TAKEN	

INTERVIEWER BEGINS HERE

PHYSICIAN: INQUIRE ABOUT EACH DISEASE LISTED	RESPONSE: NO	RESPONSE: YES	RESPONSE: UNK.	AGE ONSET	DIAGNOSIS WARRANTED?	DESCRIPTION AND COMMENT
1. CHILDHOOD DISEASES						
PERTUSSIS						
CHICKEN POX						
MUMPS						
GERMAN MEASLES						
MEASLES						
DIPHTHERIA						
SCARLET FEVER						
2. OTHER INFECTIOUS DISEASES						
POLIOMYELITIS						
HERPES SIMPLEX						
HERPES ZOSTER						
ENCEPHALITIS						
MENINGITIS						
TOXOPLASMOSIS						
OTHER *(Specify)*						
3. PARASITIC DISEASES *(Specify)*						

INTERVIEWER'S SECTION
CHECK and describe if a positive history is obtained.

PHYSICIAN'S SECTION
CHECK and describe each diagnosis made. Establish as closely as possible the date of onset and duration

4. RESPIRATORY SYSTEM: Ever have trouble with your breathing ☐ ? Trouble with adenoids or tonsils ☐ ? Pneumonia ☐ ? Have many colds a year ☐ ? Do you have a persistent cough ☐ ?
PATIENT'S COMMENTS:

- ☐ Chronic Bronchitis
- ☐ Bronchiectasis
- ☐ Tuberculosis
- ☐ Pneumonia
- ☐ Other

5. ALLERGIES: Ever had hay fever ☐ ? Asthma ☐ ? Hives ☐ ? Food allergies ☐ ? Drug sensitivities ☐ ?
PATIENT'S COMMENTS:

- ☐ Asthma
- ☐ Hay Fever
- ☐ Hives
- ☐ Food Intolerances
- ☐ Drug or Serum Sensitivity
- ☐ Other

6. SKIN AND CELLULAR TISSUE: Ever had a rash or skin breaking out ☐ ? Swollen glands ☐ ? Swelling any where else ☐ ? Eczema ☐ ? Boils ☐ ?
PATIENT'S COMMENTS:

- ☐ Chronic Cellulitis
- ☐ Chronic Dermatitis
- ☐ Chronic Acne
- ☐ Psoriasis
- ☐ Other

COLLABORATIVE RESEARCH
PERINATAL RESEARCH BRANCH, NINDS, NIH
BETHESDA 14, MD.

COLLAB.-OB-7
1-65

INFECTIOUS DISEASE AND SYSTEM REVIEW

INTERVIEWER'S SECTION	PHYSICIAN'S SECTION
7. **DIGESTIVE SYSTEM:** Ever been put on a special diet ☐ ? Ever had ulcers ☐ ? Stomach trouble ☐ ? Jaundice ☐ ? Ever had any trouble with your bowels? ☐ ? PATIENT'S COMMENTS:	☐ Ulcer ☐ Chronic Diarrhea ☐ Ulcerative Colitis ☐ Cholecystitis ☐ Cholelithiasis ☐ Other
8. **GENITO-URINARY:** Ever had any trouble with your bladder ☐ ? Burning ☐ ? Hurt to empty ☐ ? Kidney trouble ☐ ? Infections ☐ ? Blood in urine ☐ ? Gravel or stones in urine ☐ ? Ever any infection of your tubes or ovaries ☐ ? Inflammation of genitals ☐ ? PATIENT'S COMMENTS:	☐ Syphilis ☐ Neisseria ☐ Nephritis ☐ Nephrotic Syndrome ☐ Hydronephrosis ☐ Nephrolithiasis ☐ Recurrent Pyelonephritis ☐ Recurrent Cystitis ☐ Chronic Salpingo-Oophoritis ☐ Other
9. **CIRCULATORY SYSTEM:** Ever have any trouble with your heart ☐ ? Ever have trouble getting your breath when your heart beats fast ☐ ? Any trouble with high blood pressure ☐ ? Low blood pressure ☐ ? Any trouble with varicose veins ☐ ? Hardening of the arteries ☐ ? Swelling of legs ☐ ? Numbness or tingling in the extremities ☐ ? PATIENT'S COMMENTS:	☐ Congestive Heart Failure ☐ Rheumatic Heart Disease ☐ Myocardial Infarction ☐ Peripheral Vascular Disease ☐ Hypertension ☐ Hypotension ☐ Varicose Veins ☐ Other
10. **BLOOD:** Do you bleed easily ☐ ? Ever had anemia ☐ ? or any other trouble with your blood ☐ ? Any treatment for your blood ☐ ? PATIENT'S COMMENTS:	☐ Anemia ☐ Septicemia ☐ Other
11. **NEOPLASTIC:** Ever had a tumor ☐ ? Cyst ☐ ? Cancer ☐ ? PATIENT'S COMMENTS:	☐ Type of disease process and organ involved

COLR—[illegible]
1-60

INFECTIOUS DISEASE AND SYSTEM REVIEW

INTERVIEWER'S SECTION	PHYSICIAN'S SECTION
12. RADIATION: Ever had radium treatment ☐? X-Ray treatment ☐? Radio-isotope treatment ☐? PATIENT'S COMMENTS:	☐ Radium Therapy ☐ X-Ray Therapy ☐ Radioactive Isotope Treatment
13. ENDOCRINE: Ever had thyroid trouble ☐? Ever had a thyroid test ☐? Ever taken thyroid ☐? Ever had diabetes ☐? Ever taken hormones ☐? PATIENT'S COMMENTS:	☐ Hypothyroidism ☐ Hyperthyroidism ☐ Thyroiditis ☐ Diabetes Mellitus ☐ Other
14. BONES, JOINTS, MUSCLES: Ever had sore or swollen joints ☐? Rheumatism ☐? PATIENT'S COMMENTS:	☐ Arthritis ☐ Joint Disease ☐ Rickets ☐ Other
15. NEUROLOGICAL: Ever fainted or lost consciousness ☐? Ever had convulsions ☐? Fits or spasms ☐? Epilepsy ☐? Paralysis ☐? Do you have cerebral palsy ☐? Any trouble seeing or hearing ☐? PATIENT'S COMMENTS:	☐ Cerebral Palsy ☐ Convulsive Disorder ☐ Blindness ☐ Deafness ☐ Other
16. BIRTH AND INFANCY: Did you have any difficulty in the first few months of life ☐? Convulsions ☐? Jaundice ☐? How much did you weigh?_____ Was there anything unusual about your mother's pregnancy such as convulsions ☐? Bleeding ☐? Was there anything in your body that wasn't formed right when you were born ☐? PATIENT'S COMMENTS:	☐ Erythroblastosis ☐ Prematurity ☐ Birth Injury ☐ Other condition not listed CONGENITAL MALFORMATIONS ☐ Cardiac Malformations ☐ Coarctation of Aorta ☐ Cleft Palate ☐ Hare Lip ☐ Other Congenital Malformations
17. ACCIDENTS, POISONS, AND VIOLENCE: Ever been in any bad accidents ☐? Ever taken any poisons ☐? PATIENT'S COMMENTS:	☐ List and describe

Form Item Numbers linked to Data Items on OB-7, Infectious Disease and System Review

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
	447...OB-7	0307	17	18	Form OB-7 date (day)
	446...OB-7	0307	15	16	Form OB-7 date (mo)
	448...OB-7	0307	19	20	Form OB-7 date (yr)
1	451...OB-7	0307	24	24	Childhood diseases; chicken pox
1	452...OB-7	0307	25	26	Childhood diseases; chicken pox, age onset
1	459...OB-7	0307	36	36	Childhood diseases; diphtheria
1	460...OB-7	0307	37	38	Childhood diseases; diphtheria, age onset
1	457...OB-7	0307	33	33	Childhood diseases; measles
1	458...OB-7	0307	34	35	Childhood diseases; measles, age onset
1	453...OB-7	0307	27	27	Childhood diseases; mumps
1	454...OB-7	0307	28	29	Childhood diseases; mumps, age onset
1	449...OB-7	0307	21	21	Childhood diseases; pertussis
1	450...OB-7	0307	22	23	Childhood diseases; pertussis, age onset
1	455...OB-7	0307	30	30	Childhood diseases; rubella; German measles
1	456...OB-7	0307	31	32	Childhood diseases; rubella; German measles, age onset
1	461...OB-7	0307	39	39	Childhood diseases; scarlet fever
1	462...OB-7	0307	40	41	Childhood diseases; scarlet fever, age onset
2	476...OB-7	0307	61	62	Infectious diseases, 1st other, age onset
2	475...OB-7	0307	60	60	Infectious diseases, 1st other, type
2	478...OB-7	0307	64	65	Infectious diseases, 2nd other, age onset
2	477...OB-7	0307	63	63	Infectious diseases, 2nd other, type
2	480...OB-7	0307	67	68	Infectious diseases, 3rd other, age onset
2	479...OB-7	0307	66	66	Infectious diseases, 3rd other, type
2	469...OB-7	0307	51	51	Infectious diseases; encephalitis
2	470...OB-7	0307	52	53	Infectious diseases; encephalitis, age onset
2	465...OB-7	0307	45	45	Infectious diseases; herpes simplex
2	466...OB-7	0307	46	47	Infectious diseases; herpes simplex, age onset
2	467...OB-7	0307	48	48	Infectious diseases; herpes zoster
2	468...OB-7	0307	49	50	Infectious diseases; herpes zoster, age onset
2	471...OB-7	0307	54	54	Infectious diseases; meningitis
2	472...OB-7	0307	55	56	Infectious diseases; meningitis, age onset
2	463...OB-7	0307	42	42	Infectious diseases; poliomyelitis
2	464...OB-7	0307	43	44	Infectious diseases; poliomyelitis, age onset
2	473...OB-7	0307	57	57	Infectious diseases; toxoplasmosis
2	474...OB-7	0307	58	59	Infectious diseases; toxoplasmosis, age onset
3	482...OB-7	0307	70	71	Infectious diseases; parasitic 1st, age onset
3	481...OB-7	0307	69	69	Infectious diseases; parasitic 1st, type
3	484...OB-7	0307	73	74	Infectious diseases; parasitic 2nd, age onset
3	483...OB-7	0307	72	72	Infectious diseases; parasitic 2nd, type
3	486...OB-7	0307	76	77	Infectious diseases; parasitic 3rd, age onset
3	485...OB-7	0307	75	75	Infectious diseases; parasitic 3rd, type

DEFINITION OF CODES
INFECTIOUS DISEASE AND SYSTEM REVIEW
FORM OB-7 CARD 0307

FIELD		CARD COLUMN
1.	**Card Number** Code: 0	1
2.	**Form Number** Code: 307	2-4
3.	**Revision Number *** Code: 0 - Form Dated: 1/59	5
4.	**NINDB Number** Nine-digit number for Patient Identification Code: As given	6-14
5.	**Date History Taken** Six-digit code for month (cols. 15-16), day (cols. 17-18) and year (cols. 19-20) Code: As given 99 - Month and/or day, and/or year unknown	15-20
	CHILDHOOD DISEASE	
6.	**Pertussis** Item 1 Three-digit code for response (col. 21), and Age of Onset (cols. 22-23). Code for column 21: 0 - No 1 - Yes 2 - Yes (more than one episode) 9 - Unknown Code for columns 22-23: 00 - Birth to 11 months 01-50 - As given 05 - Pre-school 95 - School age 99 - Unknown, no disease **Note:** For field, no disease = 099	21-23
7.	**Chicken Pox** Item 1 Code: Same as in Field 6	24-26
8.	**Mumps** Item 1 Code: Same as in Field 6	27-29

FIELD		CARD COLUMN
9.	German Measles Item 1 Code: Same as in Field 6	30-32
10.	Measles Item 1 Code: Same as in Field 6	33-35
11.	Diphtheria Item 1 Code: Same as in Field 6	36-38
12.	Scarlet Fever Item 1 Code: Same as in Field 6	39-41
	OTHER INFECTIOUS DISEASES	
13.	Poliomyelitis Item 2 Code: Same as in Field 6	42-44
	Herpes Simplex Item 2 Code: Same as in Field 6	45-47
15.	Herpes Zoster Item 2 Code: Same as in Field 6	48-50
16.	Encephalitis Item 2 Code: Same as in Field 6	51-53
17.	Meningitis Item 2 Code: Same as in Field 6	54-56
18.	Toxoplasmosis Item 2 Code: Same as in Field 6	57-59

FIELD		CARD COLUMN
19.	Other - First Disease Reported Item 2 Three-digit code for Type (col. 60) and Age of Onset (cols. 61-62) Code for column 60: 0 - None 3 - Rickettsial 4 - Viral 5 - Bacterial 6 - Other, unknown etiology 9 - Unknown Code for columns 61-62: Same as in Field 6 columns 22-23, "Note" also applies	60-62
20.	Other - Second Disease Reported Item 2 Code: Same as in Field 19	63-65
21.	Other - Third Disease Reported Item 2 Code: Same as in Field 19	66-68
	PARASITIC DISEASES	
22.	Parasitic Disease - First Reported Item 3 Three-digit code for Type (col. 69) and Age of Onset (cols. 70-71) Code for Col. 69: 0 - None 3 - Malaria 4 - Ringworm 5 - Pinworm 6 - Definite intestinal worms (other than pinworm), and muscle infesting worms 7 - Protozoans, yeast and other fungi 9 - Unknown	69-71

FIELD		CARD COLUMN
22.	Parasitic Disease - First Reported (continued) Code for columns 70-71: Same as in Field 6 columns 22-23, "Note" also applies	69-71
23.	Parasitic Disease - Second Reported Item 3 Code: Same as in Field 22	72-74
24.	Parasitic Disease - Third Reported Item 3 Code: Same as in Field 22	75-77

INFECTIOUS DISEASE AND SYSTEM REVIEW
FORM OB-7

INFECTIOUS DISEASE AND SYSTEM REVIEW
(For Form OB-7, Dated 1-59)

PURPOSE OF THIS FORM

Par. 1 Study of the epidemiology of pregnancy wastage is made difficult by the fact that important events or conditions may occur only once in many thousands of pregnancies. Therefore, analysis of the relationship between supposed causes and the outcome of pregnancy often must be based on relatively small numbers of cases.

Par. 2 In such a situation, analysis is particularly vulnerable to the haphazard introduction of cases having rare or obscure diseases that are undiagnosed. For this reason scrupulous assessment of the state of health of each gravida is a fundamental part of this or any similar study.

Par. 3 The Infectious Disease and System Review, OB-7, is designed to enable the interviewer and physician, working together, to establish as complete a medical history as is possible within the limits of this study. To do so requires careful and systematic questioning of the patient. This may at times be a burdensome task, but it will always be an important one. Poor medical histories might render useless other very careful observations of the mother and child.

INSTRUCTIONS FOR INTERVIEWER

Par. 1 At the top of page 1, record your first and last name and your title or position, such as "Lay interviewer", "Nurse interviewer" or "Social worker". Beneath this record the date on which the history is taken, writing the month, day, and year numerically, such as 6/22/59.

Par. 2 The review is divided into seventeen categories. The first three of these are entirely to be done by the physician, so that you should begin your interview with category #4, Respiratory System.

Par. 3 For each category you should attempt to discover all the relevant symptoms that the patient has experienced at any time during her life. The questions listed are not necessarily all the questions that you may need to ask, nor is the wording the best for all patients. Make sure that the patient understands the questions, before you accept a negative answer.

Par. 4 For those categories for which the patient gives a negative history, write the figure "0" (zero) in the space reserved for patient's comments, and make no other mark in the block. If the patient gives a positive history record in the space under "Patient's Comments" all detail that will be helpful to the physician. Ask about dates of onset and duration, and record these. If the patient knows any diagnosis that may have been made, record this also.

INSTRUCTIONS FOR INTERVIEWER (Con't)

Par. 5 The small check boxes are only for your convenience. Use them to save writing, by checking questions that the patient has answered affirmatively.

Category #10 "Blood"

This refers to any actual blood abnormality. If the patient states that she has been treated for "bad blood", record this fact here and under category #8 (genito-urinary) also, since it may indicate previous syphilis.

Category #12 "Radiation"

This category refers only to therapeutic radiation, not diagnostic x-ray.

Category #17 "Accidents, Poisons, and Violence"

If the patient has had a serious accident or injury note the type of accident and ask about immediate and long-term effects.

INSTRUCTIONS FOR PHYSICIANS

Par. 1 This form provides the only opportunity in the obstetrical protocol for a physician to determine whether or not a patient's history of previous illness is valid and complete. When it reaches you, it should contain the interviewer's notation of positive history. You should add the following information:

1. All warranted current and retrospective diagnoses that you are able to make.
2. For each diagnosis, your estimation of the probability that it is correct.
3. Any information (in addition to that elicited by the interviewer) about the symptoms of or circumstances surrounding a disease or event.
4. Your estimation of the date of onset and duration of each diagnosed illness.

Par. 2 Base this information on:

1. Interviewer's notations on this form.
2. Discussion with the patient of symptoms, treatment, physician attendance, circumstances surrounding the illness or event, etc.
3. Any medical records available.

Estimating the Reliability of Retrospective Diagnosis

Par. 3 Diagnoses may be classified, according to the probability that they are correct, as:

Definite
Probable
Possible
Remote

Whenever in the course of this interview you feel that a diagnosis is warranted, indicate your estimate of its reliability by writing in parentheses one of the following:

(DF) - Definite. There is objective evidence to show that the disease has existed or does exist.

(PR) - Probable. The chances that this patient has had this disease are greater than the chances that she has not.

(PS) - Possible. The chances that this patient has had this disease are less than the chances that she has not. Further, the possibility is not remote.

Remote possibility should not warrant any specific diagnosis on this form.

Par. 4 In those instances in which some diagnosis seems warranted, but you are unable to specify a particular disease, name a group of diseases or type of disease if this is possible. All diagnostic information will be coded according to the International List of Causes of Morbidity and Mortality, 1957 revision.

Identifying Data (Page 1)

Par. 5 At the top of the page fill in your first and last name. Record your title or position, such as "project obstetrician", "intern", "medical student", or "resident". Record the date numerically in the order month, day, and year.

Infectious and Parasitic Diseases

(Page 1; Categories 1, 2, and 3)

Par. 6 The interviewer will not ask the patient about these diseases. The list includes only the more common or important diseases, and does not pretend to be complete. You should make every effort to add to it other infectious or parasitic diseases that the patient has had. (Note that tuberculosis, pneumonia, and venereal diseases are covered in other categories, and need not be mentioned here.) In adding to this list, bear in mind the prevalent diseases in regions in which the patient has lived. In the southern states, for example, malaria, amebiasis, and

Infectious and Parasitic Diseases (Con't)

hookworm should be considered. Patients from Puerto Rico should be questioned about these and ascariasis, trichuriasis, and schistosomiasis, among others.

Par. 7 Ask the patient if she has had each disease listed, and other diseases that you think it prudent to inquire about. When necessary, recite the symptoms in addition to naming the disease. Record her answer as "no", "yes", or "unknown", by placing an X in the appropriate box. If "yes", note the approximate age at onset (to the nearest year, even though this may be uncertain).

Par. 8 If you have checked "yes" in the response column, in the column headed "Diagnosis Warranted?" write either "yes" or "no". If a diagnosis is warranted, qualify it by recording under "Description" and "Comment" either DF, PR, or PS, for definite, probable, or possible. Also record any unusual or severe complications. If there were none, write "normal course" or "mild", etc.

System Review

(Pages 1, 2, and 3; Categories 4 through 17)

Par. 9 By asking questions such as those listed on the left, the interviewer will attempt to furnish "clues" to past and present illness. Follow them up and attempt to establish diagnoses. When you are able to do this, name the disease by checking it, if it is listed, or by checking the box marked "other" and writing it in the space provided. Qualify each diagnosis by using the symbols DF, PR, or PS. Record the date of onset to the nearest year (except to the nearest month for diseases occurring within the last year), and estimate the duration in days, months, or years, whichever seems most suitable.

Par. 10 Also note in each category any symptoms, events, etc., that the patient relates to you if these have not been noted by the interviewer. You should ask probing questions in each category in which the interviewer has recorded no symptoms, in order to confirm this. If you have nothing to record for a particular category, place a "0" (zero) in that space.

OB-8 Repeat Prenatal History

Form OB-8 was used to record prenatal history between visits. It was filled out at each repeat prenatal visit and at the time the patient was admitted to the hospital for delivery. The form was first used in January 1959; it was revised in July 1959. Items were renumbered and reworded in the July 1959 revision. Coding differs between the January 1959 form and the July 1959 revision on items 6 (sickness in any way) and 36 (frequency of intercourse). Information from form OB-8 was recorded on card 0308 (Table OB-8.1).

TABLE OB-8.1 Cards and Data Records by Revision for Form OB-8

CARD NAME	CARD NUMBER	REV. NO.	NUMBER RECORDS
OB-8: Illness, Disturbances Since Last Clinic Visit	0308		
		0	29,596
		1	347,652
			377,248
	total for form		377,248

Data Items Referencing Form OB-8, Repeat Prenatal History

DATA ITEM ID	ITEM ON FORM	CARD NUM	FROM	TO	DATA ITEM NAME
488.....		030R	1	5	Card number (sequence, form type, form number, revision number)
489.....		030R	6	14	NYNDB case number
490...OR-R	4	030R	15	16	Form OB-8 date (mo)
491...OR-R	4	030R	17	18	Form OB-8 date (day)
492...OR-R	4	030R	19	20	Form OB-8 date (yr)
493...OR-R	6	030R	21	21	Sick in any way
494...OR-R	7	030R	22	22	Headache
495...OR-R	8	030R	23	23	Visual disturbance
496...OR-R	9	030R	24	24	Weakness; numbness; dizziness
497...OR-R	10	030R	25	25	Vomiting
498...OR-R	11	030R	26	26	Pain, abdomen, pelvis, back
499...OR-R	12	030R	27	27	Urinary urgency; dysuria
500...OR-R	13	030R	28	28	Diarrhea
501...OR-R	14	030R	29	29	Cold; sore throat; cough
502...OR-R	15	030R	30	30	Fever
503...OR-R	16	030R	31	31	Eye inflammation
504...OR-R	17	030R	32	32	Rash; skin condition
505...OR-R	18	030R	33	33	Jaundice
506...OR-R	19	030R	34	34	Swollen glands
507...OR-R	20	030R	35	35	Cold sores
508...OR-R	21	030R	36	36	Boils; abscessed teeth
509...OR-R	22	030R	37	37	Earache
510...OR-R	23	030R	38	38	Swelling of feet or legs
511...OR-R	24	030R	39	39	Swelling of hands or face
512...OR-R	25	030R	40	40	Vaginal bleeding
513...OR-R	26	030R	41	41	Fainting
514...OR-R	27	030R	42	42	Convulsions
515...OR-R	28	030R	43	43	Accident; poison; injury
516...OR-R	29	030R	44	44	Operation; surgery
517...OR-R	30	030R	45	45	Radiation; x-ray
518...OR-R	31	030R	46	46	Air travel
519...OR-R	32	030R	47	47	Injection; vaccination
520...OR-R	33	030R	48	48	Infectious disease in home
521...OR-R	34	030R	49	49	Pet in home, sick
522...OR-R	35	030R	50	50	Work outside home
523...OR-R	36	030R	51	52	Intercourse frequency
524.....		030R	53	62	Blank
525...OB-R	37	030R	63	64	Smoking; cigarettes, number per day
526...OB-R	38	030R	65	65	Medication taken
527...OR-R	39	030R	66	66	Physician visited
528.....		030R	67	80	Blank
4985....VAR	37		52	53	Smoking history; cigarettes per day now, number

Data Items Referencing Form OB-8, Repeat Prenatal History

DATA ITEM ID	ITEM ON FORM	CARD NUM	FROM	TO	DATA ITEM NAME
4986....VAR			54	54	Smoking history: cigarettes per day now, coded: smoker, non-smoker
4987....VAR	4		55	56	Prenatal visits, total number
4994....VAR	4		75	80	Perinatal follow up visit, OB-8, date of first (mo/day/yr)
5197....VAR	25		305	305	[Hemorrhage]: vaginal bleeding by trimester of report
5198....VAR	15		306	306	Fever by trimester of report
5199....VAR	10		307	307	Vomiting by trimester of report
5200....VAR	18		308	308	Jaundice by trimester of report
5201....VAR	24		309	309	Edema hands or face by trimester of report
5202....VAR	27		310	310	Convulsions by trimester of report

[illegible]

1. PATIENT IDENTIFICATION

REPEAT PRENATAL HISTORY

(Interviewer)
(Since Last Visit)

2. HISTORY TAKEN BY

3.

4. DATE — Mo. Day Year

5. NEXT SCHEDULED VISIT — Mo. Day Year

	CHECK APPROPRIATE COLUMN	
	NO 0	YES 1
6. FELT SICK IN ANY WAY	X	X
7. HEADACHE		
8. VISUAL DISTURBANCE		
9. WEAKNESS, NUMBNESS, DIZZINESS		
10. VOMITING		
11. PAIN: ABDOMEN, PELVIS, BACK		
12. URINARY URGENCY DYSURIA		
13. DIARRHEA		
14. COLD, SORE THROAT, COUGH		
15. FEVER		
16. EYE INFLAMMATION		
17. RASH OR SKIN TROUBLE		
18. JAUNDICE		
19. SWOLLEN GLANDS		
20. COLD SORES		
21. BOILS OR ABSCESSED TEETH		
22. EARACHE		
23. SWELLING OF FEET OR LEGS		
24. SWELLING OF HANDS OR FACE		
25. VAGINAL BLEEDING		
26. FAINTING		
27. CONVULSIONS		
28. ACCIDENT, POISON, INJURY		
29. OPERATION		
30. RADIATION, X-RAY		
31. AIR TRAVEL		
32. INJECTION, VACCINATION		
33. INFECTIOUS DISEASE IN HOME		
34. SICK PET IN HOME		
35. WORKS OUTSIDE HOME		

36. INTERCOURSE FREQUENCY [illegible]

37. NO. OF CIGARETTES SMOKED PER DAY

38. MEDICATION TAKEN, AND FREQUENCY [illegible]

39. PHYSICIAN VISITED ☐ NO 0 ☐ YES 1

40. NAME OF PHYSICIAN

41. ADDRESS

42. LIST BY NUMBER AND DESCRIBE ANY CONDITION NOTED PRESENT AT LEFT WITH APPROXIMATE DATE OF ONSET, DURATION AND SEVERITY.

Collaborative Research
Perinatal Research Branch, NINDB, NIH
Bethesda 14, Md.

(Rev. [illegible]) (OB-8)

Form Item Numbers linked to Data Items on OB-8, Repeat Prenatal History

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
	4986....VAR		54	54	Smoking history: cigarettes per day now, coded: smoker, non-smoker
4	491...OB-8	030R	17	18	Form OB-8 date (day)
4	490...OB-8	030R	15	16	Form OB-8 date (mo)
4	492...OB-8	030R	19	20	Form OB-8 date (yr)
4	4994....VAR		75	80	Perinatal follow up visit, OB-8, date of first (mo/day/yr)
4	4987....VAR		55	56	Prenatal visits, total number
6	493...OB-8	030R	21	21	Sick in any way
7	494...OB-8	030R	22	22	Headache
8	495...OB-8	030R	23	23	Visual disturbance
9	496...OB-8	030R	24	24	Weakness; numbness; dizziness
10	497...OB-8	030R	25	25	Vomiting
10	5199....VAR		307	307	Vomiting by trimester of report
11	498...OB-8	030R	26	26	Pain, abdomen, pelvis, back
12	499...OB-8	030R	27	27	Urinary urgency; dysuria
13	500...OB-8	030R	28	28	Diarrhea
14	501...OB-8	030R	29	29	Cold; sore throat; cough
15	502...OB-8	030R	30	30	Fever
15	5198....VAR		306	306	Fever by trimester of report
16	503...OB-8	030R	31	31	Eye inflammation
17	504...OB-8	030R	32	32	Rash; skin condition
18	505...OB-8	030R	33	33	Jaundice
18	5200....VAR		308	308	Jaundice by trimester of report
19	506...OB-8	030R	34	34	Swollen glands
20	507...OB-8	030R	35	35	Cold sores
21	508...OB-8	030R	36	36	Boils; abscessed teeth
22	509...OB-8	030R	37	37	Earache
23	510...OB-8	030R	38	38	Swelling of feet or legs
24	5201....VAR		309	309	Edema hands or face by trimester of report
24	511...OB-8	030R	39	39	Swelling of hands or face
25	5197....VAR		305	305	(Hemorrhage); vaginal bleeding by trimester of report
25	512...OB-8	030R	40	40	Vaginal bleeding
26	513...OB-8	030R	41	41	Fainting
27	514...OB-8	030R	42	42	Convulsions
27	5202....VAR		310	310	Convulsions by trimester of report
28	515...OB-8	030R	43	43	Accident; poison; injury
29	516...OB-8	030R	44	44	Operation; surgery
30	517...OB-8	030R	45	45	Radiation; x-ray
31	518...OB-8	030R	46	46	Air travel
32	519...OB-8	030R	47	47	Injection; vaccination
33	520...OB-8	030R	48	48	Infectious disease in home
34	521...OB-8	030R	49	49	Pet in home, sick
35	522...OB-8	030R	50	50	Work outside home

Form Item Numbers linked to Data Items on OB-8, Repeat Prenatal History

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
36	523...OB-8	030R	51	52	Intercourse frequency
37	4985....VAR		52	53	Smoking history# cigarettes per day now, number
37	525...OB-8	030R	63	64	Smoking; cigarettes, number per day
38	526...OB-8	030R	65	65	Medication taken
39	527...OB-8	030R	66	66	Physician visited

DEFINITION OF CODES
REPEAT PRENATAL HISTORY
FORM OB-8 CARD 0308

FIELD		CARD COLUMN
1.	Card Number Code: 0	1
2.	Form Number Code: 308	2-4
3.	Revision Number * Code: 0 - Form dated: 1/59 1 - Form dated: Rev. 7/59	5
4.	NINDB Number Item 1 Nine-digit number for Patient Identification Code: As given	6-14
5.	Date Item 4 Six-digit code for month (cols. 15-16), day (cols. 17-18) and year (cols. 19-20) Code: As given 99 - Month, day and/or year unknown	15-20
6.	Felt Sick In Any Way (Rev. "0" only) Item 6 Code: 0 - No 1 - Yes 7 - Not on Revision "1" 8 - Questionable 9 - Unknown	21
7.	Headache Item 7 Code: 0 - No 1 - Yes 8 - Questionable 9 - Unknown	22
8.	Visual Disturbance Item 8 Code: Same as in Field 7	23

* Unless specified, Fields, Codes and Card Columns refer to Revisions "0" and "1". Item numbers refer to Form Dated: Rev. 7/59

FIELD		CARD COLUMN
9.	Weakness, Numbness, Dizziness Item 9 Code: Same as in Field 7	24
10.	Vomiting Item 10 Code: Same as in Field 7	25
11.	Pain: Abdomen, Pelvis, Back Item 11 Code: Same as in Field 7	26
12.	Urinary Urgency, Dysuria Item 12 Code: Same as in Field 7	27
13.	Diarrhea Item 13 Code: Same as in Field 7	28
14.	Cold, Sore Throat, Cough Item 14 Code: Same as in Field 7	29
15.	Fever Item 15 Code: Same as in Field 7	30
16.	Eye Inflammation Item 16 Code: Same as in Field 7	31
17.	Rash or Skin Trouble Item 17 Code: Same as in Field 7	32
18.	Jaundice Item 18 Code: Same as in Field 7	33
19.	Swollen Glands Item 19 Code: Same as in Field 7	34

FIELD		CARD COLUMN
20.	Cold Sores Item 20 Code: Same as in Field 7	35
21.	Boils or Abscessed Teeth Item 21 Code: Same as in Field 7	36
22.	Earache Item 22 Code: Same as in Field 7	37
23.	Swelling of Feet or Legs Item 23 Code: Same as in Field 7	38
24.	Swelling of Hands or Face Item 24 Code: Same as in Field 7	39
25.	Vaginal Bleeding Item 25 Code: Same as in Field 7	40
26.	Fainting Item 26 Code: Same as in Field 7	41
27.	Convulsions Item 27 Code: Same as in Field 7	42
28.	Accident, Poison, Injury Item 28 Code: Same as in Field 7	43
29.	Operation Item 29 Code: Same as in Field 7	44
30.	Radiation, X-Ray Item 30 Same as in Field 7	45

DEFINITION OF CODES (Continued)

FORM OB-8
Card 0308

FIELD	CARD COLUMN
31. Air Travel Item 31 Code: Same as in Field 7	46
32. Injection, Vaccination Item 32 Code: Same as in Field 7	47
33. Infectious Disease in Home Item 33 Code: Same as in Field 7	48
34. Sick Pet in Home Item 34 Code: Same as in Field 7	49
35. Works Outside Home Item 35 Code: Same as in Field 7	50
36. Intercourse Frequency During Last Month Item 36 Code for Rev. "0": 00 - None 01-79 - Number of times per week as given 80 - Less than once a week 81-87 As given 88 - Frequently, innumerable 89-98 As given 99 - Unknown Code for Rev. "1": 00 - None 01-78 - Number of times per month as given 79 - 79 or more 80 - Less than once a month 88 - Frequently, innumerable 99 - Unknown	51-52
Note: Rev. 1 - Use codes 89-98 as 79 or more in tabulations. Frequencies for "0" and "1" revisions cannot be combined.	
37. Blank	53-62

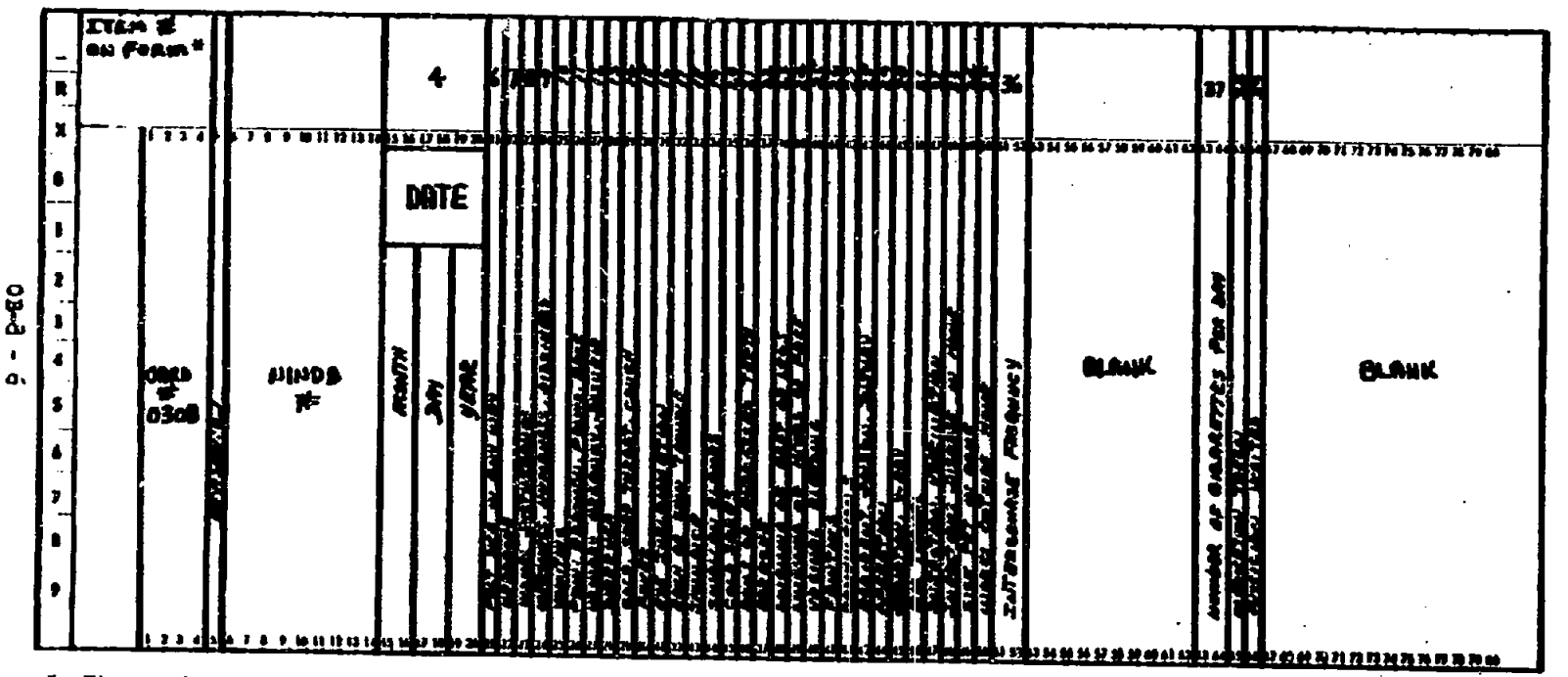
DEFINITION OF CODES (Continued)

FORM OB-8
Card 0308

FIELD		CARD COLUMN
38.	**Number of Cigarettes Smoked Per Day** Item 37 Code: 00 - None, never smoked 01-60 - Number of cigarettes smoked per day as given 61 - 61 or more daily 70 - Regular smoker but less than one cigarette per day 80 - Irregular smoker, less than 4 cigarettes per month 99 - Unknown	63-64
39.	**Medication Taken** Item 38 Code: 0 - No 1 - Yes 9 - Unknown	65
40.	**Physician Visited** Item 39 Code: Same as in Field 39	66

Note: A card is punched for each visit with columns 1-66 same as above.

REPEAT PRENATAL HISTORY
FORM OB-8



OB-8 - 9

* Item numbers refer to form dated: Rev. 7/59

REPEAT PRENATAL HISTORY
(For Form OB-8, Revised 7-59)

INSTRUCTIONS FOR INTERVIEWER

This form must be filled out at each repeat prenatal visit and at the time the patient is admitted to the hospital - preferably before delivery.

Item #2 "History Taken By"

Record your first and last name.

Item #4 "Date"

Record the date of this interview in the order designated: month, day, and year (9/30/59). Record the date of the next scheduled visit in similar manner.

This "Repeat Prenatal History", OB-8, is quite similar to the "History Since Last Menstrual Period", OB-3, and all instructions given for OB-3 apply to OB-8 also. In this form there is one new item, #38 "Medication Taken and Frequency". In this category, the patient should be asked the medication she is taking and how often she is actually taking it. In this connection, it is not necessary to know the dosage prescribed, but in the patient's own words how she is actually taking it. If the patient does not know the name of the medication, record her description of it and determine whether it was prescribed by her present obstetrician. If not prescribed by him attempt to identify the medication.

INSTRUCTIONS FOR LABOR OBSERVER

A regular "Repeat Prenatal History", OB-8, must be completed by the labor room observer at the time of admission of the patient to the labor room. Consult detailed instructions given in manual for Form OB-3, and OB-8. If the patient is admitted in advanced labor so that this history cannot be obtained prior to delivery, it should be taken at anytime before the patient leaves the hospital. Write "Taken after delivery" in large letters at the top of the space reserved for comments.

1 ea - Blue
Trans - blank + white

1. PATIENT IDENTIFICATION

REPEAT PRENATAL HISTORY

(Interviewer)
(Since Last Visit)

no change in content

2. HISTORY TAKEN BY	3.
4. DATE Mo. Day Year	5. NEXT SCHEDULED VISIT Mo. Day Year

	CHECK APPROPRIATE COLUMN	
	NO 0	YES 1
6. FELT SICK IN ANY WAY		
7. HEADACHE		
8. VISUAL DISTURBANCE		
9. WEAKNESS, NUMBNESS, DIZZINESS		
10. VOMITING		
11. PAIN: ABDOMEN, PELVIS, BACK		
12. URINARY URGENCY DYSURIA		
13. DIARRHEA		
14. COLD, SORE THROAT, COUGH		
15. FEVER		
16. EYE INFLAMMATION		
17. RASH OR SKIN TROUBLE		
18. JAUNDICE		
19. SWOLLEN GLANDS		
20. COLD SORES		
21. BOILS OR ABSCESSED TEETH		
22. EARACHE		
23. SWELLING OF FEET OR LEGS		
24. SWELLING OF HANDS OR FACE		
25. VAGINAL BLEEDING		
26. FAINTING		
27. CONVULSIONS		
28. ACCIDENT, POISON, INJURY		
29. OPERATION		
30. RADIATION, X-RAY		
31. AIR TRAVEL		
32. INJECTION, VACCINATION		
33. INFECTIOUS DISEASE IN HOME		
34. SICK PET IN HOME		
35. WORKS OUTSIDE HOME		

36. INTERCOURSE FREQUENCY (Record number of times during last month)

37. NO. OF CIGARETTES SMOKED PER DAY

38. MEDICATION TAKEN, AND FREQUENCY (Any discussed by Patient)

39. PHYSICIAN VISITED ☐ NO 0 ☐ YES 1

40. NAME OF PHYSICIAN

41. ADDRESS

40. LIST BY NUMBER AND DESCRIBE ANY CONDITION NOTED PRESENT AT LEFT WITH APPROXIMATE DATE OF ONSET, DURATION AND SEVERITY.

Collaborative Research
Perinatal Research Branch, NINDS, NIH
Bethesda, Md.

PHS-6000-8
1-59

REPEAT PRENATAL HISTORY

(For Interviewer)

superseded by 7-59 rev.

HISTORY TAKEN BY

DATE (Mo-Da-Yr) | DATE NEXT SCHEDULED VISIT

HISTORY SINCE LAST VISIT	CHECK APPROPRIATE COLUMN	
	ABSENT	PRESENT
1. FELT SICK IN ANY WAY		
2. HEADACHE		
3. VISUAL DISTURBANCE		
4. WEAKNESS, NUMBNESS, DIZZINESS		
5. NAUSEA OR VOMITING		
6. PAIN: ABDOMEN, PELVIS, BACK		
7. URINARY URGENCY, DYSURIA		
8. DIARRHEA		
9. COLD, SORE THROAT, COUGH		
10. FEVER		
11. EYE INFLAMMATION		
12. RASH OR SKIN TROUBLE		
13. JAUNDICE		
14. SWOLLEN GLANDS		
15. COLD SORES		
16. BOILS OR ABSCESSED TEETH		
17. EARACHE		
18. SWELLING OF FEET OR LEGS		
19. SWELLING OF HANDS OR FACE		
20. BLEEDING		
21. FAINTING		
22. CONVULSIONS		
23. ACCIDENT, POISON, INJURY		
24. OPERATION		
25. RADIATION, X-RAY		
26. AIR TRAVEL		
27. INJECTION, VACCINATION		
28. SICKNESS IN HOME		
29. PET IN HOME, PET SICK		
30. WORKS OUTSIDE HOME		

31. INTERCOURSE FREQUENCY PER WEEK

32. NO. OF CIGARETTES SMOKED PER DAY

33. MEDICATION TAKEN, AND FREQUENCY
(As described by Patient)

34. PHYSICIAN VISITED

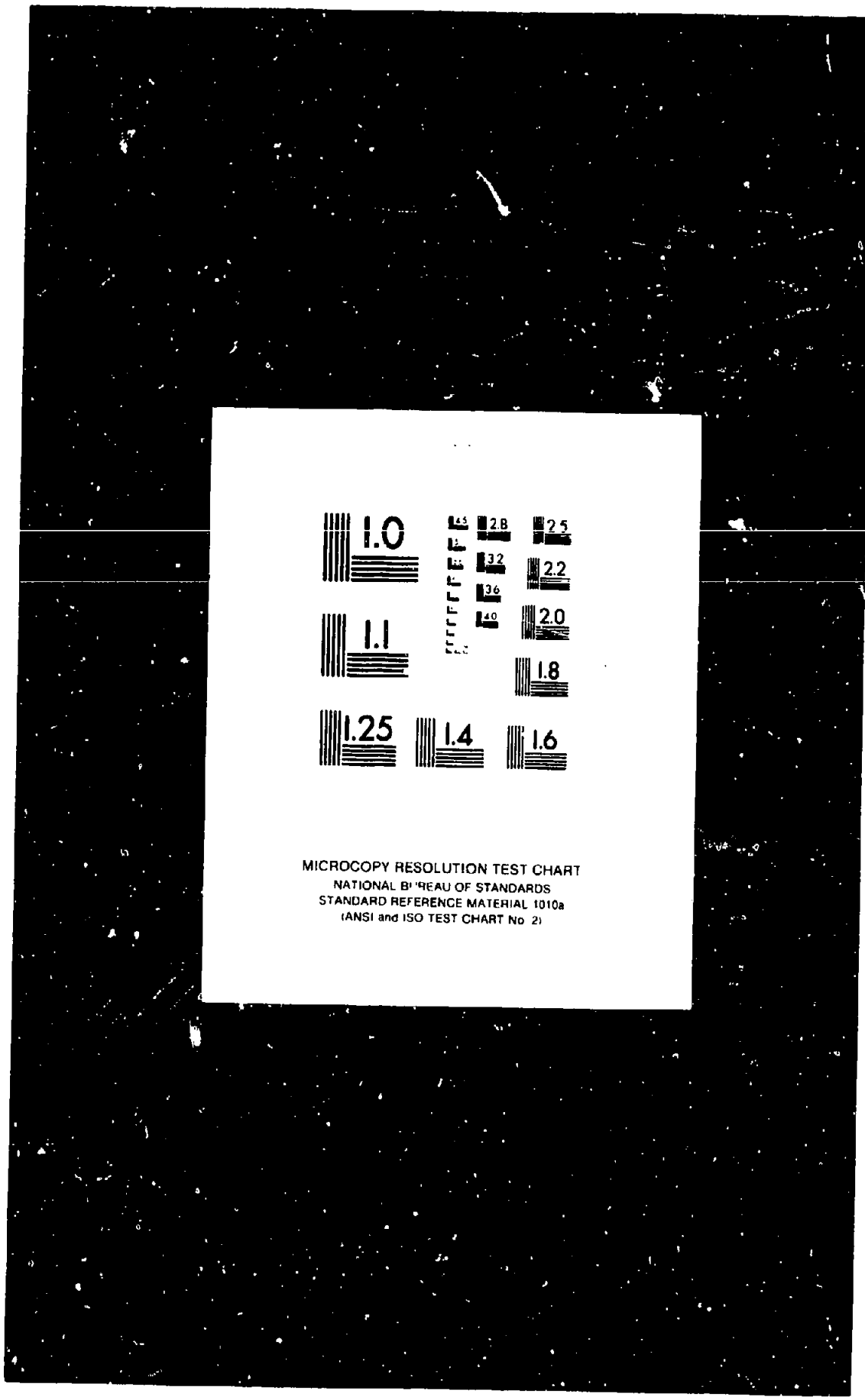
NAME

ADDRESS

LIST BY NUMBER AND DESCRIBE ANY CONDITION NOTED PRESENT AT LEFT WITH APPROXIMATE DATE OF ONSET, DURATION AND SEVERITY.

Department of Health, Education and Welfare,
Public Health Service

(OB-8)


1.0
1.1
1.25
1.4
1.6
1.8
2.0
2.2
2.5
2.8
3.2
3.6
4.0
MICROCOPY RESOLUTION TEST CHART
NATIONAL BUREAU OF STANDARDS
STANDARD REFERENCE MATERIAL 1010a
(ANSI and ISO TEST CHART No. 2)

CONTINUED ON NEXT FICHE