SEQIRUS INFLUENZA VACCINE PREGNANCY REGISTRY

REGISTRATION FORM

Return to INC Research by:
Fax: +1-800-836-2076 (toll-free fax)
Email: Segiruspregnancyregistry@increscarch.com
Mail: INC Research, LLC, 1011 Ashes Drive, Wilmington, NC 28405
Phone: +1-800-901-5042 (toll-free telephone)

Registry Patient ID _____ ☐ Update

HCP ID_____ Argus Number: _____

Date of completion _____ / _____ / _____ ☐ Phone
DD MMM YYYY

Patient Name: _____ **Patient Date of Birth:** _____ / _____ / _____
DD MMM YYYY

1. MATERNAL INFORMATION

1.1 Patient Age: _____ Years *(at conception)*

1.2 Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian or Other Pacific Islander ☐ Other (Specify) _____

1.3 Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

1.4 Weight (Pounds): _____ *(pre-pregnancy)*

1.5 Height (Inches): _____

1.6 Body Mass Index (BMI): _____ *(for Registry use only)*

1.7 Occupation: _____

2. PATERNAL INFORMATION

2.1 Paternal Age: _____ Years

3. MATERNAL PRENATAL INFORMATION

3.1 Last Menstrual Period (LMP): _____ / _____ / _____
DD MMM YYYY

3.2 Estimated Delivery Date: _____ / _____ / _____ *(by LMP)*
DD MMM YYYY

3.3 Corrected EDD (CEDD): _____ / _____ / _____ *(by ultrasound)*
DD MMM YYYY

3.4 Type of Pregnancy: ☐ Singleton ☐ Multiple

4. OBSTETRICAL HISTORY

4.1 Any Previous Pregnancies? ☐ Yes ☐ No *(If no, proceed to Section 5)*
Please exclude current pregnancy from the below list

4.2 Total number of Previous Pregnancies: _____

4.3 Number of previous full term live births: _____

4.4 Number of previous preterm live births: _____

4.5 Number of previous ectopic pregnancies: _____

4.6 Number of previous elective abortions: _____

4.7 Number of previous spontaneous abortions: _____

4.8 Number of previous molar pregnancies: _____

4.9 Number of previous still births: _____

4.10 Were any Birth Defects reported? ☐ Yes ☐ No

4.11 Number of previous outcomes with birth defects: _____

4.12 If yes, specify defect(s): _____

5. FAMILY HISTORY OF MAJOR CONGENITAL MALFORMATIONS (MCMs)

5.1 Does the patient have a history of offspring with Major Congenital Malformations (MCMs)? ☐ Yes ☐ No

5.2 If yes, please specify MCM(s):

_____

5.3 Does the patient have maternal family history of Major Congenital Malformations (MCMs)? ☐ Yes ☐ No

5.4 If yes, please specify MCM(s):

_____

5.5 Does the patient have paternal family history of Major Congenital Malformations (MCMs)? ☐ Yes ☐ No

5.6 If yes, please specify MCM(s):

_____

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Patient Name: _____

6. TOBACCO, ALCOHOL & ILLICIT DRUG USE

6.1 Has the patient used tobacco, alcohol and/or illicit drugs during current pregnancy? ☐ Yes ☐ No *(If no, go to Section 7)*

6.2 Tobacco use during current pregnancy? ☐ Yes ☐ No *(If yes, complete the following section)*

6.2.1 Type of tobacco:

☐ Cigarettes ☐ E-Cigarettes ☐ Nicotine Gum
☐ Cigar ☐ Chewing Tobacco ☐ Nicotine Lozenges
☐ Pipe ☐ Nicotine Topical Patches ☐ Other (Specify) _____

6.2.2 Number of Cigarettes/Tobacco Products used per day: _____ 6.2.3 Ongoing? ☐ Yes ☐ No

6.3 Alcohol use during current pregnancy? ☐ Yes ☐ No *(If yes, complete the following section)*

6.3.1 Number of drinks consumed per day: _____ 6.3.2 Ongoing? ☐ Yes ☐ No

6.4 Illicit drug use during current pregnancy? ☐ Yes ☐ No 6.4.1 If yes, type of drug used: _____

6.4.2 Amount of drug consumed per day: _____ 6.4.3 Ongoing? ☐ Yes ☐ No

7. PREGNANCY STATUS

7.1 Were any pregnancy complications noted during this pregnancy? ☐ Yes ☐ No *(If no, go to Section 8)*

7.2 If yes, check all that apply:

☐ Preterm labor not resulting in birth ☐ Placental abruption
☐ Eclampsia ☐ Other (Specify): _____

8. PRENATAL TESTS

8.1 Was a prenatal test performed? ☐ Yes ☐ No *(If no, go to Section 9)*

	Prenatal Test Type *(Ultrasound, Amniocentesis, Cystic Fibrosis Mutation Analysis, Fetal Echo, 1st Trimester Screen, MSAFP/Serum Markers, Nuchal Translucency, Other (Specify))*	**Prenatal Test Date** *(dd/mmm/yyyy) OR Gestational Age (in weeks)*	**Was a Major Congenital Malformation Noted?** *(1 = Yes; 2 = No; 3 = Unknown)*	**If an MCM was noted, please list the major structural and/or chromosomal malformation(s) identified.**
1.				
2.				
3.				
4.				
5.				

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9. CONCURRENT MEDICAL CONDITIONS DURING THIS PREGNANCY ☐ None

Body System *(Cardiovascular, Respiratory, Gastrointestinal/Hepatobiliary, Renal, Neurological/Psychiatric, Metabolic/Endocrine, Hematological/Lymphatic, Immunological/Allergies, Dermatologic, Genitourinary, Drug Allergies, Other (Specify)*	Concurrent Medical Condition	Start Date *(dd/mmm/yyyy) OR (0 weeks = prior to conception)*	Stop Date *(dd/mmm/yyyy or (✓) if ongoing)*
1.			☐ Ongoing
2.			☐ Ongoing
3.			☐ Ongoing
4.			☐ Ongoing
5.			☐ Ongoing

10. CONCOMITANT MEDICATIONS TAKEN DURING THIS PREGNANCY ☐ None

List all concomitant medications taken, including prescription and non-prescription or "over-the-counter" medications, vitamins, vaccines, etc.

Medication / Therapy Name	Indication	Dosage / Units *(i.e., mg, mL, tablet, etc.)*	Frequency *(i.e., QD, BID, PRN, etc.)*	Route *(i.e., Oral, Topical, Subcutaneous, etc.)*	Start Date *(dd/mmm/yyyy) OR (0 weeks = prior to conception)*	Stop Date *(dd/mmm/yyyy or (✓) if ongoing)*
1.						☐ Ongoing
2.						☐ Ongoing
3.						☐ Ongoing
4.						☐ Ongoing
5.						☐ Ongoing

HEALTH CARE PROVIDER INFORMATION

Name _____

Address _____ Phone _____

_____ Fax _____

Alternate Contact _____ Email _____

Provider's Signature _____ Date _____ / _____ / _____
DD MMM YYYY