Appendix 1.

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Afshar Y, Gaw SL, Flaherman VJ, Chambers BD, Krakow D, Berghella V, et al. Clinical presentation of coronavirus disease 2019 (COVID-19) in pregnant and recently pregnant people. Obstet Gynecol 2020;136. The authors provided this information as a supplement to their article.

Demographics

1. Date of Birth ☐☐/☐☐/☐☐☐☐

2. How would you describe your racial or ethnic group? (Mark all that apply):

   O White or Caucasian
   O Black or African American
   O Hispanic or Latina
   O Asian
   O Native Hawaiian or Other Pacific Islander
   O American Indian/Alaska Native
   O Don't Know
   O Decline to state
   O Other
   If Other, please specify: _____

3. What is your current relationship status? Are you...
   O Married or domestic partner
   O Living as married
   O Divorced
   O Widowed
   O Separated
   O In a significant relationship
   O Single
   O Other (specify below)
   O Decline to State
   If Other, please specify: _____

4. What is the highest level of education that you have completed?
   O Less than high school
   O High school
   O Some college/Associate Degree
   O College graduate (4 years B.A. or equivalent)
   O Advanced Degree (Master's, PhD, MD, EdD, DVM, DDS, JD, etc.)
   O Decline to State

5. How would you describe your current employment or main activities? (mark all that apply)
   O Full time paid employment
   O Full time/part time homemaker and/or childcare provider, not paid for employment
   O Part time paid employment
   O Disability for an injury
   O Student or in job training
   O Seeking employment
   O Self employed
   O Retired
   O Other
   O Decline to State

If Other, please specify: _____

6. Do you work in health care or provide direct patient care?
   - O Yes, I work in health care and provide direct patient care → 6a
   - O Yes, I work in health care but I do not provide direct patient care
   - O No
   - O Decline to State

6a. If yes, Are you a:
   - O Physician → go to 6b
   - O Dentist/Orthodontist
   - O Nurse
   - O Nurse Practitioner/Physician Assistant
   - O CNM/Midwife
   - O Pharmacists
   - O Physical Therapist
   - O Home health worker
   - O Other, please specify
   - O Decline to State

6b. What is your specialty area?
   - O Emergency Medicine
   - O Obstetrics and Gynecology
   - O Infectious disease
   - O Critical care
   - O Anesthesiology
   - O Other, please specify:
   - O Decline to state

7. What is the approximate gross income of your household in a year?
   - O Less than $25,000
   - O $25,000-$50,000
   - O $50,000-$100,000
   - O More than $100,000
   - O Decline to State

8. Do you think of yourself as…
   - O Straight/heterosexual
   - O Gay or Lesbian
   - O Bisexual
   - O Other

If Other, please specify: _____

9. Do you think of yourself as transgender, transsexual, or gender non-conforming?
   - O Transgender/transsexual – Female to male
   - O Gender non-conforming
   - O No/Neither

Pregnancy Form

Are you currently pregnant?

- O Yes → QUESTIONNAIRE COMPLETED
- O No → go to 1a.
- O No but I have reported the details of my pregnancy (i.e., live birth, miscarriage) previously → form completed

1a. If no, when did the pregnancy end? _____ (date)

1b. If No, did the pregnancy end with…. (For multiples, i.e., twins, triplets, etc. mark all that apply):

- O Abortion? --> Go to Question 1d.
- O Miscarriage? --> Go to Question 1c.
- O Ectopic pregnancy? --> Go to Question 1f.
- O Molar pregnancy? --> QUESTIONNAIRE COMPLETED
- O Death of an infant or fetus >20 weeks (5 months) of pregnancy --> Go to Question 2
- O Live birth of an infant(s)? --> Go to Question 5 and complete Neonatal Form (Birth)

Miscarriage Questions:

1c. How far along in the pregnancy were you when the miscarriage occurred? _____ (in weeks from last menstrual period)

QUESTIONNAIRE COMPLETED

Abortion Questions:

1d. How far along in the pregnancy were you when the abortion occurred? _____ (in weeks from last menstrual period)

1e. What kind of abortion did you have? *Please select all that apply and remember, your answers will be kept confidential*

- O I had a surgical procedure at a clinic/health facility
- O I took pills → Complete below
- O I took herbs
- O I hit myself in the abdomen
- O I did something else
- O Decline to State

If you took pills or medication, where did you get the pills? *Select all that apply*.

- O I got pills from a clinic/health facility
- O I ordered pills on the internet
- O I got pills from a pharmacy
- O I got pills from someone else
- O Decline to state

QUESTIONNAIRE COMPLETED

Ectopic Pregnancy Questions:

1f. How was your ectopic pregnancy treated (check all that apply):

- O With methotrexate medication
- O With surgery
- O No treatment

QUESTIONNAIRE COMPLETED

Death of Infant or Fetus Questions:

2. How far along in the pregnancy were you when the infant(s) death occured? (in weeks from last menstrual period) ____

3. Did the infant(s) death occur:
   - O Prior to birth (still in the womb/uterus)
   - O During labor
   - O After delivery, within 6 weeks
   - O Other (specify below)

   Other, please specify: _____

4. What was the cause of the infant(s) death (check all that apply)?
   - O Unknown
   - O Infection
   - O Birth defect (e.g. congenital heart disease or other malformation)
   - O Other (specify below)

   Other, please specify: _____

Live Birth AND/OR Death of Infant or Fetus Questions:

5. Did you have any of the following conditions during pregnancy (check all that apply):
   - O Diabetes, pregnancy related (gestational diabetes)
   - O High blood pressure, pregnancy related (gestational hypertension)
   - O Preeclampsia (sometimes called "toxemia")
   - O Seizures
   - O Placenta previa (when the placenta covers the opening to the uterus, the cervix)
   - O Placenta abruption (when the placenta separates off from the uterus)
   - O Uterine rupture (when the wall of the uterus opens)
   - O Preterm premature rupture of membranes (when the bag of water breaks and at a time when the baby would be born premature)
   - O Abnormal amniotic fluid levels (oligohydramnios or polyhydramnios)
   - O Other (specify)
   - O None

   Other, please specify: _____

6. Did you take any medications regularly during your pregnancy besides prenatal vitamins or iron?
   - O Yes (please list below)
   - O No

   Please list medications: _____

7. Did you have any of the following conditions during or after the birth (check all that apply)
   - O Hemorrhage or excessive bleeding
   - O Blood transfusion
   - O Uterine Infection (also called chorioamnionitis or endometritis) during or after the birth
   - O Other (please explain below):
   - O None

   If Other pregnancy condition, please explain: _____

Neonatal Form (Birth)

1. Was your infant born at home?
   - O Yes → go to 3
   - O No

2. What is the name of the hospital or facility your infant was born at? _____

3. Did you receive prenatal care during your pregnancy?
   - O Yes, I had 6 or more prenatal visits
   - O Yes, I had 2-5 prenatal visits
   - O Yes, I had one prenatal visit
   - O No, I did not have a prenatal visit

4. What was your due date? _____

5. How many infants were born?

6. Was your infant/infants born breech presentation?
   - O Yes
   - O No
   - O I had twins, one was breech and one was not

7. Was your infant/infants born by:
   - O Vaginal delivery --> Go to Question 9
   - O Cesarean section --> Go to Question 8
   - O Vaginal delivery AND Cesarean section, for twins/other multiple births

8. If Cesarean section, what was the reason you had a Cesarean Section?
   - O Planned Cesarean section because I had a prior Cesarean Section
   - O Abnormal progress in labor
   - O Concern about your infant based on the heart monitor
   - O Baby was breech
   - O Uterine infection
   - O Emergency due to risk to baby or myself
   - O I was too sick to be in labor
   - O Other, please explain below

   8a. If Other reason for Cesarean section, please explain:
   _____

If Caesarean section only, go to Question 11

9. Was a vacuum (suction cup) used to try to deliver the baby?
   - O Yes
   - O No
   - O Don't Know

10. Were forceps used to try to deliver the baby?
   - O Yes
   - O No
   - O Don't Know

11. ***If multiples repeat Questions A - H for each infant born***

Please report infant information in the order of baby's birth from 1st to last (i.e., enter information for the baby who came first in the birth order under "Infant 1", the 2nd baby under "Infant 2", etc)

A. What is the infant's sex?
   - O Male
   - O Female

B. How much did the infant weigh at birth?

   Pounds: _____ (lbs (pounds))

   Ounces: _____ (oz (ounces))

C. Did you and your infant "room in" (share the same hospital room) while in the hospital?
   - O Yes → C1.
   - O No

C1. Did you take any precautions related to COVID-19 while sharing a room with your infant in the hospital, such as: (check all that apply)
   - O I wore a mask
   - O I washed my hands before caring for the infant
   - O There was a curtain or screen between me and my infant
   - O I did not care for the infant while in the hospital and others provided care
   - O No, I did not take any precautions related to COVID-19
   - O Other, please describe

D. Has the infant breastfed or received ANY breast milk?
   - O Yes → go to D1.
   - O No → got to E

D1. Did the infant breastfeed directly from your breast?
   - O Yes → go to D2.
   - O No → go to D6.

D2. How long after birth did you first try to breastfeed your infant?
   - O <30 min
   - O 30-60min

- O 60-120 min
- O 120 min-24 hours
- O After 24 hours

D3. Did you take any precautions related to COVID-19 during breastfeeding, such as: (check all that apply)

- O I wore a mask during breastfeeding
- O I washed my hands before breastfeeding
- O I washed my breasts before breastfeeding
- O No, I did not take any precautions related to COVID-19
- O Other, please describe: _____

D4. Are you currently breastfeeding your infant?

- O Yes→ got to E
- O No → go to D5

D5. What date did you stop breastfeeding your infant? _____→ go to E

D6. Did you provide expressed breast milk to your infant?

- O Yes → go to D7
- O No→ go to E

D7. Is your infant still receiving expressed breast milk?

- O Yes → go to E
- O No → go to D8

D8. What date did your infant last receive expressed breast milk? _____ → go to E

E. How long after birth was your infant placed skin-to-skin with you?

- O <30 min
- O 30-60min
- O 60-120 min
- O 120 min-24 hours
- O >24 hours
- O Infant was not placed skin-to-skin with me

F. Did your infant have any of the following problems during pregnancy labor, or delivery (check all that apply):

- O Baby diagnosed with COVID-19
- O Abnormal genetic screening (specify:_____)
- O Birth defect (specify:_____)
- O Fetal growth restriction (size was too small)
- O Meconium (brown stained fluid at the time of birth)
- O Other abnormalities (specify:_____)
- O None

G. Did your infant have any of the following problems after birth (check all that apply):

- O Baby diagnosed with COVID-19

- O Pneumonia
- O Received antibiotics
- O Abnormal genetic test (specify:_____)
- O Birth defect (specify:_____)
- O Fast breathing or difficulty breathing
- O Stopped breathing (apnea)
- O High heart rate
- O High temperature
- O Low temperature
- O Low blood sugar
- O High bilirubin level
- O Received antibiotics
- O Abnormal hearing screening test
- O Abnormal oxygen screening test
- O Seizure
- O Therapeutic hypothermia (cooling)
- O Abnormal bleeding or problem with blood clotting
- O Microcephaly (small head size for gestational age)
- O Abnormal findings on the newborn exam (specify:_____)
- O Problem with kidneys (specify:_____)
- O Problem with liver (specify:_____)
- O Problem with heart (specify:_____)
- O Other infection (specify:_____)
- O Other abnormalities (specify:_____)
- O None

H. Was your infant admitted to the neonatal intensive care unit (NICU)?
- O Yes → go to H1
- O No → Form Complete

H1. What is the name of the hospital where the infant was admitted to the NICU?
_____

H2. How many days was your infant in the neonatal intensive care unit? _____ (days (enter one whole number))

H3. Did your baby need oxygen or a breathing tube (ventilator) for respiratory support?
- O Yes → go to H4
- O No

H4. If yes, check all that apply:
- O Oxygen by nasal prongs (not connected to a separate machine to deliver pressure)
- O Positive airway pressure (CPAP), with or without extra oxygen) by nasal prongs or mask
- O Mechanical ventilation through breathing tube inserted into windpipe/trachea

H5a. Has your infant been discharged from the hospital?
- O Yes → Go to H5b

O No → Form complete

H5b. What date was your infant discharged from the hospital? _____

H6. When your infant left the hospital, where did the infant go?

O Home with mother
O Home without mother
O Other, please describe: _____

Health History and COVID-19 Questions

1. What is your height:
   _____feet
   _____inches

2. What is your pre-pregnancy weight: _____ pounds (lbs)

3. In a typical week, do you do any vigorous-intensity or moderate-intensity sports, fitness or recreational activities that cause increases in breathing or heart rate like walking, bicycling or swimming for at least 10 minutes continuously?
   O Yes
   O No

4. Did you receive a flu vaccination in the last year?
   O Yes
   O No

5. Has a doctor or other health care provider told you that you have any of the following conditions: (CHECK ALL THAT APPLY)

   O High blood pressure prior to pregnancy → go to 5a
   O Diabetes prior to pregnancy → go to 5b.
   O Asthma
   O Other lung conditions → go to 5c
   O Heart problems → go to 5d
   O Thyroid problems
   O Blood clot in your legs, lungs, or other area of your body that required you to be on blood thinners
   O Depression
   O Anxiety
   O HIV or AIDS
   O Any condition that decreases your ability to fight infection (immunosuppression). →go to 5e.
   O Other major medical condition → go to 5f
   O None of the above

   5a. Do you take medications for high blood pressure?
      O Yes
      O No

   5b. Do you take medications for your diabetes?
      O Yes
      O No

   5c. Please describe your lung condition: _____

5d. Please describe your heart problems: _____
5e. Please describe your condition that decreases your ability to fight infection (immunosuppression):
5f. Other major medical condition, please describe: _____

6. Are you taking any medications that decrease your ability to fight infection (immunosuppressant)?
   O Yes, please specify
   O No

6a. If yes, please specify the medications: _____

7. Are you taking any other medications regularly besides vitamins or iron?
   o Yes (please list below)
   o No
   Please list medications: _____

Coronavirus/COVID-19 Questions

8. What symptoms did you have that led you to be tested or suspected of Coronavirus/COVID-19? (Check all that apply)
   O Fever
   O Cough → go to 9a/9b
   O Shortness of breath
   O Dizziness or fainting
   O Body aches
   O Runny nose
   O Sore throat
   O Loss of sense of smell or taste
   O Sneezing
   O Fatigue
   O Nausea
   O Vomiting
   O Diarrhea
   O Headache
   O Other symptoms → go to 8c
   O None → Go to 11

   8a. Dry cough?
   O Yes
   O No

   8b. “Wet” cough (one that makes a lot of mucus or sputum)?
   O Yes

O No

8c. If other symptoms, please specify: _____

9. Which of these symptoms was the first thing you noticed? (mark only one)
   O Fever
   O Cough → go to 9a/9b
   O Shortness of breath
   O Dizziness or fainting
   O Body aches
   O Runny nose
   O Sore throat
   O Loss of sense of smell or taste
   O Sneezing
   O Fatigue
   O Nausea
   O Vomiting
   O Diarrhea
   O Headache
   O Other symptoms→ go to 9c
   O None

   9a. Dry cough?
   O Yes
   O No

   9b. "Wet" cough (one that makes a lot of mucus or sputum)?
   O Yes
   O No

   9c. If other symptoms, please specify: _____

10. When did your symptoms start? (If you don't know the exact date, make your best guess) _____DATE

11. Have you traveled outside of your city or town in the last month?
   O Yes
   O No

   11a. If yes, Where did you travel: _____

12. Has anyone you have close contact with tested positive for Coronavirus?
   O Yes
   O No

13. Has anyone you have close contact with had a fever, cough, or flu-like symptoms in the last month?
    - O Yes
    - O No

14. What is your current status with Coronavirus/COVID-19?
    - O Diagnosed with Coronavirus (tested positive for Coronavirus) → go to 14a.
    - O Tested negative for Coronavirus → go to 14b.
    - O Waiting for my test results
    - O I have not been tested
    - O Other → go to 14c.

    14a. What date were you told you had COVID-19? _____

    14b. What date were you told you were negative for COVID-19? _____

    14c. If other, please specify: _____

15. Have you been tested for the flu virus?
    - O Yes → go to 15a
    - O No

15a. Have you been diagnosed with the flu?
    - O Yes
    - O No

16. Are you currently in the hospital?
    - O Yes → go to 16a
    - O No → go to 16b

16a. Are you in the Intensive Care Unit (ICU)?
    - O Yes
    - O No

16b. Are you quarantined (including self-quarantined)?
    - O Yes, I am quarantined alone
    - O Yes, I am quarantined with others
    - O No, I am not quarantined

Reproductive Health History

If you do not know the exact answer to any question, please make your best guess.

1. Are you currently pregnant?
   - O Yes → go to 1a.
   - O No → go to 2.

1a. Do you know how far along you are in pregnancy?
   - O Yes → go to 1b.
   - O No → go to 1c

1b. How many weeks are you into pregnancy? That is, how many weeks has it been since the first day of your last menstrual period? If you don't know, please make your best guess
___ weeks

1c. During your pregnancy, did you ever consider having an abortion?
   - O Yes → continue
   - O No → Skip to 1e
   - O Decline to State → Skip to 1e

1d. Are you still considering having an abortion?
   - O Yes → Skip to 2
   - O No → continue
   - O Decline to State → continue

1e. Do you know your due date?
   - O Yes → go to 1f.
   - O No → go to 1g.

1f. What is your due date? _____

1g. Are you pregnant with one fetus or infant or multiples?
   - O One fetus/infant
   - O Twins
   - O Triplets
   - O Quadruplets
   - O Don't Know

2. How many times have you been pregnant (including your current/recent pregnancy, previous pregnancies, live births, miscarriages, still births or abortions)? _____

3. How many of these pregnancies resulted in...(Enter "0", if not applicable)
    a. The live birth of an infant? _____

    b. A miscarriage _____

    c. An abortion _____

    d. The death of an infant at more than 20 weeks (or 5 months) of pregnancy, but before birth _____

    e. Other _____

If other, please specify:_____

4. ONLY ANSWERED BY women who have had at least 1 pregnancy that was live birth or death of an infant.

In prior pregnancies, have you had any of the following conditions occur (check all that apply):

- O Preterm birth (before 37 weeks of pregnancy are completed) of an infant→ go to 4a
- O Hemorrhage (major bleeding) after birth that required a blood transfusion
- O Diabetes during pregnancy
- O High blood pressure during pregnancy
- O Preeclampsia
- O Death of a fetus >20 weeks
- O Hospitalized during pregnancy → go to 4b
- O None of the Above

4a. How far along in the pregnancy was the infant born? ___weeks

4b. If you were hospitalized during pregnancy, please explain:
_____

5. For this current pregnancy, did you use any medications or procedures provided to you by a health care provider to become pregnant, such as in vitro fertilization (IVF)?
    - O Yes
    - O No

Alcohol, Drug and Tobacco Use

1. In the past 30 days, how often did you have a drink containing alcohol?
   - o Never **(skip to question 4)**
   - o Monthly or less
   - o 2 to 4 times a month
   - o 2 to 3 times a week
   - o 4 or more times a week
   - o Decline to state

2. In the past 30 days, how many drinks containing alcohol did you have on a typical day when you were drinking?
   One drink is equivalent to a 12-ounce beer, a 5-ounce glass of wine, or a drink with one shot of liquor.
   - o 1 or 2
   - o 3 or 4
   - o 5 or 6
   - o 7, 8, or 9
   - o 10 or more
   - o Decline to state

3. In the past 30 days, how often did you have 4 or more drinks on one occasion?
   - o Never
   - o Less than monthly
   - o Monthly
   - o Weekly
   - o Daily or almost daily
   - o Decline to state

4. Have you smoked 100 cigarettes (about 5 packs) or more in your entire life?
   - O Yes
   - O No
   - O Decline to state

5. Do you smoke cigarettes now?
   - O Yes
   - O No

6. Does anyone that you live with smoke cigarettes?
   - O Yes
   - O No
   - O Decline to state

7. In the past 30 days, have you vaped tobacco?
   - O Yes

- O No
- O Decline to state

8. In the past 30 days, how often did you use cannabis or marijuana?
   - O Never→ Go to Question 10
   - O Monthly or less
   - O 2 to 4 times a month
   - O 2 to 3 times a week
   - O 4 or more times a week
   - O Decline to state

9. In the past 30 days, have you vaped marijuana?
   - O Yes
   - O No
   - O Decline to state

10. In the past 30 days, did you use any of the following substances? *[Check all that apply]*
    - O Cocaine (coke, crack, etc.)
    - O Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)
    - O Methamphetamine (speed, crystal, ice, etc.)
    - O Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)
    - O Sedatives or sleeping pills (Valium, Serepax, Ativan, Xanax, Librium, Rohypnol, GHB)
    - O Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy or Molly, etc.)
    - O Street opioids (heroin, opium, etc.)
    - O Prescription opioids as prescribed (fentanyl, oxycodone [Oxycontin, Percoset], hydrocodone [Vicodin], methadone, buprenorphine, etc)
    - O Prescription opioids without a prescription or differently from how they were prescribed (fentanyl, oxycodone [Oxycontin, Percoset], hydrocodone [Vicodin], methadone, buprenorphine, etc.
    - O Other (Specify) _____
    - O None of the above → Form Completed

11. In the past 30 days, how often did you use any of these substances [the substances from Q10]?
    - O Never
    - O Less than monthly
    - O Monthly
    - O Weekly
    - O Daily or almost daily
    - O Decline to state

COVID-19 Follow-up

1. What is your current status with Coronavirus/COVID-19, based on your most recent test result?
   - O Diagnosed with Coronavirus (tested positive for Coronavirus) → go to 1a.
   - O Tested negative for Coronavirus → go to 1b.
   - O Waiting for my test results
   - O I have not been tested → go to 1c.
   - O Other

   1a. What date were you told you had COVID-19? _____

   1b. What date were you told you were negative for COVID-19? _____

   1c. If other, please specify: _____

2. Have you been tested for the flu virus?
   - O Yes → go to 2a
   - O No

2a. Have you been diagnosed with the flu?
   - O Yes
   - O No

3. Are you currently in the hospital?
   - O Yes → go to 3a
   - O No → go to 3b

3a. Are you in the Intensive Care Unit (ICU)?
   - O Yes
   - O No

3b. Are you quarantined (including self-quarantined)?
   - O Yes, I am quarantined alone
   - O Yes, I am quarantined with other family members
   - O No

4. What symptoms do you currently have? Check all that apply:
   - O Fever
   - O Cough → go to 4a/4b
   - O Shortness of breath
   - O Dizziness or fainting
   - O Body aches
   - O Runny nose
   - O Sore throat
   - O Loss of sense of smell or taste
   - O Sneezing
   - O Fatigue
   - O Nausea
   - O Vomiting
   - O Diarrhea
   - O Headache

- O Other symptoms → go to 4c
- O None

4a. Dry cough?
- O Yes
- O No

4b. "Wet" cough (one that makes a lot of sputum or mucus)?
- O Yes
- O No

4c. If other symptoms, please specify: _____

5. Has anyone you have close contact with tested positive for coronavirus?
   - O Yes
   - O No

6. Has anyone you have close contact with had a fever, cough, or flu-like symptoms in the last month?
   - O Yes
   - O No