## Prenatal History

These elements are most relevant to pediatric studies.

1. Mother’s age at the time she gave birth to the participant/subject (years):
2. Number of live born children the participant/subject’s mother has delivered:
3. Total number of times the participant/subject’s mother has been pregnant, regardless of whether these pregnancies were carried to term (A current pregnancy, if any, is included in this count):
4. Does the participant/subject’s mother have a history of:
   1. Previous pregnancy loss?

Yes  No  Unknown

* 1. Preeclampsia during pregnancy of the participant/subject? (Preeclampsia is defined as a physician diagnosis of either preeclampsia or pregnancy-induced hypertension.)

Yes  No  Unknown

* 1. Another hypertensive disorder during pregnancy of the participant/subject?

Yes  No  Unknown

* 1. Oligohydramnios (condition in pregnancy characterized by a deficiency of amniotic fluid)?

Yes  No  Unknown

* 1. Gestational onset diabetes during pregnancy of the participant/subject?

Yes  No  Unknown

* 1. Fever during delivery of participant/subject?

Yes  No  Unknown

* 1. Prolonged rupture of membranes (i.e., > 24 hours) during delivery of participant/subject?

Yes  No  Unknown

* 1. Second stage of labor more than two hours?

Yes  No  Unknown

* 1. Meconium staining of the amniotic fluid?

Yes  No  Unknown

## Delivery History

1. Birth weight
2. Gestational age at birth (weeks):
3. APGAR 5 minute score:

0

1

2

3

4

5

6

7

8

9

10

1. APGAR 10 minute score:

0

1

2

3

4

5

6

7

8

9

10

1. Mode of delivery of the neonate:

Spontaneous  Induced  Unknown

1. Route of delivery of the neonate:

Vaginal  Caesarean

If Caesarean, timing of the procedure?:

Emergency  Elective  Unknown

1. Delivery modality type of the neonate:

Breech  Cephalic  Unknown

1. Instrument(s) used to assist with the delivery of the participant/subject?

None  Vaccum  Forceps  Vaccum and Forceps  Unknown

1. Is there a history of the following:
   1. Resuscitation of the participant/subject at delivery?

Yes  No  Unknown

* 1. Intravascular catheter placed in newborn period?

Yes  No  Unknown

* 1. Placenta sent for pathology?

Yes  No  Unknown

* 1. Placental abnormalities?

Yes  No  Unknown

* 1. Cord abnormalities? (Cord abnormalities include tight nuchal cord, umbilical cord knot, and body cord.)

Yes  No  Unknown

* 1. Fetal heart rate abnormality? (Fetal heart rate abnormalities are considered present if a treating physician noted repetitive or prolonged late decelerations, fetal bradycardia, nonreassuring fetal heart tracing, or fetal distress according to electronic fetal heart rate monitoring.)

Yes  No  Unknown

* 1. Decreased fetal movement? (Decreased fetal movement refers to a maternal report of decreased fetal movement before labor or decreased fetal movement during a nonstress test.)

Yes  No  Unknown

* 1. Chorioamnionitis? (Chorioamnionitis is defined as a maternal temperature of at least 37.8 degrees C [100.4 degrees F] or a physician diagnosis of chorioamnionitis according to clinical symptoms alone.)

Yes  No  Unknown

* 1. Other pregnancy/delivery risk factors?

Yes  No  Unknown

## General Instructions

This case report form (CRF) contains data elements related to pregnancy and perinatal history. The questions on the CRF are applicable to pediatric Friedreich’s Ataxia studies. Important note: None of the data elements included on this CRF is considered Core (i.e., strongly recommended for all Friedreich’s Ataxia clinical studies to collect). Rather, all of the data elements are exploratory and should only be collected if the research team considers them appropriate for their study.

## Specific Instructions

Please see the Data Dictionary for definitions for each of the data elements included in this CRF Module.