**Section 500.APPENDIX A Birth Records**

**Section 500.ILLUSTRATION B Information for Medical and Health Use Only**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| VR100 REV 11/89 | | | | | | | | |  | | | | | | | INFORMATION FOR MEDICAL AND HEALTH USE ONLY | | | | | | | | | | | | | | | | (BASED ON 1989 U.S. STANDARD CERTIFICATE | | | | | | | | | | | | | | | |
|  | OF HISPANIC ORGIN? | | | | | | | | | | | |  | | RACE-American Indian, | | | | | | | | | 26. EDUCATION | | | | | | | | | | | | | 27. OCCUPATION AND BUSINESS/INDUSTRY | | | | | | | | | | |
|  | (Specify No or Yes-If Yes | | | | | | | | | | | |  | | Black, White, etc. | | | | | | | | | (Specify only highest grade completed) | | | | | | | | | | | | | (Worked during last year) | | | | | | | | | | |
|  | specify Cuban, Mexican, | | | | | | | | | | | |  | | (Specify below) | | | | | | | | | Elementary/Secondary (0-12) | | | | | | College (1-4 or 5+) | | | | | | | Occupation | | | | | | Business/Industry | | | | |
| 24. | Puerto Rican, etc.) | | | | | | | | | | | | 25. | |  | | | | | | | | |  | | | | | |  | | | | | | |  | | | | | |  | | | | |
|  |  | | No | |  | | | Yes | | | | |  | |  | | | | | | | | |  | | | | | |  | | | | | | |  | | | | | |  | | | | |
| MOTHER | | 24a. | Specify: | | | | | | | | | | | | 25a. |  | | | | | | | | | | 26a. | | | | | |  | | | | | | | 27a. | | | | | | 27b. | | | | |
|  |  | | No | | |  | Yes | | | | | |  | |  | | | | | | | | |  | | | | | |  | | | | | | |  | | | | | |  | | | | |
| FATHER | | 24b. | Specify: | | | | | | | | | | | | 25b. | | | | |  | | | | | | 26b. | | | | | |  | | | | | | | 27c. | | | | | | 27d. | | | | |
| 28. PREGNANCY HISTORY  (Complete each section)  MULTIPLE BIRTHS  Enter State File Number for Mate(s)  LIVE BIRTH(S)  FETAL DEATH(S) | | | | | | | | | | | | | | | | | | | | | | | | | | MOTHER MARRIED? (at delivery, conception or at | | | | | | | | | | | | | DATE LAST NORMAL MENSES BEGAN | | | | | | | | |
| any time between) (Yes or No) | | | | | | | | | | | | | (Month, Day, Year) | | | | | | | | |
| 29. | | | | | | | | | | | | | 30. | | | | | | | | |
| LIVE BIRTHS  (Do not include this child) | | | | | | | | | | | | OTHER TERMINATIONS  (Spontaneous and induced at  any time after conception) | | | | | | | | | | | | | | MONTH OF PREGNANCY PRENATAL CARE BEGAN | | | | | | | | | | | | | PRENATAL VISTS | | | | | | | | |
| First, Second, Third, Etc. (Specify) | | | | | | | | | | | | | Total Number (if none, so state) | | | | | | | | |
| 31. | | | | | | | | | | | | | 32. | | | | | | | | |
| NOW LIVING | | | | NOW DEAD | | | | | | | |  | | | | | | | | | | | | | | BIRTHWEIGHT | | | | | | | | | | | | | CLINICAL ESTIMATE OF GESTATION | | | | | | | | |
| Number \_\_\_\_  Printed by the Authority of the State of Illinois – Illinois Department of Public Health – Division of Vital Records | | | | Number \_\_\_\_ | | | | | | | | Number \_\_\_\_\_ | | | | | | | | | | | | | | (Specify Units) | | | | | | | | | | | | |  | | | | | | | | |
| 28a.  None | | | | 28b.  None | | | | | | | | 28d.  None | | | | | | | | | | | | | | 33. | | | | | | | | | | | | | 34. | | Weeks | | | | | | |
| DATE OF LAST LIVE BIRTH | | | | | | | | | | | | DATE OF LAST OTHER TERMINATION | | | | | | | | | | | | | | PLURALITY | | | | | | | | | | | | | IF NOT SINGLE BIRTH - Born | | | | | | | | |
| (Month, Year) | | | | | | | | | | | | (Month, Year) | | | | | | | | | | | | | | Single, Twin, Triplet, etc. (Specify) | | | | | | | | | | | | | First, Second, Third, etc. (Specify) | | | | | | | | |
| 28c. | | | | | | | | | | | | 28e. | | | | | | | | | | | | | | 35a. | | | | | | | | | | | | | 35b. | | | | | | | | |
| 36. APGAR SCORE | | | | | | | | | | MOTHER TRANSFERRED PRIOR TO DELIVERY?  No  Yes | | | | | | | | | | | | | | | | | | | | | IF YES, ENTER NAME AND LOCATION OF FACILITY TRANSFERRED FROM | | | | | | | | | | | | | | | | |
| 37a. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1 MINUTE | | | | 5 MINUTES | | | | | | | INFANT TRANSFERRED? | | | | | | | | | | | | No | | | | Yes | | IF YES, ENTER NAME AND LOCATION OF FACILITY TRANSFERRED TO | | | | | | | | | | | | | | | | | | |
|  | 36a. | | | | 36b. | | | | | | | 37b. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 38a. | | MEDICAL RISK FACTORS FOR THIS PREGNANCY  (Check all that apply) | | | | | | | | | | | | | | | | | | | | 40. | | | COMPLICATIONS OF LABOR AND/OR DELIVERY (Check all that apply) | | | | | | | | | | | | | 43. | | CONGENITAL ANOMALIES OF CHILD  (Check all that apply) | | | | | | | |
|
| Anemia (Hct.<30/Hgb. <10) | | | | | | | | | | | | | | | | | | | | 01 |  | Febrile (>100°F. or 38°C.) | | | | | | | | | | | | | 01 |  | | Anencephalus | | | | | | | | 01 |  |
| Cardiac disease | | | | | | | | | | | | | | | | | 02 | |  |  |  | Meconium, moderate, heavy | | | | | | | | | | | 02 |  |  |  | | Spina bifida/Meningocele | | | | | | 02 |  |  |  |
| Acute or chronic lung disease | | | | | | | | | | | | | | | | | | | | 03 |  | Premature rupture of membrane (>12 hours) | | | | | | | | | | | | | 03 |  | | Hydrocephalus | | | | | | | | 03 |  |
| Diabetes | | | | | | | | | | | | | | | | | 04 | |  |  |  | Abruptio placenta | | | | | | | | | | | 04 |  |  |  | | Microcephalus | | | | | | 04 |  |  |  |
| Genital herpes | | | | | | | | | | | | | | | | | | | | 05 |  | Placenta previa | | | | | | | | | | | | | 05 |  | | Other central nervous system anomalies | | | | | | | |  |  |
| Hydramnios/Oligohydramnios | | | | | | | | | | | | | | | | | 06 | |  |  |  | Other excessive bleeding | | | | | | | | | | | 06 |  |  |  | | (Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | 05 |  |
| Hemoglobinopathy | | | | | | | | | | | | | | | | | | | | 07 |  | Seizures during labor | | | | | | | | | | | | | 07 |  | | Heart malformations | | | | | | 06 |  |  |  |
| Hypertension, chronic | | | | | | | | | | | | | | | | | 08 | |  |  |  | Precipitous labor (<3 hours) | | | | | | | | | | | 08 |  |  |  | | Other circulatory/respiratory anomalies | | | | | | | |  |  |
| Hypertension, pregnancy associated | | | | | | | | | | | | | | | | | | | | 09 |  | Prolonged labor (>20 hours) | | | | | | | | | | | | | 09 |  | | (Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | 07 |  |
| Eclampsia | | | | | | | | | | | | | | | | | 10 | |  |  |  | Dysfunctional labor | | | | | | | | | | | 10 |  |  |  | | Rectal atresia/stenosis | | | | | | 08 |  |  |  |
| Incompetent cervix | | | | | | | | | | | | | | | | | | | | 11 |  | Breech/Malpresentation | | | | | | | | | | | | | 11 |  | | Tracheo-esophageal fistula/ | | | | | |  |  |  |  |
| Previous infant 4000 + grams | | | | | | | | | | | | | | | | | 12 | |  |  |  | Cephalopelvic disproportion | | | | | | | | | | | 12 |  |  |  | | Esophageal atresia | | | | | | | | 09 |  |
| Previous preterm or small-for-gestational-age infant | | | | | | | | | | | | | | | | | | | | 13 |  | Cord prolapse | | | | | | | | | | | | | 13 |  | | Omphalocele/gastroschisis | | | | | | 10 |  |  |  |
| Renal disease | | | | | | | | | | | | | | | | | 14 | |  |  |  | Anesthetic complications | | | | | | | | | | | 14 |  |  |  | | Other gastrointestinal anomalies | | | | | |  |  |  |  |
| Rh sensitization | | | | | | | | | | | | | | | | | | | | 15 |  | Fetal Distress | | | | | | | | | | | | | 15 |  | | (Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | 11 |  |
| Uterine bleeding | | | | | | | | | | | | | | | | | 16 | |  |  |  | None | | | | | | | | | | | 00 |  |  |  | | Malformed genitalia | | | | | | 12 |  |  |  |
| None | | | | | | | | | | | | | | | | | | | | 00 |  | Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | 16 |  | | Renal agenesis | | | | | | | | 13 |  |
| Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | 17 | |  |  |  |  | | | | | | | | | | | | | |  | | Other urogenital anomalies | | | | | |  |  |  |  |
|  | | | | | | | | | | | | | | | | |  | |  |  |  | 41. METHOD OF DELIVERY (Check all that apply) | | | | | | | | | | | | | |  | | (Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | 14 |  |  |  |
| 38b. OTHER RISK FACTORS FOR THIS | | | | | | | | | | | | | | | | |  | |  |  |  | Vaginal | | | | | | | | | | | | | 01 |  | | Cleft lip palate | | | | | | | | 15 |  |
| PREGNANCY (Complete all items) | | | | | | | | | | | | | | | | |  | |  |  |  | Vaginal birth after previous C-section | | | | | | | | | | | 02 |  |  |  | | Polydactyly/syndactyly/Adactyly | | | | | | 16 |  |  |  |
| Tobacco use during pregnancy | | | | | | | | | | | | | | | | | Yes | |  | No |  | Primary C-section | | | | | | | | | | | | | 03 |  | | Club foot | | | | | | | | 17 |  |
| Average number of cigarettes per day \_\_\_ | | | | | | | | | | | | | | | | |  | |  |  |  | Repeat C-section | | | | | | | | | | | 04 |  |  |  | | Diaphragmatic hernia | | | | | | 18 |  |  |  |
| Alcohol use during pregnancy | | | | | | | | | | | | | | | | | Yes | |  | No |  | Forceps | | | | | | | | | | | | | 05 |  | | Other musculoskeletal/integumental anomalies | | | | | | | | |  |
| Average number drinks per week \_\_\_\_\_ | | | | | | | | | | | | | | | | |  | |  |  |  | Vacuum | | | | | | | | | | | 06 |  |  |  | | (Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | 19 |  |
| Weight gain during pregnancy \_\_\_\_\_ lbs. | | | | | | | | | | | | | | | | |  | |  |  |  | 42. ABNORMAL CONDITIONS OF THE | | | | | | | | | | |  |  |  |  | | Down's syndrome | | | | | | 20 |  |  |  |
| PARENTS REQUEST FOR A SOC. SEC. NO. ISSUANCE  □ | | | | | | | | | | | | | | | | |  | |  |  |  | NEWBORN (Check all that apply) | | | | | | | | | | |  |  |  |  | | Other chromosomal anomalies | | | | | |  |  |  |  |
| 39. OBSTETRIC PROCEDURES | | | | | | | | | | | | | | | | |  | |  |  |  | Anemia (Hct.<39/Hgb. <13) | | | | | | | | | | | | | 01 |  | | (Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | 21 |  |
| (Check all that apply) | | | | | | | | | | | | | | | | |  | |  |  |  | Birth injury | | | | | | | | | | | 02 |  |  |  | | None | | | | | | 00 |  |  |  |
| Amniocentesis | | | | | | | | | | | | | | | | | | | | 01 |  | Fetal alcohol syndrome | | | | | | | | | | | | | 03 |  | | Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | 22 |  |
| Electronic fetal monitoring | | | | | | | | | | | | | | | | | 02 | |  |  |  | Hyaline membrane disease/RDS | | | | | | | | | | | 04 |  |  |  | | 44a. DATE OF MOTHER'S BLOOD TEST FOR SYPHILIS | | | | | | | | | |
| Induction of labor | | | | | | | | | | | | | | | | | | | | 03 |  | Meconium aspiration syndrome | | | | | | | | | | | | | 05 |  | | (MONTH, DAY, YEAR) | | | | | |  |  |  |  |
| Stimulation of labor | | | | | | | | | | | | | | | | | 04 | |  |  |  | Assisted ventilation <30 min. | | | | | | | | | | | 06 |  |  |  | |  | | | | | |  |  |  |  |
| Tocolysis | | | | | | | | | | | | | | | | | | | | 05 |  | Assisted ventilation ≥30 min. | | | | | | | | | | | | | 07 |  | |  | | | | | | | | | |
| Ultrasound | | | | | | | | | | | | | | | | | 06 | |  |  |  | Seizures | | | | | | | | | | | 08 |  |  |  | | 44b. LABORATORY DOING THE SEROLOGY | | | | | | | | | |
| None | | | | | | | | | | | | | | | | | | | | 00 |  | None | | | | | | | | | | | | | 00 |  | |  | | | | | |  |  |  |  |
| Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | 07 | |  |  |  | Other (Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | 09 |  |  |  | |  | | | | | |  |  |  |  |
|  | | | | | | | | | | | | | | | | |  | |  |  |  | MOTHER | | | | | | Social Security Number | | | | | | | | | | FATHER | | | | Social Security Number | | | | | |
| 45. | | | | | | | | | | 46. | | | | | |

(Source: Added at 15 Ill. Reg. 11706, effective August 1, 1991)