**Section 500.APPENDIX A Birth Records**

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

|  |  |  |  |
| --- | --- | --- | --- |
| 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 BIRTHSEnter 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 atany 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)