

NYSOMOTC-TWIN DATA REGISTRY

This form is to be filled out by a parent of multiples. The information about you and your multiples will be entered in a data base maintained by the New York State Organization of Mothers of Twins Clubs for research purposes. Read each question carefully and place the appropriate letter or answer in the space provided. If you have more than one set of multiples, please complete a separate form for each set and indicate if form is for Set A or Set B.

You can have your information updated or deleted from the data base upon written notification to NYSOMOTC Research Chairman. This form is available from the website – www.nysomotc.org. Information provided on this form is confidential.

Mail this form to the current NYSOMOTC Research/Twin Data Registry Chairman or give to your local club's State Representative. Thank you!

Date _____ Check if this is: First time Filing _____ Update _____

Last Name _____ First _____ MI _____

Address _____

City _____ State _____ Zip Code _____

E-mail: _____ Telephone: _____ - _____

Member of NYSOMOTC? Yes _____ No _____

Club Name: _____

Parent Information: Select the letter that best describes your answer; fill in the blanks.

Relationship to multiples: _____ A) Biological Parent B) Adoptive Parent C) Step-parent
D) Other _____ (specify)

Multiples: _____ A) One set of multiples B) Two sets of multiples C) Three sets of multiples
D) Higher Order Multiples _____ Indicate if triplets, quads, quints.....
& How many sets?

Age of biological mother at time of birth: _____ 1) Under 18 3) 26-30 5) 36-40 7) Over 50
2) 18-25 4) 31-35 6) 41-50 8) Unknown

Present status of mother of multiples: _____ A) Single B) Married C) Divorced D) Widowed
E) Remarried F) Committed Relationship

Mother of multiples' career: *(Circle all that apply both before pregnancy and/or after. Provide specific job title(s) on last line.)*

- | | | |
|----------------------------|--------------------------------|-------------------------|
| 1) Accounting | 10) Education | 19) Management |
| 2) Administrative Support | 11) Engineering | 20) News Media |
| 3) Advertising/ Marketing | 12) Finance/ Banking | 21) Public Relations |
| 4) Arts/ Entertainment | 13) Health Care/ Medicine | 22) Retired |
| 5) Child Care | 14) Hospitality/ Food Services | 23) Scientific Research |
| 6) Communications | 15) Human Resources | 24) Social Work |
| 7) Construction | 16) Information Technology | 25) Stay at Home Mother |
| 8) Consulting | 17) Law/ Government | 26) Other |
| 9) Customer Service/ Sales | 18) Law Enforcement | |

Note Specific Job Title(s) _____

Biological Mother is _____ A) Singleton B) Multiple C) Unknown

Biological Father is _____ A) Singleton B) Multiple C) Unknown

Family history of biological parents: *(Immediate family is defined by parents and siblings. Extended family is defined as first cousins, aunts, uncles and grandparents.)*

Biological Mother has multiples on her side of the family: _____

- | | |
|---|------------|
| 1) Other multiples in immediate family – if yes, how many sets? _____ | 3) None |
| 2) Other multiples in extended family only – if yes, how many sets? _____ | 4) Unknown |

Biological Father has multiples on his side of the family: _____

- | | |
|---|------------|
| 1) Other multiples in immediate family – if yes, how many sets? _____ | 3) None |
| 2) Other multiples in extended family only – if yes, how many sets? _____ | 4) Unknown |

Are your multiples multi-racial? _____ 1) Yes 2) No

Ethnic background of multiples: *(Please circle all that apply.)*

- | | | |
|--------------|--------------------|-----------------------------|
| 1) Caucasian | 3) Hispanic | 5) Asian & Pacific Islander |
| 2) Black | 4) Native American | 6) Unknown |

Multiples have the following number of siblings (excluding multiples): _____

- 1) One 2) Two 3) Three 4) Four 5) Five or more 6) None 7) Unknown

Was this pregnancy your _____ A) First B) Second C) Third D) Fourth E) Other

Were birth control pills taken prior to this pregnancy? _____ 1) Yes 2) No

Multiple pregnancy was diagnosed during: _____ A) 1st trimester B) 2nd trimester C) 3rd trimester

Multiple pregnancy was confirmed by: _____ A) Sonogram B) X-ray C) At delivery D) Other _____

The multiple pregnancy was: _____ A) natural conception B) by fertility treatment

If pregnancy was a result of fertility treatment or Assisted Reproductive Technology (ART), indicate type of treatment used: _____ Drugs/Medications: 1) Clomid 2) hMG 3) GnRH

_____ InVitro Treatment: 1) IVF-ET 2) GIFT 3) TET or ZIFT 4) ICSI

Biological mother's weight gain during pregnancy? _____ lbs.

Indicate complications developed during the pregnancy:

Multiples were delivered: _____ A) Vaginal without anesthesia B) Vaginal with anesthesia
C) Caesarian D) Combination vaginal & caesarian E) Unknown

Multiples were delivered during which month of pregnancy? _____ A) 5th or earlier B) 6th C) 7th
D) 8 – 8 ½ months E) 8 ½ - 9th month F) after 9th month G) Unknown

Multiples Information: Multiple A is first-born; Multiple B is second-born, etc.

Birth date of multiples: _____ (m/d/y)

Low Birth Weight: Did any of the multiples weigh less than 2,500 grams (5.5 lbs.) at birth?

_____ 1) Yes 2) No

Type of multiples:

_____ 1) Twins 2) Triplets 3) Quadruplets 4) Quintuplets 5) Sextuplets

	Multiple A	Multiple B	Multiple C	Multiple D	Multiple E	Multiple F
Sex of multiples 1)Male 2)Female	_____	_____	_____	_____	_____	_____
Handedness: 1)Right-handed 2)Left-handed 3)Ambidextrous(both) 4)Unknown	_____	_____	_____	_____	_____	_____
Zygosity: 1)Identical 2)Fraternal 3)Mixed (HOM only) 4)Unknown	_____	_____	_____	_____	_____	_____
Has death of a multiple occurred? 1) Yes 2) No	_____	_____	_____	_____	_____	_____
If yes, please note age at time of death:	_____	_____	_____	_____	_____	_____

Special Needs Information

Special Needs: *Refer to the list of conditions below. Note any medical conditions that exist, beginning with the most predominate, by putting the corresponding # of the condition next to the appropriate person (i.e., 2,5,6).*

Biological Mother: _____

Biological Father: _____

Multiple A: _____

Multiple B: _____

Multiple C: _____

Multiple D: _____

Multiple E: _____

Multiple F: _____

Conditions:

- | | | |
|---|---------------------------------------|---|
| 1) No known medical diseases or defects | 11) Deformity of limbs | 23) Learning Disabilities |
| 2) Allergies (Note type above, i.e., Environmental, food, etc.) | 12) Diabetes | 24) Lungs/ Respiratory |
| 3) Anemia | 13) Digestive Disorders (diagnosed) | 25) Mental Retardation |
| 4) Arthritis | 14) Down's Syndrome | 26) Multiple Sclerosis |
| 5) Asthma | 15) Dyslexia | 27) Muscular Dystrophy |
| 6) Autism Spectrum Disorder | 16) Epilepsy/Convulsions | 28) Rheumatic Disease |
| 7) Cancer | 17) Hearing Impaired | 29) Scoliosis |
| 8) Cerebral Palsy | 18) Heart Disease | 30) Spina Bifida |
| 9) Cleft Palate | 19) High Blood Pressure/ Hypertension | 31) Other: Please describe on the appropriate line above. |
| 10) Cystic Fibrosis | 20) Hyperactivity (diagnosed) | |
| | 21) Hydrocephalic Disease | |
| | 22) Kidney/Urinary Disease | |

Consent

Information provided on this form is confidential and will be released only with your permission. Information may be released to qualified researchers who have an approved research data request form on file. Information may also be used within the organization in order to better target services to specific groups. Please check the appropriate boxes below to indicate those areas in which you **DO NOT CONSENT** to the release of personal information. Your signature shall constitute approval to use this data for these purposes unless you check the box or boxes below.

☐

Please check here if you **DO NOT** wish to have your name released to researchers.

☐

Please check here if you **DO NOT** wish to have NYSOMOTC use your personal information for internal purposes.

SIGNATURE: _____ DATE: _____