LIFE

$sitecode	User:	System Date:	Mode: Production

Site Name:

Women's Journal (FJL)

Version: 3.00; 08-15-06

Week Beginning:

OMB# 0925-0543
Exp. 06/30/2010

Public reporting burden for this collection of information is estimated to average 2 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. **An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.** Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0543).

Your journal collects information for each week of participation. Please answer the questions each day so that we will have the very best information. When answering the questions, consider that each day ends at midnight. Please try to complete the card about the same time each day. Please do not leave any spaces blank. Need help? Click the 'i' symbol for additional instructions.

JOURNAL QUESTIONS	Sun	Mon	Tue	Wed	Thu	Fri	Sat
1. **Menstruation: bleeding or spotting** **0**=None **1**=Spotting **2**=Light **3**=Moderate **4**=Heavy	☐	☐	☐	☐	☐	☐	☐
2. **Sexual intercourse frequency** Please fill in number of times; **0**=None	☐	☐	☐	☐	☐	☐	☐
3. **Did you do anything to prevent pregnancy?** **0**=No **1**=Yes	☐	☐	☐	☐	☐	☐	☐
4. **Pregnancy test results** **1**=Pregnant **0**=Not pregnant **X**=Did not test	☐	☐	☐	☐	☐	☐	☐
5. **Multivitamin taken** **0**=No **1**=Yes, over-the-	☐	☐	☐	☐	☐	☐	☐

counter multivitamin **2**=Yes, prescription multivitamin							
6. **Number of aspirin (or other pain relievers taken)** Please fill in number; **0**=None	☐	☐	☐	☐	☐	☐	☐
7. **Overall stress level** **1**=Almost no stress **2**=Relatively little **3**=A moderate amount **4**=A lot of stress	☐	☐	☐	☐	☐	☐	☐
8. **Number of cigarettes smoked** Please fill in number; **0**=None	☐	☐	☐	☐	☐	☐	☐
9. **Number of alcoholic drinks consumed** Please fill in number; **0**=None	☐	☐	☐	☐	☐	☐	☐
10. **Number of caffeinated drinks consumed** Please fill in number; **0**=None	☐	☐	☐	☐	☐	☐	☐
11. **Number of 4oz. servings of fish or shellfish eaten** Please fill in number; **0**=None	☐	☐	☐	☐	☐	☐	☐
12. **Took a hot bath, whirlpool, or sauna** **0**=No **1**=Yes	☐	☐	☐	☐	☐	☐	☐

☐ This week, did you START taking any prescription medication? ☐ 0-No ☐ 1-Yes

☐ If yes, please list medication(s) STARTED:

☐ This week, did you STOP taking any prescription medication? ☐ 0-No ☐ 1-Yes

☐ If yes, please list medication(s) STOPPED:

Comments:

☐

Note: Please consult your health care provider before taking any over-the-counter or prescription medications during pregnancy.