OMB control number: 0925-0593
Expiration Date: 07/31/2013

Pregnancy Health Care Log

BRING THIS LOG TO ALL HEALTH CARE VISITS.
USE THIS LOG FOR ALL TELEPHONE CALLS OR VISITS.
Save all bottles and containers of medications including:

- Medications (those prescribed by a health care provider and those bought over-the-counter)
- Vitamins, minerals, herbs, and any other supplements

Last name: _____ First name: _____

This Pregnancy Health Care Log will help you keep track of all your visits to doctors or other health care providers (such as your obstetrician (OB-GYN), family doctor, nurse, midwife, or other type of provider) during your pregnancy. We will ask you about all of your visits whenever we interview you by telephone or in person.

The log has two parts:

1. **Health Care Provider Log** is to record information about where you visit your doctor or other health care provider.

2. **Health Care Visits and Overnight Hospital Stays Log** is to record information about all your visits to doctors, other health care providers, or an emergency room. This includes overnight hospital stays as well as outpatient visits. **Use one page for each visit or hospital stay.**

BRING this Pregnancy Health Care Log with you to all health care and National Children's Study visits. Also, have it available for all National Children's Study telephone interviews.

If you forget to bring it with you to a health care visit, please fill it in as soon as possible.

Health Care Provider Log Instructions

The Health Care Provider is the person who cared for you at this visit (doctor, midwife, nurse, etc.)

Column 1	A number is listed for each health care provider (for example, 1,2,3,4, etc). This number will be referred to on the Health Care Visits and Overnight Hospital Stays log page.
Column 2	Attach the health care provider's business card here.
Fill in columns 3–10 only if you have <u>not</u> attached the health care provider's business card.	
Column 3	Write in the name of the health care provider.
Column 4	Check the box for the type of provider. If it was "Another Type of Provider," write in the type of health care provider.
Column 5	Check the box for the type of place where you saw the provider. If it was "Some other place," write in the type of place where you visited the health care provider.
Columns 6–9	Write in the address of the place including city/town, state, and ZIP Code.
Column 10	Write in the telephone number of the health care provider

See sample log on next page.

After you fill out the Health Care Provider Log, please fill out the Health Care Visits and Overnight Hospital Stays Log.

Health Care Provider Log

		Fill in ONLY if you HAVE NOT attached a business card							
1	2	3	4	5	6	7	8	9	10
Health Care Provider Number	**Attach Health Care Provider Business Card**	**Name of Health Care Provider**	**Type of Health Care Provider**	**Type of Place**	**Street Number and Name**	**City or Town**	**State**	**ZIP Code**	**Telephone Number**
0 *(Sample)*		Dr. Robert Jones	☒ Obstetrician/ Gynecologist (OB/GYN) ☐ Family Physician ☐ Nurse ☐ Midwife ☐ Another Type of Provider (specify) _____	☒ Doctor's office, clinic, or health center ☐ Emergency room ☐ Urgent care center ☐ Hospital for hospitalization ☐ Some other place (specify): _____	400 Main Street	Capitol City	MN	56087	937-889-9275
1			☐ Obstetrician/ Gynecologist (OB/GYN) ☐ Family Physician ☐ Nurse ☐ Midwife ☐ Another Type of Provider (specify) _____	☐ Doctor's office, clinic, or health center ☐ Emergency room ☐ Urgent care center ☐ Hospital for hospitalization ☐ Some other place (specify): _____					
2			☐ Obstetrician/ Gynecologist (OB/GYN) ☐ Family Physician ☐ Nurse ☐ Midwife ☐ Another Type of Provider (specify) _____	☐ Doctor's office, clinic, or health center ☐ Emergency room ☐ Urgent care center ☐ Hospital for hospitalization ☐ Some other place (specify): _____					
3			☐ Obstetrician/ Gynecologist (OB/GYN) ☐ Family Physician ☐ Nurse ☐ Midwife ☐ Another Type of Provider (specify) _____	☐ Doctor's office, clinic, or health center ☐ Emergency room ☐ Urgent care center ☐ Hospital for hospitalization ☐ Some other place (specify): _____					

Bring this log to all health care visits. Use this log for all National Children's Study telephone calls and visits. Save all bottles and containers of medications and bring to National Children's Study visits and have available for telephone calls:

- Medicines (those prescribed by a health care provider and those bought "over-the-counter")
- Vitamins, minerals, herbs, and any other supplements

Please remember to fill out the Health Care Visits and Overnight Hospital Stays Log.

THE NATIONAL CHILDREN'S STUDY

Health Care Provider Log

		Fill in ONLY if you HAVE NOT attached a business card							
1	2	3	4	5	6	7	8	9	10
Health Care Provider Number	**Attach Health Care Provider Business Card**	**Name of Health Care Provider**	**Type of Health Care Provider**	**Type of Place**	**Street Number and Name**	**City or Town**	**State**	**ZIP Code**	**Telephone Number**
4			☐ Obstetrician/ Gynecologist (OB/GYN) ☐ Family Physician ☐ Nurse ☐ Midwife ☐ Another Type of Provider (specify) _____	☐ Doctor's office, clinic, or health center ☐ Emergency room ☐ Urgent care center ☐ Hospital for hospitalization ☐ Some other place (specify): _____					
5			☐ Obstetrician/ Gynecologist (OB/GYN) ☐ Family Physician ☐ Nurse ☐ Midwife ☐ Another Type of Provider (specify) _____	☐ Doctor's office, clinic, or health center ☐ Emergency room ☐ Urgent care center ☐ Hospital for hospitalization ☐ Some other place (specify): _____					
6			☐ Obstetrician/ Gynecologist (OB/GYN) ☐ Family Physician ☐ Nurse ☐ Midwife ☐ Another Type of Provider (specify) _____	☐ Doctor's office, clinic, or health center ☐ Emergency room ☐ Urgent care center ☐ Hospital for hospitalization ☐ Some other place (specify): _____					
7			☐ Obstetrician/ Gynecologist (OB/GYN) ☐ Family Physician ☐ Nurse ☐ Midwife ☐ Another Type of Provider (specify) _____	☐ Doctor's office, clinic, or health center ☐ Emergency room ☐ Urgent care center ☐ Hospital for hospitalization ☐ Some other place (specify): _____					

Bring this log to all health care visits. Use this log for all National Children's Study telephone calls and visits. Save all bottles and containers of medications and bring to National Children's Study visits and have available for telephone calls:

- Medicines (those prescribed by a health care provider and those bought "over-the-counter")
- Vitamins, minerals, herbs, and any other supplements

Please remember to fill out the Health Care Visits and Overnight Hospital Stays Log.

THE NATIONAL CHILDREN'S STUDY

Health Care Provider Log

		Fill in ONLY if you HAVE NOT attached a business card							
1	2	3	4	5	6	7	8	9	10
Health Care Provider Number	**Attach Health Care Provider Business Card**	**Name of Health Care Provider**	**Type of Health Care Provider**	**Type of Place**	**Street Number and Name**	**City or Town**	**State**	**ZIP Code**	**Telephone Number**
8			☐ Obstetrician/ Gynecologist (OB/GYN) ☐ Family Physician ☐ Nurse ☐ Midwife ☐ Another Type of Provider (specify) _____	☐ Doctor's office, clinic, or health center ☐ Emergency room ☐ Urgent care center ☐ Hospital for hospitalization ☐ Some other place (specify): _____					
9			☐ Obstetrician/ Gynecologist (OB/GYN) ☐ Family Physician ☐ Nurse ☐ Midwife ☐ Another Type of Provider (specify) _____	☐ Doctor's office, clinic, or health center ☐ Emergency room ☐ Urgent care center ☐ Hospital for hospitalization ☐ Some other place (specify): _____					
10			☐ Obstetrician/ Gynecologist (OB/GYN) ☐ Family Physician ☐ Nurse ☐ Midwife ☐ Another Type of Provider (specify) _____	☐ Doctor's office, clinic, or health center ☐ Emergency room ☐ Urgent care center ☐ Hospital for hospitalization ☐ Some other place (specify): _____					
11			☐ Obstetrician/ Gynecologist (OB/GYN) ☐ Family Physician ☐ Nurse ☐ Midwife ☐ Another Type of Provider (specify) _____	☐ Doctor's office, clinic, or health center ☐ Emergency room ☐ Urgent care center ☐ Hospital for hospitalization ☐ Some other place (specify): _____					

Bring this log to all health care visits. Use this log for all National Children's Study telephone calls and visits. Save all bottles and containers of medications and bring to National Children's Study visits and have available for telephone calls:

- Medicines (those prescribed by a health care provider and those bought "over-the-counter")
- Vitamins, minerals, herbs, and any other supplements

Please remember to fill out the Health Care Visits and Overnight Hospital Stays Log.

THE NATIONAL CHILDREN'S STUDY

Health Care Visits and Overnight Hospital Stays Log Instructions:

Each time you go to the doctor or any other health care provider (for example, midwife or nurse practitioner) or are hospitalized overnight, write the information about the visit on a new page in the "Health Care Visits and Overnight Hospital Stays" log.

At the top of the page, write the visit date and also copy the provider number and provider name from the Health Care Provider Log.

Column 1	Check the box for the reason for the visit. If you were hospitalized, include the number of nights you stayed at the hospital. If the reason is not listed, check "Some other reason" and write in the reason for the visit.
Column 2	Weight
Column 3	Blood pressure
Column 4	If you received any pregnancy care related procedures, check the box(es) for those procedures. If the procedure is not listed, check the box "Other tests to check on the health of your baby" and write in a description.
Column 5	Enter information about any vaccinations ("shots") you received.
Column 6	List any other tests or procedures (such as a glucose tolerance test, etc.).
Column 7	If you received any treatments or were told to take any medications (over-the-counter or prescription medications), write them here.
Column 8	If you were told that you had a medical condition or diagnosis at this visit (for example, high blood pressure, diabetes, infection), write the diagnosis here.
Column 9	Check the box showing whether you or the office staff completed the log. After you report the visit to the National Children's Study staff, write in the date reported.

Visit Date: 03 (Month) / 18 (Day) / 2010 (Year)

Provider Number from Health Care Provider Log: 0

Name of Provider Seen: Dr. Robert Jones

Be sure to also write this provider's contact information in the HEALTH CARE PROVIDER LOG.

Health Care Visits and Overnight Hospital Stays

Sample Log

1	2	3	4	5	6	7	8	9
Reason for visit	**Weight**	**Blood Pressure**	**Pregnancy Care Procedures (Tests to check on your baby's health)**	**Vaccination / Shot / Immunization**	**Other Tests and Procedures (Tests to check on YOUR health) For example, lab tests (blood, urine, etc.)**	**Medications/ Other Treatments (For example, over-the-counter or prescribed medications)**	**Diagnoses**	**Completed by Office or Self** **Date Reported to National Children's Study**
☒ Routine Pregnancy Care ☐ Illness or Injury ☐ **Overnight hospital stay (Hospitalized)** How many nights? _____ ☐ Some other reason (explain):	155 lb ☐ Not done/ Don't know	120 / 80 ☐ Not done/ Don't know	**(Check all that apply)** ☒ Ultrasound or Sonogram ☐ Chorionic Villus Sampling (CVS) ☐ Amniocentesis ☒ Other tests to check on the health of your baby (describe below): Triple Screen Test	☒ No ☐ Yes (Specify type below. Check all that apply). ☐ Influenza ☐ Hepatitis B ☐ Hepatitis A ☐ Tetanus / Diphtheria (Td) ☐ Tetanus / Diphtheria Pertussis (Tdap) ☐ Meningococcal ☐ Pneumococcal ☐ Other: _____	Urine Test Glucose tolerance test Blood test Ankle x-ray	Tylenol Amoxicillin Folic Acid Rhogam Injection Physical therapy	Protein in Urine Urinary tract infection Sprained ankle	☐ Office ☒ Self Date: 4/1/10

Bring this log to all health care visits. Use this log for all National Children's Study telephone calls and visits. Save all bottles and containers of medications and bring to National Children's Study visits and have available for telephone calls:

- Medications (those prescribed by a health care provider and those bought "over-the-counter")
- Vitamins, minerals, herbs, and any other supplements

THE NATIONAL CHILDREN'S STUDY

Visit Date: __ __ / __ __ / __ __ __ __
Month *Day* *Year*

Provider Number from Health Care Provider Log: _____

Name of Provider Seen: _____

Be sure to also write this provider's contact information in the HEALTH CARE PROVIDER LOG.

Health Care Visits and Overnight Hospital Stays Log

Health Care Visit/Hospital Stay 1

1	2	3	4	5	6	7	8	9
Reason for visit	**Weight**	**Blood Pressure**	**Pregnancy Care Procedures (Tests to check on your baby's health)**	**Vaccination / Shot / Immunization**	**Other Tests and Procedures (Tests to check on YOUR health) For example, lab tests (blood, urine, etc.)**	**Medications/Other Treatments (For example, over-the-counter or prescribed medications)**	**Diagnoses**	**Completed by Office or Self** **Date Reported to National Children's Study**
☐ Routine Pregnancy Care ☐ Illness or Injury ☐ **Overnight hospital stay (Hospitalized)** How many nights? _____ ☐ Some other reason (explain): _____ _____ _____ _____ _____ _____ _____ _____	_____ *lb* ☐ Not done/ Don't know	__ __ __ /__ __ __ ☐ Not done/ Don't know	**(Check all that apply)** ☐ Ultrasound or Sonogram ☐ Chorionic Villus Sampling (CVS) ☐ Amniocentesis ☐ Other tests to check on the health of your baby (describe below): _____ _____ _____ _____ _____ _____ _____	☐ No ☐ Yes (Specify type below. Check all that apply). ☐ Influenza ☐ Hepatitis B ☐ Hepatitis A ☐ Tetanus / Diphtheria (Td) ☐ Tetanus / Diphtheria Pertussis (Tdap) ☐ Meningococcal ☐ Pneumococcal ☐ Other: _____				☐ Office ☐ Self Date: _____

Bring this log to all health care visits. Use this log for all National Children's Study telephone calls and visits. Save all bottles and containers of medications and bring to National Children's Study visits and have available for telephone calls:

- Medications (those prescribed by a health care provider and those bought "over-the-counter")
- Vitamins, minerals, herbs, and any other supplements

THE NATIONAL CHILDREN'S STUDY

Visit Date: __ __ / __ __ / __ __ __ __
Month *Day* *Year*

Provider Number from Health Care Provider Log: _____

Name of Provider Seen: _____

Be sure to also write this provider's contact information in the HEALTH CARE PROVIDER LOG.

Health Care Visits and Overnight Hospital Stays Log

Health Care Visit/Hospital Stay 2

1	2	3	4	5	6	7	8	9
Reason for visit	**Weight**	**Blood Pressure**	**Pregnancy Care Procedures (Tests to check on your baby's health)**	**Vaccination / Shot / Immunization**	**Other Tests and Procedures (Tests to check on YOUR health) For example, lab tests (blood, urine, etc.)**	**Medications/Other Treatments (For example, over-the-counter or prescribed medications)**	**Diagnoses**	**Completed by Office or Self** **Date Reported to National Children's Study**
☐ Routine Pregnancy Care ☐ Illness or Injury ☐ **Overnight hospital stay (Hospitalized)** How many nights? _____ ☐ Some other reason (explain): _____ _____ _____ _____ _____ _____ _____ _____	_____ *lb* ☐ Not done/ Don't know	__ __ __ / __ __ __ ☐ Not done/ Don't know	**(Check all that apply)** ☐ Ultrasound or Sonogram ☐ Chorionic Villus Sampling (CVS) ☐ Amniocentesis ☐ Other tests to check on the health of your baby (describe below): _____ _____ _____ _____ _____ _____ _____	☐ No ☐ Yes (Specify type below. Check all that apply). ☐ Influenza ☐ Hepatitis B ☐ Hepatitis A ☐ Tetanus / Diphtheria (Td) ☐ Tetanus / Diphtheria Pertussis (Tdap) ☐ Meningococcal ☐ Pneumococcal ☐ Other: _____				☐ Office ☐ Self Date: _____

Bring this log to all health care visits. Use this log for all National Children's Study telephone calls and visits. Save all bottles and containers of medications and bring to National Children's Study visits and have available for telephone calls:

- Medications (those prescribed by a health care provider and those bought "over-the-counter")
- Vitamins, minerals, herbs, and any other supplements

THE NATIONAL CHILDREN'S STUDY

Visit Date: __ __ / __ __ / __ __ __ __
Month *Day* *Year*

Provider Number from Health Care Provider Log: _____

Name of Provider Seen: _____

Be sure to also write this provider's contact information in the HEALTH CARE PROVIDER LOG.

Health Care Visits and Overnight Hospital Stays Log

Health Care Visit/Hospital Stay 3

1	2	3	4	5	6	7	8	9
Reason for visit	**Weight**	**Blood Pressure**	**Pregnancy Care Procedures (Tests to check on your baby's health)**	**Vaccination / Shot / Immunization**	**Other Tests and Procedures (Tests to check on YOUR health) For example, lab tests (blood, urine, etc.)**	**Medications/Other Treatments (For example, over-the-counter or prescribed medications)**	**Diagnoses**	**Completed by Office or Self** **Date Reported to National Children's Study**
☐ Routine Pregnancy Care ☐ Illness or Injury ☐ **Overnight hospital stay (Hospitalized)** How many nights? _____ ☐ Some other reason (explain): _____ _____ _____ _____ _____ _____ _____ _____	_____ *lb* ☐ Not done/ Don't know	__ __ __ /__ __ __ ☐ Not done/ Don't know	**(Check all that apply)** ☐ Ultrasound or Sonogram ☐ Chorionic Villus Sampling (CVS) ☐ Amniocentesis ☐ Other tests to check on the health of your baby (describe below): _____ _____ _____ _____ _____ _____ _____	☐ No ☐ Yes (Specify type below. Check all that apply). ☐ Influenza ☐ Hepatitis B ☐ Hepatitis A ☐ Tetanus / Diphtheria (Td) ☐ Tetanus / Diphtheria Pertussis (Tdap) ☐ Meningococcal ☐ Pneumococcal ☐ Other: _____				☐ Office ☐ Self Date: _____

Bring this log to all health care visits. Use this log for all National Children's Study telephone calls and visits. Save all bottles and containers of medications and bring to National Children's Study visits and have available for telephone calls:

- Medications (those prescribed by a health care provider and those bought "over-the-counter")
- Vitamins, minerals, herbs, and any other supplements

THE NATIONAL CHILDREN'S STUDY

Visit Date: __ __ / __ __ / __ __ __ __
Month *Day* *Year*

Provider Number from Health Care Provider Log: _____

Name of Provider Seen: _____

Be sure to also write this provider's contact information in the HEALTH CARE PROVIDER LOG.

Health Care Visits and Overnight Hospital Stays Log

Health Care Visit/Hospital Stay 4

1	2	3	4	5	6	7	8	9
Reason for visit	**Weight**	**Blood Pressure**	**Pregnancy Care Procedures (Tests to check on your baby's health)**	**Vaccination / Shot / Immunization**	**Other Tests and Procedures (Tests to check on YOUR health) For example, lab tests (blood, urine, etc.)**	**Medications/Other Treatments (For example, over-the-counter or prescribed medications)**	**Diagnoses**	**Completed by Office or Self** **Date Reported to National Children's Study**
☐ Routine Pregnancy Care ☐ Illness or Injury ☐ **Overnight hospital stay (Hospitalized)** How many nights? _____ ☐ Some other reason (explain): _____ _____ _____ _____ _____ _____ _____ _____	_____ *lb* ☐ Not done/ Don't know	__ __ __ /__ __ __ ☐ Not done/ Don't know	**(Check all that apply)** ☐ Ultrasound or Sonogram ☐ Chorionic Villus Sampling (CVS) ☐ Amniocentesis ☐ Other tests to check on the health of your baby (describe below): _____ _____ _____ _____ _____ _____ _____	☐ No ☐ Yes (Specify type below. Check all that apply). ☐ Influenza ☐ Hepatitis B ☐ Hepatitis A ☐ Tetanus / Diphtheria (Td) ☐ Tetanus / Diphtheria Pertussis (Tdap) ☐ Meningococcal ☐ Pneumococcal ☐ Other: _____				☐ Office ☐ Self Date: _____

Bring this log to all health care visits. Use this log for all National Children's Study telephone calls and visits. Save all bottles and containers of medications and bring to National Children's Study visits and have available for telephone calls:

- Medications (those prescribed by a health care provider and those bought "over-the-counter")
- Vitamins, minerals, herbs, and any other supplements

THE NATIONAL CHILDREN'S STUDY

Visit Date: __ __ / __ __ / __ __ __ __
Month *Day* *Year*

Provider Number from Health Care Provider Log: _____

Name of Provider Seen: _____

Be sure to also write this provider's contact information in the HEALTH CARE PROVIDER LOG.

Health Care Visits and Overnight Hospital Stays Log

Health Care Visit/Hospital Stay 5

1	2	3	4	5	6	7	8	9
Reason for visit	**Weight**	**Blood Pressure**	**Pregnancy Care Procedures (Tests to check on your baby's health)**	**Vaccination / Shot / Immunization**	**Other Tests and Procedures (Tests to check on YOUR health) For example, lab tests (blood, urine, etc.)**	**Medications/Other Treatments (For example, over-the-counter or prescribed medications)**	**Diagnoses**	**Completed by Office or Self** **Date Reported to National Children's Study**
☐ Routine Pregnancy Care ☐ Illness or Injury ☐ **Overnight hospital stay (Hospitalized)** How many nights? _____ ☐ Some other reason (explain): _____ _____ _____ _____ _____ _____ _____ _____	_____ *lb* ☐ Not done/ Don't know	__ __ __ /__ __ __ ☐ Not done/ Don't know	**(Check all that apply)** ☐ Ultrasound or Sonogram ☐ Chorionic Villus Sampling (CVS) ☐ Amniocentesis ☐ Other tests to check on the health of your baby (describe below): _____ _____ _____ _____ _____ _____ _____	☐ No ☐ Yes (Specify type below. Check all that apply). ☐ Influenza ☐ Hepatitis B ☐ Hepatitis A ☐ Tetanus / Diphtheria (Td) ☐ Tetanus / Diphtheria Pertussis (Tdap) ☐ Meningococcal ☐ Pneumococcal ☐ Other: _____				☐ Office ☐ Self Date: _____

Bring this log to all health care visits. Use this log for all National Children's Study telephone calls and visits. Save all bottles and containers of medications and bring to National Children's Study visits and have available for telephone calls:

- Medications (those prescribed by a health care provider and those bought "over-the-counter")
- Vitamins, minerals, herbs, and any other supplements

THE NATIONAL CHILDREN'S STUDY

Visit Date: __ __ / __ __ / __ __ __ __
Month Day Year

Provider Number from Health Care Provider Log: _____

Name of Provider Seen: _____

Be sure to also write this provider's contact information in the HEALTH CARE PROVIDER LOG.

Health Care Visits and Overnight Hospital Stays Log

Health Care Visit/Hospital Stay 6

1	2	3	4	5	6	7	8	9
Reason for visit	**Weight**	**Blood Pressure**	**Pregnancy Care Procedures (Tests to check on your baby's health)**	**Vaccination / Shot / Immunization**	**Other Tests and Procedures (Tests to check on YOUR health) For example, lab tests (blood, urine, etc.)**	**Medications/Other Treatments (For example, over-the-counter or prescribed medications)**	**Diagnoses**	**Completed by Office or Self** **Date Reported to National Children's Study**
☐ Routine Pregnancy Care ☐ Illness or Injury ☐ **Overnight hospital stay (Hospitalized)** How many nights? _____ ☐ Some other reason (explain): _____ _____ _____ _____ _____ _____ _____ _____	_____ lb ☐ Not done/ Don't know	__ __ __ /__ __ __ ☐ Not done/ Don't know	**(Check all that apply)** ☐ Ultrasound or Sonogram ☐ Chorionic Villus Sampling (CVS) ☐ Amniocentesis ☐ Other tests to check on the health of your baby (describe below): _____ _____ _____ _____ _____ _____ _____	☐ No ☐ Yes (Specify type below. Check all that apply). ☐ Influenza ☐ Hepatitis B ☐ Hepatitis A ☐ Tetanus / Diphtheria (Td) ☐ Tetanus / Diphtheria Pertussis (Tdap) ☐ Meningococcal ☐ Pneumococcal ☐ Other: _____				☐ Office ☐ Self Date: _____

Bring this log to all health care visits. Use this log for all National Children's Study telephone calls and visits. Save all bottles and containers of medications and bring to National Children's Study visits and have available for telephone calls:

- Medications (those prescribed by a health care provider and those bought "over-the-counter")
- Vitamins, minerals, herbs, and any other supplements

THE NATIONAL CHILDREN'S STUDY

Visit Date: __ __ / __ __ / __ __ __ __
Month *Day* *Year*

Provider Number from Health Care Provider Log: _____

Name of Provider Seen: _____

Be sure to also write this provider's contact information in the HEALTH CARE PROVIDER LOG.

Health Care Visits and Overnight Hospital Stays Log

Health Care Visit/Hospital Stay 7

1	2	3	4	5	6	7	8	9
Reason for visit	**Weight**	**Blood Pressure**	**Pregnancy Care Procedures (Tests to check on your baby's health)**	**Vaccination / Shot / Immunization**	**Other Tests and Procedures (Tests to check on YOUR health) For example, lab tests (blood, urine, etc.)**	**Medications/Other Treatments (For example, over-the-counter or prescribed medications)**	**Diagnoses**	**Completed by Office or Self** **Date Reported to National Children's Study**
☐ Routine Pregnancy Care ☐ Illness or Injury ☐ **Overnight hospital stay (Hospitalized)** How many nights? _____ ☐ Some other reason (explain): _____ _____ _____ _____ _____ _____ _____ _____	_____ *lb* ☐ Not done/ Don't know	__ __ __ /__ __ __ ☐ Not done/ Don't know	**(Check all that apply)** ☐ Ultrasound or Sonogram ☐ Chorionic Villus Sampling (CVS) ☐ Amniocentesis ☐ Other tests to check on the health of your baby (describe below): _____ _____ _____ _____ _____ _____ _____	☐ No ☐ Yes (Specify type below. Check all that apply). ☐ Influenza ☐ Hepatitis B ☐ Hepatitis A ☐ Tetanus / Diphtheria (Td) ☐ Tetanus / Diphtheria Pertussis (Tdap) ☐ Meningococcal ☐ Pneumococcal ☐ Other: _____				☐ Office ☐ Self Date: _____

Bring this log to all health care visits. Use this log for all National Children's Study telephone calls and visits. Save all bottles and containers of medications and bring to National Children's Study visits and have available for telephone calls:

- Medications (those prescribed by a health care provider and those bought "over-the-counter")
- Vitamins, minerals, herbs, and any other supplements

THE NATIONAL CHILDREN'S STUDY

Visit Date: __ __ / __ __ / __ __ __ __
Month Day Year

Provider Number from Health Care Provider Log: _____

Name of Provider Seen: _____

Be sure to also write this provider's contact information in the HEALTH CARE PROVIDER LOG.

Health Care Visits and Overnight Hospital Stays Log

Health Care Visit/Hospital Stay 8

1	2	3	4	5	6	7	8	9
Reason for visit	**Weight**	**Blood Pressure**	**Pregnancy Care Procedures (Tests to check on your baby's health)**	**Vaccination / Shot / Immunization**	**Other Tests and Procedures (Tests to check on YOUR health) For example, lab tests (blood, urine, etc.)**	**Medications/Other Treatments (For example, over-the-counter or prescribed medications)**	**Diagnoses**	**Completed by Office or Self** **Date Reported to National Children's Study**
☐ Routine Pregnancy Care ☐ Illness or Injury ☐ **Overnight hospital stay (Hospitalized)** How many nights? _____ ☐ Some other reason (explain): _____ _____ _____ _____ _____ _____ _____ _____	_____ lb ☐ Not done/ Don't know	__ __ __ /__ __ __ ☐ Not done/ Don't know	**(Check all that apply)** ☐ Ultrasound or Sonogram ☐ Chorionic Villus Sampling (CVS) ☐ Amniocentesis ☐ Other tests to check on the health of your baby (describe below): _____ _____ _____ _____ _____ _____ _____	☐ No ☐ Yes (Specify type below. Check all that apply). ☐ Influenza ☐ Hepatitis B ☐ Hepatitis A ☐ Tetanus / Diphtheria (Td) ☐ Tetanus / Diphtheria Pertussis (Tdap) ☐ Meningococcal ☐ Pneumococcal ☐ Other: _____				☐ Office ☐ Self Date: _____

Bring this log to all health care visits. Use this log for all National Children's Study telephone calls and visits. Save all bottles and containers of medications and bring to National Children's Study visits and have available for telephone calls:

- Medications (those prescribed by a health care provider and those bought "over-the-counter")
- Vitamins, minerals, herbs, and any other supplements

THE NATIONAL CHILDREN'S STUDY

Visit Date: __ __ / __ __ / __ __ __ __
Month *Day* *Year*

Provider Number from Health Care Provider Log: _____

Name of Provider Seen: _____

Be sure to also write this provider's contact information in the HEALTH CARE PROVIDER LOG.

Health Care Visits and Overnight Hospital Stays Log

Health Care Visit/Hospital Stay 9

1	2	3	4	5	6	7	8	9
Reason for visit	**Weight**	**Blood Pressure**	**Pregnancy Care Procedures (Tests to check on your baby's health)**	**Vaccination / Shot / Immunization**	**Other Tests and Procedures (Tests to check on YOUR health) For example, lab tests (blood, urine, etc.)**	**Medications/Other Treatments (For example, over-the-counter or prescribed medications)**	**Diagnoses**	**Completed by Office or Self** **Date Reported to National Children's Study**
☐ Routine Pregnancy Care ☐ Illness or Injury ☐ **Overnight hospital stay (Hospitalized)** How many nights? _____ ☐ Some other reason (explain): _____ _____ _____ _____ _____ _____ _____ _____	_____ *lb* ☐ Not done/ Don't know	__ __ __ /__ __ __ ☐ Not done/ Don't know	**(Check all that apply)** ☐ Ultrasound or Sonogram ☐ Chorionic Villus Sampling (CVS) ☐ Amniocentesis ☐ Other tests to check on the health of your baby (describe below): _____ _____ _____ _____ _____ _____ _____	☐ No ☐ Yes (Specify type below. Check all that apply). ☐ Influenza ☐ Hepatitis B ☐ Hepatitis A ☐ Tetanus / Diphtheria (Td) ☐ Tetanus / Diphtheria Pertussis (Tdap) ☐ Meningococcal ☐ Pneumococcal ☐ Other: _____				☐ Office ☐ Self Date: _____

Bring this log to all health care visits. Use this log for all National Children's Study telephone calls and visits. Save all bottles and containers of medications and bring to National Children's Study visits and have available for telephone calls:

- Medications (those prescribed by a health care provider and those bought "over-the-counter")
- Vitamins, minerals, herbs, and any other supplements

THE NATIONAL CHILDREN'S STUDY

Visit Date: __ __ / __ __ / __ __ __ __
Month *Day* *Year*

Provider Number from Health Care Provider Log: _____

Name of Provider Seen: _____

Be sure to also write this provider's contact information in the HEALTH CARE PROVIDER LOG.

Health Care Visits and Overnight Hospital Stays Log

Health Care Visit/Hospital Stay 10

1	2	3	4	5	6	7	8	9
Reason for visit	**Weight**	**Blood Pressure**	**Pregnancy Care Procedures (Tests to check on your baby's health)**	**Vaccination / Shot / Immunization**	**Other Tests and Procedures (Tests to check on YOUR health) For example, lab tests (blood, urine, etc.)**	**Medications/Other Treatments (For example, over-the-counter or prescribed medications)**	**Diagnoses**	**Completed by Office or Self** **Date Reported to National Children's Study**
☐ Routine Pregnancy Care ☐ Illness or Injury ☐ **Overnight hospital stay (Hospitalized)** How many nights? _____ ☐ Some other reason (explain): _____ _____ _____ _____ _____ _____ _____ _____	_____ *lb* ☐ Not done/ Don't know	__ __ __ /__ __ __ ☐ Not done/ Don't know	**(Check all that apply)** ☐ Ultrasound or Sonogram ☐ Chorionic Villus Sampling (CVS) ☐ Amniocentesis ☐ Other tests to check on the health of your baby (describe below): _____ _____ _____ _____ _____ _____ _____	☐ No ☐ Yes (Specify type below. Check all that apply). ☐ Influenza ☐ Hepatitis B ☐ Hepatitis A ☐ Tetanus / Diphtheria (Td) ☐ Tetanus / Diphtheria Pertussis (Tdap) ☐ Meningococcal ☐ Pneumococcal ☐ Other: _____				☐ Office ☐ Self Date: _____

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- Vitamins, minerals, herbs, and any other supplements

THE NATIONAL CHILDREN'S STUDY

Visit Date: __ __ / __ __ / __ __ __ __
Month *Day* *Year*

Provider Number from Health Care Provider Log: _____

Name of Provider Seen: _____

Be sure to also write this provider's contact information in the HEALTH CARE PROVIDER LOG.

Health Care Visits and Overnight Hospital Stays Log

Health Care Visit/Hospital Stay 11

1	2	3	4	5	6	7	8	9
Reason for visit	**Weight**	**Blood Pressure**	**Pregnancy Care Procedures (Tests to check on your baby's health)**	**Vaccination / Shot / Immunization**	**Other Tests and Procedures (Tests to check on YOUR health) For example, lab tests (blood, urine, etc.)**	**Medications/Other Treatments (For example, over-the-counter or prescribed medications)**	**Diagnoses**	**Completed by Office or Self** **Date Reported to National Children's Study**
☐ Routine Pregnancy Care ☐ Illness or Injury ☐ **Overnight hospital stay (Hospitalized)** How many nights? _____ ☐ Some other reason (explain): _____ _____ _____ _____ _____ _____ _____ _____	_____ *lb* ☐ Not done/ Don't know	__ __ __ /__ __ __ ☐ Not done/ Don't know	**(Check all that apply)** ☐ Ultrasound or Sonogram ☐ Chorionic Villus Sampling (CVS) ☐ Amniocentesis ☐ Other tests to check on the health of your baby (describe below): _____ _____ _____ _____ _____ _____ _____	☐ No ☐ Yes (Specify type below. Check all that apply). ☐ Influenza ☐ Hepatitis B ☐ Hepatitis A ☐ Tetanus / Diphtheria (Td) ☐ Tetanus / Diphtheria Pertussis (Tdap) ☐ Meningococcal ☐ Pneumococcal ☐ Other: _____				☐ Office ☐ Self Date: _____

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- Vitamins, minerals, herbs, and any other supplements

THE NATIONAL CHILDREN'S STUDY

Visit Date: __ __ / __ __ / __ __ __ __
Month *Day* *Year*

Provider Number from Health Care Provider Log: _____

Name of Provider Seen: _____

Be sure to also write this provider's contact information in the HEALTH CARE PROVIDER LOG.

Health Care Visits and Overnight Hospital Stays Log

Health Care Visit/Hospital Stay 12

1	2	3	4	5	6	7	8	9
Reason for visit	**Weight**	**Blood Pressure**	**Pregnancy Care Procedures (Tests to check on your baby's health)**	**Vaccination / Shot / Immunization**	**Other Tests and Procedures (Tests to check on YOUR health) For example, lab tests (blood, urine, etc.)**	**Medications/Other Treatments (For example, over-the-counter or prescribed medications)**	**Diagnoses**	**Completed by Office or Self** **Date Reported to National Children's Study**
☐ Routine Pregnancy Care ☐ Illness or Injury ☐ **Overnight hospital stay (Hospitalized)** How many nights? _____ ☐ Some other reason (explain): _____ _____ _____ _____ _____ _____ _____ _____	_____ *lb* ☐ Not done/ Don't know	__ __ __ /__ __ __ ☐ Not done/ Don't know	**(Check all that apply)** ☐ Ultrasound or Sonogram ☐ Chorionic Villus Sampling (CVS) ☐ Amniocentesis ☐ Other tests to check on the health of your baby (describe below): _____ _____ _____ _____ _____ _____ _____	☐ No ☐ Yes (Specify type below. Check all that apply). ☐ Influenza ☐ Hepatitis B ☐ Hepatitis A ☐ Tetanus / Diphtheria (Td) ☐ Tetanus / Diphtheria Pertussis (Tdap) ☐ Meningococcal ☐ Pneumococcal ☐ Other: _____				☐ Office ☐ Self Date: _____

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- Vitamins, minerals, herbs, and any other supplements

THE NATIONAL CHILDREN'S STUDY

Visit Date: __ __ / __ __ / __ __ __ __
Month *Day* *Year*

Provider Number from Health Care Provider Log: _____

Name of Provider Seen: _____

Be sure to also write this provider's contact information in the HEALTH CARE PROVIDER LOG.

Health Care Visits and Overnight Hospital Stays Log

Health Care Visit/Hospital Stay 13

1	2	3	4	5	6	7	8	9
Reason for visit	**Weight**	**Blood Pressure**	**Pregnancy Care Procedures (Tests to check on your baby's health)**	**Vaccination / Shot / Immunization**	**Other Tests and Procedures (Tests to check on YOUR health) For example, lab tests (blood, urine, etc.)**	**Medications/Other Treatments (For example, over-the-counter or prescribed medications)**	**Diagnoses**	**Completed by Office or Self** **Date Reported to National Children's Study**
☐ Routine Pregnancy Care ☐ Illness or Injury ☐ **Overnight hospital stay (Hospitalized)** How many nights? _____ ☐ Some other reason (explain): _____ _____ _____ _____ _____ _____ _____ _____	_____ *lb* ☐ Not done/ Don't know	__ __ __ /__ __ __ ☐ Not done/ Don't know	**(Check all that apply)** ☐ Ultrasound or Sonogram ☐ Chorionic Villus Sampling (CVS) ☐ Amniocentesis ☐ Other tests to check on the health of your baby (describe below): _____ _____ _____ _____ _____ _____ _____	☐ No ☐ Yes (Specify type below. Check all that apply). ☐ Influenza ☐ Hepatitis B ☐ Hepatitis A ☐ Tetanus / Diphtheria (Td) ☐ Tetanus / Diphtheria Pertussis (Tdap) ☐ Meningococcal ☐ Pneumococcal ☐ Other: _____				☐ Office ☐ Self Date: _____

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- Medications (those prescribed by a health care provider and those bought "over-the-counter")
- Vitamins, minerals, herbs, and any other supplements

THE NATIONAL CHILDREN'S STUDY

Visit Date: __ __ / __ __ / __ __ __ __
Month *Day* *Year*

Provider Number from Health Care Provider Log: _____

Name of Provider Seen: _____

Be sure to also write this provider's contact information in the HEALTH CARE PROVIDER LOG.

Health Care Visits and Overnight Hospital Stays Log

Health Care Visit/Hospital Stay 14

1	2	3	4	5	6	7	8	9
Reason for visit	**Weight**	**Blood Pressure**	**Pregnancy Care Procedures (Tests to check on your baby's health)**	**Vaccination / Shot / Immunization**	**Other Tests and Procedures (Tests to check on YOUR health) For example, lab tests (blood, urine, etc.)**	**Medications/Other Treatments (For example, over-the-counter or prescribed medications)**	**Diagnoses**	**Completed by Office or Self** **Date Reported to National Children's Study**
☐ Routine Pregnancy Care ☐ Illness or Injury ☐ **Overnight hospital stay (Hospitalized)** How many nights? _____ ☐ Some other reason (explain): _____ _____ _____ _____ _____ _____ _____ _____	_____ *lb* ☐ Not done/ Don't know	__ __ __ /__ __ __ ☐ Not done/ Don't know	**(Check all that apply)** ☐ Ultrasound or Sonogram ☐ Chorionic Villus Sampling (CVS) ☐ Amniocentesis ☐ Other tests to check on the health of your baby (describe below): _____ _____ _____ _____ _____ _____ _____	☐ No ☐ Yes (Specify type below. Check all that apply). ☐ Influenza ☐ Hepatitis B ☐ Hepatitis A ☐ Tetanus / Diphtheria (Td) ☐ Tetanus / Diphtheria Pertussis (Tdap) ☐ Meningococcal ☐ Pneumococcal ☐ Other: _____				☐ Office ☐ Self Date: _____

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- Medications (those prescribed by a health care provider and those bought "over-the-counter")
- Vitamins, minerals, herbs, and any other supplements

THE NATIONAL CHILDREN'S STUDY

Visit Date: __ __ / __ __ / __ __ __ __
Month *Day* *Year*

Provider Number from Health Care Provider Log: _____

Name of Provider Seen: _____

Be sure to also write this provider's contact information in the HEALTH CARE PROVIDER LOG.

Health Care Visits and Overnight Hospital Stays Log

Health Care Visit/Hospital Stay 15

1	2	3	4	5	6	7	8	9
Reason for visit	**Weight**	**Blood Pressure**	**Pregnancy Care Procedures (Tests to check on your baby's health)**	**Vaccination / Shot / Immunization**	**Other Tests and Procedures (Tests to check on YOUR health) For example, lab tests (blood, urine, etc.)**	**Medications/Other Treatments (For example, over-the-counter or prescribed medications)**	**Diagnoses**	**Completed by Office or Self** **Date Reported to National Children's Study**
☐ Routine Pregnancy Care ☐ Illness or Injury ☐ **Overnight hospital stay (Hospitalized)** How many nights? _____ ☐ Some other reason (explain): _____ _____ _____ _____ _____ _____ _____ _____	_____ *lb* ☐ Not done/ Don't know	__ __ __ /__ __ __ ☐ Not done/ Don't know	**(Check all that apply)** ☐ Ultrasound or Sonogram ☐ Chorionic Villus Sampling (CVS) ☐ Amniocentesis ☐ Other tests to check on the health of your baby (describe below): _____ _____ _____ _____ _____ _____ _____	☐ No ☐ Yes (Specify type below. Check all that apply). ☐ Influenza ☐ Hepatitis B ☐ Hepatitis A ☐ Tetanus / Diphtheria (Td) ☐ Tetanus / Diphtheria Pertussis (Tdap) ☐ Meningococcal ☐ Pneumococcal ☐ Other: _____				☐ Office ☐ Self Date: _____

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- Vitamins, minerals, herbs, and any other supplements

THE NATIONAL CHILDREN'S STUDY

Visit Date: __ __ / __ __ / __ __ __ __
Month Day Year

Provider Number from Health Care Provider Log: _____

Name of Provider Seen: _____

Be sure to also write this provider's contact information in the HEALTH CARE PROVIDER LOG.

Health Care Visits and Overnight Hospital Stays Log

Health Care Visit/Hospital Stay 16

1	2	3	4	5	6	7	8	9
Reason for visit	**Weight**	**Blood Pressure**	**Pregnancy Care Procedures (Tests to check on your baby's health)**	**Vaccination / Shot / Immunization**	**Other Tests and Procedures (Tests to check on YOUR health) For example, lab tests (blood, urine, etc.)**	**Medications/Other Treatments (For example, over-the-counter or prescribed medications)**	**Diagnoses**	**Completed by Office or Self** **Date Reported to National Children's Study**
☐ Routine Pregnancy Care ☐ Illness or Injury ☐ **Overnight hospital stay (Hospitalized)** How many nights? _____ ☐ Some other reason (explain): _____ _____ _____ _____ _____ _____ _____ _____	_____ lb ☐ Not done/ Don't know	__ __ __ / __ __ __ ☐ Not done/ Don't know	**(Check all that apply)** ☐ Ultrasound or Sonogram ☐ Chorionic Villus Sampling (CVS) ☐ Amniocentesis ☐ Other tests to check on the health of your baby (describe below): _____ _____ _____ _____ _____ _____ _____	☐ No ☐ Yes (Specify type below. Check all that apply). ☐ Influenza ☐ Hepatitis B ☐ Hepatitis A ☐ Tetanus / Diphtheria (Td) ☐ Tetanus / Diphtheria Pertussis (Tdap) ☐ Meningococcal ☐ Pneumococcal ☐ Other: _____				☐ Office ☐ Self Date: _____

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THE NATIONAL CHILDREN'S STUDY

Visit Date: __ __ / __ __ / __ __ __ __
Month *Day* *Year*

Provider Number from Health Care Provider Log: _____

Name of Provider Seen: _____

Be sure to also write this provider's contact information in the HEALTH CARE PROVIDER LOG.

Health Care Visits and Overnight Hospital Stays Log

Health Care Visit/Hospital Stay 17

1	2	3	4	5	6	7	8	9
Reason for visit	**Weight**	**Blood Pressure**	**Pregnancy Care Procedures (Tests to check on your baby's health)**	**Vaccination / Shot / Immunization**	**Other Tests and Procedures (Tests to check on YOUR health) For example, lab tests (blood, urine, etc.)**	**Medications/Other Treatments (For example, over-the-counter or prescribed medications)**	**Diagnoses**	**Completed by Office or Self** **Date Reported to National Children's Study**
☐ Routine Pregnancy Care ☐ Illness or Injury ☐ **Overnight hospital stay (Hospitalized)** How many nights? _____ ☐ Some other reason (explain): _____ _____ _____ _____ _____ _____ _____ _____	_____ *lb* ☐ Not done/ Don't know	__ __ __ /__ __ __ ☐ Not done/ Don't know	**(Check all that apply)** ☐ Ultrasound or Sonogram ☐ Chorionic Villus Sampling (CVS) ☐ Amniocentesis ☐ Other tests to check on the health of your baby (describe below): _____ _____ _____ _____ _____ _____ _____	☐ No ☐ Yes (Specify type below. Check all that apply). ☐ Influenza ☐ Hepatitis B ☐ Hepatitis A ☐ Tetanus / Diphtheria (Td) ☐ Tetanus / Diphtheria Pertussis (Tdap) ☐ Meningococcal ☐ Pneumococcal ☐ Other: _____				☐ Office ☐ Self Date: _____

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THE NATIONAL CHILDREN'S STUDY

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
National Institutes of Health
Centers for Disease Control and Prevention
U.S. ENVIRONMENTAL PROTECTION AGENCY

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