



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: _____

Public reporting for this collection of information is estimated to average 20 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 (0925-0593). Do not return the completed form to this address.

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 not 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 <i>(Sample)</i>		Dr. Robert Jones	<input checked="" type="checkbox"/> Obstetrician/ Gynecologist (OB/GYN) <input type="checkbox"/> Family Physician <input type="checkbox"/> Nurse <input type="checkbox"/> Midwife <input type="checkbox"/> Another Type of Provider (specify) _____	<input checked="" type="checkbox"/> Doctor's office, clinic, or health center <input type="checkbox"/> Emergency room <input type="checkbox"/> Urgent care center <input type="checkbox"/> Hospital for hospitalization <input type="checkbox"/> Some other place (specify): _____	400 Main Street	Capital City	MN	56087	937-889-9275
1			<input type="checkbox"/> Obstetrician/ Gynecologist (OB/GYN) <input type="checkbox"/> Family Physician <input type="checkbox"/> Nurse <input type="checkbox"/> Midwife <input type="checkbox"/> Another Type of Provider (specify) _____	<input type="checkbox"/> Doctor's office, clinic, or health center <input type="checkbox"/> Emergency room <input type="checkbox"/> Urgent care center <input type="checkbox"/> Hospital for hospitalization <input type="checkbox"/> Some other place (specify): _____					
2			<input type="checkbox"/> Obstetrician/ Gynecologist (OB/GYN) <input type="checkbox"/> Family Physician <input type="checkbox"/> Nurse <input type="checkbox"/> Midwife <input type="checkbox"/> Another Type of Provider (specify) _____	<input type="checkbox"/> Doctor's office, clinic, or health center <input type="checkbox"/> Emergency room <input type="checkbox"/> Urgent care center <input type="checkbox"/> Hospital for hospitalization <input type="checkbox"/> Some other place (specify): _____					
3			<input type="checkbox"/> Obstetrician/ Gynecologist (OB/GYN) <input type="checkbox"/> Family Physician <input type="checkbox"/> Nurse <input type="checkbox"/> Midwife <input type="checkbox"/> Another Type of Provider (specify) _____	<input type="checkbox"/> Doctor's office, clinic, or health center <input type="checkbox"/> Emergency room <input type="checkbox"/> Urgent care center <input type="checkbox"/> Hospital for hospitalization <input type="checkbox"/> 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.



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			<input type="checkbox"/> Obstetrician/ Gynecologist (OB/GYN) <input type="checkbox"/> Family Physician <input type="checkbox"/> Nurse <input type="checkbox"/> Midwife <input type="checkbox"/> Another Type of Provider (specify) _____	<input type="checkbox"/> Doctor's office, clinic, or health center <input type="checkbox"/> Emergency room <input type="checkbox"/> Urgent care center <input type="checkbox"/> Hospital for hospitalization <input type="checkbox"/> Some other place (specify): _____					
5			<input type="checkbox"/> Obstetrician/ Gynecologist (OB/GYN) <input type="checkbox"/> Family Physician <input type="checkbox"/> Nurse <input type="checkbox"/> Midwife <input type="checkbox"/> Another Type of Provider (specify) _____	<input type="checkbox"/> Doctor's office, clinic, or health center <input type="checkbox"/> Emergency room <input type="checkbox"/> Urgent care center <input type="checkbox"/> Hospital for hospitalization <input type="checkbox"/> Some other place (specify): _____					
6			<input type="checkbox"/> Obstetrician/ Gynecologist (OB/GYN) <input type="checkbox"/> Family Physician <input type="checkbox"/> Nurse <input type="checkbox"/> Midwife <input type="checkbox"/> Another Type of Provider (specify) _____	<input type="checkbox"/> Doctor's office, clinic, or health center <input type="checkbox"/> Emergency room <input type="checkbox"/> Urgent care center <input type="checkbox"/> Hospital for hospitalization <input type="checkbox"/> Some other place (specify): _____					
7			<input type="checkbox"/> Obstetrician/ Gynecologist (OB/GYN) <input type="checkbox"/> Family Physician <input type="checkbox"/> Nurse <input type="checkbox"/> Midwife <input type="checkbox"/> Another Type of Provider (specify) _____	<input type="checkbox"/> Doctor's office, clinic, or health center <input type="checkbox"/> Emergency room <input type="checkbox"/> Urgent care center <input type="checkbox"/> Hospital for hospitalization <input type="checkbox"/> 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.



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			<input type="checkbox"/> Obstetrician/ Gynecologist (OB/GYN) <input type="checkbox"/> Family Physician <input type="checkbox"/> Nurse <input type="checkbox"/> Midwife <input type="checkbox"/> Another Type of Provider (specify) _____	<input type="checkbox"/> Doctor's office, clinic, or health center <input type="checkbox"/> Emergency room <input type="checkbox"/> Urgent care center <input type="checkbox"/> Hospital for hospitalization <input type="checkbox"/> Some other place (specify): _____					
9			<input type="checkbox"/> Obstetrician/ Gynecologist (OB/GYN) <input type="checkbox"/> Family Physician <input type="checkbox"/> Nurse <input type="checkbox"/> Midwife <input type="checkbox"/> Another Type of Provider (specify) _____	<input type="checkbox"/> Doctor's office, clinic, or health center <input type="checkbox"/> Emergency room <input type="checkbox"/> Urgent care center <input type="checkbox"/> Hospital for hospitalization <input type="checkbox"/> Some other place (specify): _____					
10			<input type="checkbox"/> Obstetrician/ Gynecologist (OB/GYN) <input type="checkbox"/> Family Physician <input type="checkbox"/> Nurse <input type="checkbox"/> Midwife <input type="checkbox"/> Another Type of Provider (specify) _____	<input type="checkbox"/> Doctor's office, clinic, or health center <input type="checkbox"/> Emergency room <input type="checkbox"/> Urgent care center <input type="checkbox"/> Hospital for hospitalization <input type="checkbox"/> Some other place (specify): _____					
11			<input type="checkbox"/> Obstetrician/ Gynecologist (OB/GYN) <input type="checkbox"/> Family Physician <input type="checkbox"/> Nurse <input type="checkbox"/> Midwife <input type="checkbox"/> Another Type of Provider (specify) _____	<input type="checkbox"/> Doctor's office, clinic, or health center <input type="checkbox"/> Emergency room <input type="checkbox"/> Urgent care center <input type="checkbox"/> Hospital for hospitalization <input type="checkbox"/> 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.





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 / 18 / 2010
Month Day 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
<input checked="" type="checkbox"/> Routine Pregnancy Care <input type="checkbox"/> Illness or Injury <input type="checkbox"/> Overnight hospital stay (Hospitalized) How many nights? _____ <input type="checkbox"/> Some other reason (explain): _____ _____ _____ _____ _____ _____	<u>155</u> <small>lb</small> <input type="checkbox"/> Not done/ Don't know	<u>120</u> / <u>80</u> <input type="checkbox"/> Not done/ Don't know	(Check all that apply) <input checked="" type="checkbox"/> Ultrasound or Sonogram <input type="checkbox"/> Chorionic Villus Sampling (CVS) <input type="checkbox"/> Amniocentesis <input checked="" type="checkbox"/> Other tests to check on the health of your baby (describe below): <u>Triple Screen Test</u> _____ _____ _____ _____ _____	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (Specify type below. Check all that apply). <input type="checkbox"/> Influenza <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Tetanus / Diphtheria (Td) <input type="checkbox"/> Tetanus / Diphtheria Pertussis (Tdap) <input type="checkbox"/> Meningococcal <input type="checkbox"/> Pneumococcal <input type="checkbox"/> 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	<input type="checkbox"/> Office <input checked="" type="checkbox"/> Self Date: <u>4/10</u>

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



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
<input type="checkbox"/> Routine Pregnancy Care <input type="checkbox"/> Illness or Injury <input type="checkbox"/> Overnight hospital stay (Hospitalized) How many nights? _____ <input type="checkbox"/> Some other reason (explain): _____ _____ _____ _____ _____ _____	_____ <i>lb</i> <input type="checkbox"/> Not done/ Don't know	____ ____ / ____ ____ <input type="checkbox"/> Not done/ Don't know	(Check all that apply) <input type="checkbox"/> Ultrasound or Sonogram <input type="checkbox"/> Chorionic Villus Sampling (CVS) <input type="checkbox"/> Amniocentesis <input type="checkbox"/> Other tests to check on the health of your baby (describe below): _____ _____ _____ _____ _____ _____	<input type="checkbox"/> No <input type="checkbox"/> Yes (Specify type below. Check all that apply). <input type="checkbox"/> Influenza <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Tetanus / Diphtheria (Td) <input type="checkbox"/> Tetanus / Diphtheria Pertussis (Tdap) <input type="checkbox"/> Meningococcal <input type="checkbox"/> Pneumococcal <input type="checkbox"/> Other: _____				<input type="checkbox"/> Office <input type="checkbox"/> 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





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
<input type="checkbox"/> Routine Pregnancy Care <input type="checkbox"/> Illness or Injury <input type="checkbox"/> Overnight hospital stay (Hospitalized) How many nights? _____ <input type="checkbox"/> Some other reason (explain): _____ _____ _____ _____ _____ _____	_____ <i>lb</i> <input type="checkbox"/> Not done/ Don't know	____ ____ / ____ ____ <input type="checkbox"/> Not done/ Don't know	(Check all that apply) <input type="checkbox"/> Ultrasound or Sonogram <input type="checkbox"/> Chorionic Villus Sampling (CVS) <input type="checkbox"/> Amniocentesis <input type="checkbox"/> Other tests to check on the health of your baby (describe below): _____ _____ _____ _____ _____ _____	<input type="checkbox"/> No <input type="checkbox"/> Yes (Specify type below. Check all that apply). <input type="checkbox"/> Influenza <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Tetanus / Diphtheria (Td) <input type="checkbox"/> Tetanus / Diphtheria Pertussis (Tdap) <input type="checkbox"/> Meningococcal <input type="checkbox"/> Pneumococcal <input type="checkbox"/> Other: _____				<input type="checkbox"/> Office <input type="checkbox"/> 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





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
<input type="checkbox"/> Routine Pregnancy Care <input type="checkbox"/> Illness or Injury <input type="checkbox"/> Overnight hospital stay (Hospitalized) How many nights? _____ <input type="checkbox"/> Some other reason (explain): _____ _____ _____ _____ _____ _____ _____	_____ <i>lb</i> <input type="checkbox"/> Not done/ Don't know	____ ____ / ____ ____ <input type="checkbox"/> Not done/ Don't know	(Check all that apply) <input type="checkbox"/> Ultrasound or Sonogram <input type="checkbox"/> Chorionic Villus Sampling (CVS) <input type="checkbox"/> Amniocentesis <input type="checkbox"/> Other tests to check on the health of your baby (describe below): _____ _____ _____ _____ _____ _____ _____	<input type="checkbox"/> No <input type="checkbox"/> Yes (Specify type below. Check all that apply). <input type="checkbox"/> Influenza <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Tetanus / Diphtheria (Td) <input type="checkbox"/> Tetanus / Diphtheria Pertussis (Tdap) <input type="checkbox"/> Meningococcal <input type="checkbox"/> Pneumococcal <input type="checkbox"/> Other: _____				<input type="checkbox"/> Office <input type="checkbox"/> 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





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
<input type="checkbox"/> Routine Pregnancy Care <input type="checkbox"/> Illness or Injury <input type="checkbox"/> Overnight hospital stay (Hospitalized) How many nights? _____ <input type="checkbox"/> Some other reason (explain): _____ _____ _____ _____ _____ _____	_____ <i>lb</i> <input type="checkbox"/> Not done/ Don't know	____ / ____ <input type="checkbox"/> Not done/ Don't know	(Check all that apply) <input type="checkbox"/> Ultrasound or Sonogram <input type="checkbox"/> Chorionic Villus Sampling (CVS) <input type="checkbox"/> Amniocentesis <input type="checkbox"/> Other tests to check on the health of your baby (describe below): _____ _____ _____ _____ _____ _____	<input type="checkbox"/> No <input type="checkbox"/> Yes (Specify type below. Check all that apply). <input type="checkbox"/> Influenza <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Tetanus / Diphtheria (Td) <input type="checkbox"/> Tetanus / Diphtheria Pertussis (Tdap) <input type="checkbox"/> Meningococcal <input type="checkbox"/> Pneumococcal <input type="checkbox"/> Other: _____				<input type="checkbox"/> Office <input type="checkbox"/> 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



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
<input type="checkbox"/> Routine Pregnancy Care <input type="checkbox"/> Illness or Injury <input type="checkbox"/> Overnight hospital stay (Hospitalized) How many nights? _____ <input type="checkbox"/> Some other reason (explain): _____ _____ _____ _____ _____ _____	_____ <i>lb</i> <input type="checkbox"/> Not done/ Don't know	____ ____ / ____ ____ <input type="checkbox"/> Not done/ Don't know	(Check all that apply) <input type="checkbox"/> Ultrasound or Sonogram <input type="checkbox"/> Chorionic Villus Sampling (CVS) <input type="checkbox"/> Amniocentesis <input type="checkbox"/> Other tests to check on the health of your baby (describe below): _____ _____ _____ _____ _____ _____	<input type="checkbox"/> No <input type="checkbox"/> Yes (Specify type below. Check all that apply). <input type="checkbox"/> Influenza <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Tetanus / Diphtheria (Td) <input type="checkbox"/> Tetanus / Diphtheria Pertussis (Tdap) <input type="checkbox"/> Meningococcal <input type="checkbox"/> Pneumococcal <input type="checkbox"/> Other: _____				<input type="checkbox"/> Office <input type="checkbox"/> 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



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
<input type="checkbox"/> Routine Pregnancy Care <input type="checkbox"/> Illness or Injury <input type="checkbox"/> Overnight hospital stay (Hospitalized) How many nights? _____ <input type="checkbox"/> Some other reason (explain): _____ _____ _____ _____ _____ _____	_____ <i>lb</i> <input type="checkbox"/> Not done/ Don't know	____ ____ / ____ ____ <input type="checkbox"/> Not done/ Don't know	(Check all that apply) <input type="checkbox"/> Ultrasound or Sonogram <input type="checkbox"/> Chorionic Villus Sampling (CVS) <input type="checkbox"/> Amniocentesis <input type="checkbox"/> Other tests to check on the health of your baby (describe below): _____ _____ _____ _____ _____ _____	<input type="checkbox"/> No <input type="checkbox"/> Yes (Specify type below. Check all that apply). <input type="checkbox"/> Influenza <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Tetanus / Diphtheria (Td) <input type="checkbox"/> Tetanus / Diphtheria Pertussis (Tdap) <input type="checkbox"/> Meningococcal <input type="checkbox"/> Pneumococcal <input type="checkbox"/> Other: _____				<input type="checkbox"/> Office <input type="checkbox"/> 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





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
<input type="checkbox"/> Routine Pregnancy Care <input type="checkbox"/> Illness or Injury <input type="checkbox"/> Overnight hospital stay (Hospitalized) How many nights? _____ <input type="checkbox"/> Some other reason (explain): _____ _____ _____ _____ _____ _____	_____ <i>lb</i> <input type="checkbox"/> Not done/ Don't know	____ ____ / ____ ____ <input type="checkbox"/> Not done/ Don't know	(Check all that apply) <input type="checkbox"/> Ultrasound or Sonogram <input type="checkbox"/> Chorionic Villus Sampling (CVS) <input type="checkbox"/> Amniocentesis <input type="checkbox"/> Other tests to check on the health of your baby (describe below): _____ _____ _____ _____ _____ _____	<input type="checkbox"/> No <input type="checkbox"/> Yes (Specify type below. Check all that apply). <input type="checkbox"/> Influenza <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Tetanus / Diphtheria (Td) <input type="checkbox"/> Tetanus / Diphtheria Pertussis (Tdap) <input type="checkbox"/> Meningococcal <input type="checkbox"/> Pneumococcal <input type="checkbox"/> Other: _____				<input type="checkbox"/> Office <input type="checkbox"/> 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



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
<input type="checkbox"/> Routine Pregnancy Care <input type="checkbox"/> Illness or Injury <input type="checkbox"/> Overnight hospital stay (Hospitalized) How many nights? _____ <input type="checkbox"/> Some other reason (explain): _____ _____ _____ _____ _____ _____	_____ <i>lb</i> <input type="checkbox"/> Not done/ Don't know	____ ____ / ____ ____ <input type="checkbox"/> Not done/ Don't know	(Check all that apply) <input type="checkbox"/> Ultrasound or Sonogram <input type="checkbox"/> Chorionic Villus Sampling (CVS) <input type="checkbox"/> Amniocentesis <input type="checkbox"/> Other tests to check on the health of your baby (describe below): _____ _____ _____ _____ _____ _____	<input type="checkbox"/> No <input type="checkbox"/> Yes (Specify type below. Check all that apply). <input type="checkbox"/> Influenza <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Tetanus / Diphtheria (Td) <input type="checkbox"/> Tetanus / Diphtheria Pertussis (Tdap) <input type="checkbox"/> Meningococcal <input type="checkbox"/> Pneumococcal <input type="checkbox"/> Other: _____				<input type="checkbox"/> Office <input type="checkbox"/> 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



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
<input type="checkbox"/> Routine Pregnancy Care <input type="checkbox"/> Illness or Injury <input type="checkbox"/> Overnight hospital stay (Hospitalized) How many nights? _____ <input type="checkbox"/> Some other reason (explain): _____ _____ _____ _____ _____ _____	_____ <i>lb</i> <input type="checkbox"/> Not done/ Don't know	____ ____ / ____ ____ <input type="checkbox"/> Not done/ Don't know	(Check all that apply) <input type="checkbox"/> Ultrasound or Sonogram <input type="checkbox"/> Chorionic Villus Sampling (CVS) <input type="checkbox"/> Amniocentesis <input type="checkbox"/> Other tests to check on the health of your baby (describe below): _____ _____ _____ _____ _____ _____	<input type="checkbox"/> No <input type="checkbox"/> Yes (Specify type below. Check all that apply). <input type="checkbox"/> Influenza <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Tetanus / Diphtheria (Td) <input type="checkbox"/> Tetanus / Diphtheria Pertussis (Tdap) <input type="checkbox"/> Meningococcal <input type="checkbox"/> Pneumococcal <input type="checkbox"/> Other: _____				<input type="checkbox"/> Office <input type="checkbox"/> 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





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
<input type="checkbox"/> Routine Pregnancy Care <input type="checkbox"/> Illness or Injury <input type="checkbox"/> Overnight hospital stay (Hospitalized) How many nights? _____ <input type="checkbox"/> Some other reason (explain): _____ _____ _____ _____ _____ _____	_____ <i>lb</i> <input type="checkbox"/> Not done/ Don't know	____ ____ / ____ ____ <input type="checkbox"/> Not done/ Don't know	(Check all that apply) <input type="checkbox"/> Ultrasound or Sonogram <input type="checkbox"/> Chorionic Villus Sampling (CVS) <input type="checkbox"/> Amniocentesis <input type="checkbox"/> Other tests to check on the health of your baby (describe below): _____ _____ _____ _____ _____ _____	<input type="checkbox"/> No <input type="checkbox"/> Yes (Specify type below. Check all that apply). <input type="checkbox"/> Influenza <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Tetanus / Diphtheria (Td) <input type="checkbox"/> Tetanus / Diphtheria Pertussis (Tdap) <input type="checkbox"/> Meningococcal <input type="checkbox"/> Pneumococcal <input type="checkbox"/> Other: _____				<input type="checkbox"/> Office <input type="checkbox"/> Self Date: _____

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- Vitamins, minerals, herbs, and any other supplements





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
<input type="checkbox"/> Routine Pregnancy Care <input type="checkbox"/> Illness or Injury <input type="checkbox"/> Overnight hospital stay (Hospitalized) How many nights? _____ <input type="checkbox"/> Some other reason (explain): _____ _____ _____ _____ _____ _____	_____ <i>lb</i> <input type="checkbox"/> Not done/ Don't know	____ ____ / ____ ____ <input type="checkbox"/> Not done/ Don't know	(Check all that apply) <input type="checkbox"/> Ultrasound or Sonogram <input type="checkbox"/> Chorionic Villus Sampling (CVS) <input type="checkbox"/> Amniocentesis <input type="checkbox"/> Other tests to check on the health of your baby (describe below): _____ _____ _____ _____ _____ _____	<input type="checkbox"/> No <input type="checkbox"/> Yes (Specify type below. Check all that apply). <input type="checkbox"/> Influenza <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Tetanus / Diphtheria (Td) <input type="checkbox"/> Tetanus / Diphtheria Pertussis (Tdap) <input type="checkbox"/> Meningococcal <input type="checkbox"/> Pneumococcal <input type="checkbox"/> Other: _____				<input type="checkbox"/> Office <input type="checkbox"/> 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



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
<input type="checkbox"/> Routine Pregnancy Care <input type="checkbox"/> Illness or Injury <input type="checkbox"/> Overnight hospital stay (Hospitalized) How many nights? _____ <input type="checkbox"/> Some other reason (explain): _____ _____ _____ _____ _____ _____	_____ <i>lb</i> <input type="checkbox"/> Not done/ Don't know	_____ / _____ <input type="checkbox"/> Not done/ Don't know	(Check all that apply) <input type="checkbox"/> Ultrasound or Sonogram <input type="checkbox"/> Chorionic Villus Sampling (CVS) <input type="checkbox"/> Amniocentesis <input type="checkbox"/> Other tests to check on the health of your baby (describe below): _____ _____ _____ _____ _____ _____	<input type="checkbox"/> No <input type="checkbox"/> Yes (Specify type below. Check all that apply). <input type="checkbox"/> Influenza <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Tetanus / Diphtheria (Td) <input type="checkbox"/> Tetanus / Diphtheria Pertussis (Tdap) <input type="checkbox"/> Meningococcal <input type="checkbox"/> Pneumococcal <input type="checkbox"/> Other: _____				<input type="checkbox"/> Office <input type="checkbox"/> Self Date: _____

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- Vitamins, minerals, herbs, and any other supplements





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
<input type="checkbox"/> Routine Pregnancy Care <input type="checkbox"/> Illness or Injury <input type="checkbox"/> Overnight hospital stay (Hospitalized) How many nights? _____ <input type="checkbox"/> Some other reason (explain): _____ _____ _____ _____ _____ _____	_____ <i>lb</i> <input type="checkbox"/> Not done/ Don't know	____ ____ / ____ ____ <input type="checkbox"/> Not done/ Don't know	(Check all that apply) <input type="checkbox"/> Ultrasound or Sonogram <input type="checkbox"/> Chorionic Villus Sampling (CVS) <input type="checkbox"/> Amniocentesis <input type="checkbox"/> Other tests to check on the health of your baby (describe below): _____ _____ _____ _____ _____ _____	<input type="checkbox"/> No <input type="checkbox"/> Yes (Specify type below. Check all that apply). <input type="checkbox"/> Influenza <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Tetanus / Diphtheria (Td) <input type="checkbox"/> Tetanus / Diphtheria Pertussis (Tdap) <input type="checkbox"/> Meningococcal <input type="checkbox"/> Pneumococcal <input type="checkbox"/> Other: _____				<input type="checkbox"/> Office <input type="checkbox"/> 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



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
<input type="checkbox"/> Routine Pregnancy Care <input type="checkbox"/> Illness or Injury <input type="checkbox"/> Overnight hospital stay (Hospitalized) How many nights? _____ <input type="checkbox"/> Some other reason (explain): _____ _____ _____ _____ _____ _____	_____ <i>lb</i> <input type="checkbox"/> Not done/ Don't know	____ ____ / ____ ____ <input type="checkbox"/> Not done/ Don't know	(Check all that apply) <input type="checkbox"/> Ultrasound or Sonogram <input type="checkbox"/> Chorionic Villus Sampling (CVS) <input type="checkbox"/> Amniocentesis <input type="checkbox"/> Other tests to check on the health of your baby (describe below): _____ _____ _____ _____ _____ _____	<input type="checkbox"/> No <input type="checkbox"/> Yes (Specify type below. Check all that apply). <input type="checkbox"/> Influenza <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Tetanus / Diphtheria (Td) <input type="checkbox"/> Tetanus / Diphtheria Pertussis (Tdap) <input type="checkbox"/> Meningococcal <input type="checkbox"/> Pneumococcal <input type="checkbox"/> Other: _____				<input type="checkbox"/> Office <input type="checkbox"/> 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





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
<input type="checkbox"/> Routine Pregnancy Care <input type="checkbox"/> Illness or Injury <input type="checkbox"/> Overnight hospital stay (Hospitalized) How many nights? _____ <input type="checkbox"/> Some other reason (explain): _____ _____ _____ _____ _____ _____	_____ <i>lb</i> <input type="checkbox"/> Not done/ Don't know	____ ____ / ____ ____ <input type="checkbox"/> Not done/ Don't know	(Check all that apply) <input type="checkbox"/> Ultrasound or Sonogram <input type="checkbox"/> Chorionic Villus Sampling (CVS) <input type="checkbox"/> Amniocentesis <input type="checkbox"/> Other tests to check on the health of your baby (describe below): _____ _____ _____ _____ _____ _____	<input type="checkbox"/> No <input type="checkbox"/> Yes (Specify type below. Check all that apply). <input type="checkbox"/> Influenza <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Tetanus / Diphtheria (Td) <input type="checkbox"/> Tetanus / Diphtheria Pertussis (Tdap) <input type="checkbox"/> Meningococcal <input type="checkbox"/> Pneumococcal <input type="checkbox"/> Other: _____				<input type="checkbox"/> Office <input type="checkbox"/> Self Date: _____

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- Vitamins, minerals, herbs, and any other supplements



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
<input type="checkbox"/> Routine Pregnancy Care <input type="checkbox"/> Illness or Injury <input type="checkbox"/> Overnight hospital stay (Hospitalized) How many nights? _____ <input type="checkbox"/> Some other reason (explain): _____ _____ _____ _____ _____ _____	_____ <i>lb</i> <input type="checkbox"/> Not done/ Don't know	____ ____ / ____ ____ <input type="checkbox"/> Not done/ Don't know	(Check all that apply) <input type="checkbox"/> Ultrasound or Sonogram <input type="checkbox"/> Chorionic Villus Sampling (CVS) <input type="checkbox"/> Amniocentesis <input type="checkbox"/> Other tests to check on the health of your baby (describe below): _____ _____ _____ _____ _____ _____	<input type="checkbox"/> No <input type="checkbox"/> Yes (Specify type below. Check all that apply). <input type="checkbox"/> Influenza <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Tetanus / Diphtheria (Td) <input type="checkbox"/> Tetanus / Diphtheria Pertussis (Tdap) <input type="checkbox"/> Meningococcal <input type="checkbox"/> Pneumococcal <input type="checkbox"/> Other: _____				<input type="checkbox"/> Office <input type="checkbox"/> Self Date: _____

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- Vitamins, minerals, herbs, and any other supplements





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
<input type="checkbox"/> Routine Pregnancy Care <input type="checkbox"/> Illness or Injury <input type="checkbox"/> Overnight hospital stay (Hospitalized) How many nights? _____ <input type="checkbox"/> Some other reason (explain): _____ _____ _____ _____ _____ _____ _____	_____ <i>lb</i> <input type="checkbox"/> Not done/ Don't know	____ ____ / ____ ____ <input type="checkbox"/> Not done/ Don't know	(Check all that apply) <input type="checkbox"/> Ultrasound or Sonogram <input type="checkbox"/> Chorionic Villus Sampling (CVS) <input type="checkbox"/> Amniocentesis <input type="checkbox"/> Other tests to check on the health of your baby (describe below): _____ _____ _____ _____ _____ _____ _____	<input type="checkbox"/> No <input type="checkbox"/> Yes (Specify type below. Check all that apply). <input type="checkbox"/> Influenza <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Tetanus / Diphtheria (Td) <input type="checkbox"/> Tetanus / Diphtheria Pertussis (Tdap) <input type="checkbox"/> Meningococcal <input type="checkbox"/> Pneumococcal <input type="checkbox"/> Other: _____				<input type="checkbox"/> Office <input type="checkbox"/> Self Date: _____

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Centers for Disease Control and Prevention

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