

Pregnancy Health Care Log

USE THIS LOG FOR ALL TELEPHONE CALLS OR VISITS.

SAVE ALL BOTTLES AND CONTAINERS OF MEDICINES INCLUDING:

- Medicines (those prescribed by a health provider and those not prescribed)
- Vitamins, minerals, herbs, and any other supplements

LAST NAME: _____ FIRST NAME: _____

DATE OF BIRTH: _____

Pregnancy Health Care Log

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 where you will provide information about where you visit your doctor or other health care provider.
- 2. Health Care Visits Log** is for information about all your visits to your doctor, other health care provider, or emergency room. This *does* include 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 and have it available for all NCS telephone interviews.

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

- BRING THIS LOG TO ALL HEALTH CARE VISITS. USE THIS LOG FOR ALL NCS TELEPHONE CALLS AND VISITS.
SAVE ALL BOTTLES AND CONTAINERS OF MEDICINES AND BRING TO NCS VISITS & TELEPHONE CALLS:**
- Medicines (those prescribed by a health care provider and those bought 'over the counter')
 - Vitamins, minerals, herbs, and any other supplements

HEALTH CARE PROVIDER LOG INSTRUCTIONS

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

Column 1 Write in a number for the health care provider (for example, 1,2,3,4 etc).

Column 2 Attach the health care provider's business card here.

FILL IN COLUMNS 3-9 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 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 including Area Code.

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	Provider Type	Type of Place	Street Number and Name	City or Town	State	ZIP Code	Telephone Number
1		Dr. Robert Jones	<input checked="" type="checkbox"/> Obstetrician/ Gynecologist (OB/GYN) <input type="checkbox"/> Family Physician <input type="checkbox"/> Nurse/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	Capit ol City	MN	560 87	937-889- 9275

BRING THIS LOG TO ALL HEALTH CARE VISITS. USE THIS LOG FOR ALL NCS TELEPHONE CALLS AND VISITS.

SAVE ALL BOTTLES AND CONTAINERS OF MEDICINES AND BRING TO NCS VISITS & TELEPHONE CALLS:

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

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HEALTH CARE PROVIDER LOG									
1	2	Fill in ONLY if you HAVE NOT attached a business card							
		3	4	5	6	7	8	9	10
Health Care Provider Number	Attach Health Care Provider Business Card	Name of Health Care Provider	Provider Type	Type of Place	Street Number and Name	City or Town	State	ZIP Code	Telephone Number
			<input type="checkbox"/> Obstetrician/ Gynecologist (OB/GYN) <input type="checkbox"/> Family Physician <input type="checkbox"/> Nurse/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): _____ -					
			<input type="checkbox"/> Obstetrician/ Gynecologist (OB/GYN) <input type="checkbox"/> Family Physician <input type="checkbox"/> Nurse/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): _____ -					
			<input type="checkbox"/> Obstetrician/ Gynecologist (OB/GYN) <input type="checkbox"/> Family Physician <input type="checkbox"/> Nurse/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					

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 SAVE ALL BOTTLES AND CONTAINERS OF MEDICINES AND BRING TO NCS VISITS & TELEPHONE CALLS:**

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

			_____ -	hospitalization <input type="checkbox"/> Some other place (specify): _____					
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**BRING THIS LOG TO ALL HEALTH CARE VISITS. USE THIS LOG FOR ALL NCS TELEPHONE CALLS AND VISITS.
 SAVE ALL BOTTLES AND CONTAINERS OF MEDICINES AND BRING TO NCS VISITS & TELEPHONE CALLS:**

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

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 down information about the visit on a new page in the log.

- Visit Date** Write the date of the visit (month/day/year).
- Provider Number** Write the number of the provider from the PROVIDER LOG
- Name of Provider Seen** Write the name of the provider (for example, the doctor, nurse practitioner, etc) that was seen during the visit. This provider's name should also be in the PROVIDER LOG with their contact information included.
- Visit Location** Write the name of the location (clinic, office, hospital, etc.) where this visit took place. This location information (address, telephone number...) should be written in the provider log.
- Column 1** Check the box for the reason for the visit such as routine pregnancy care, illness or injury. If you were hospitalized, be sure to also write the number of nights you stayed at the hospital. If the reason is not listed, then check "Some other reason" and write in the reason for the visit.
- Column 2** If your weight was taken, write in the numbers.
- Column 3** If your blood pressure was measured, write in the numbers.
- Column 4** If you received any pregnancy care related procedures such as an ultrasound/sonogram, amniocentesis, or chorionic villus sampling (CVS), check the box(es) for those procedures. If you received a procedure that isn't listed, check the box "Other tests to check on the health of your baby" and write in a description.
- Column 5** If you had a vaccination or 'shot', put a checkmark in the "Yes" box. If no vaccination ('shot') check "No". If "Yes", then check the box by the vaccination(s) received, such as flu shot, tetanus/diphtheria, hepatitis A or B, meningococcal or pneumococcal. If you received a vaccination that isn't listed, check the box "Other" and write in a description.
- Column 6** If you received any other procedures (such as blood tests, urine test, Rhogam injection, allergy shot, glucose tolerance test, etc.), write them here.
- Column 7** If you received any treatments or were told to take any medications (over-the-counter pills 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

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pressure, diabetes, infection), write the diagnosis here.

Column 9 Check the box showing whether the office staff completed the log or if you completed the log. After you report the visit to the NCS study staff, write in the date reported.

Visit Date: <u>03</u> / <u>18</u> / <u>20</u> 10 Month Day Year	Provider Number from Log: <u>1</u>	Name of Provider Seen: <u>Dr. Robert Jones</u> Be sure to write this provider's contact information in the HEALTH CARE PROVIDER LOG too	Visit Location: <u>Dr. Robert Jones' office</u>
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EXAMPLE

HEALTH CARE VISITS AND OVERNIGHT HOSPITAL STAYS								
1	2	3	4	5	6	7	8	9
Reason for visit	Weight	Blood Pressure	Pregnancy Care Procedures (Tests to check on the health of your baby)	Vaccination / Shot / Immunization	Other 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 NCS
<input checked="" type="checkbox"/> Routine Pregnancy Care <input type="checkbox"/> Illness or Injury <input type="checkbox"/> Overnight hospital stay (Hospitalize d) How many nights? _____ <input type="checkbox"/> Some other reason (explain): _____ _____	<u>155</u> lb <input type="checkbox"/> Not done/ Don't know	For example <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 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: _____			<u>Protein in Urine</u>	<input checked="" type="checkbox"/> Office <input type="checkbox"/> Self Date: <u>4/1/09</u>

BRING THIS LOG TO ALL HEALTH CARE VISITS. USE THIS LOG FOR ALL NCS TELEPHONE CALLS AND VISITS. SAVE ALL BOTTLES AND CONTAINERS OF MEDICINES AND BRING TO NCS VISITS & TELEPHONE CALLS:

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

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- Vitamins, minerals, herbs, and any other supplements

Health Care Visit/Hospital Stay 1

Visit Date: ___ / ___ / ____ Month Day Year	Provider Number from Log: _____ _____	Name of Provider Seen: _____ Be sure to write this provider's contact information in the HEALTH CARE PROVIDER LOG too	Visit Location: _____
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HEALTH CARE VISITS AND OVERNIGHT HOSPITAL STAYS

1	2	3	4	5	6	7	8	9
Reason for visit	Weight	Blood Pressure	Pregnancy Care Procedures (Tests to check on the health of your baby)	Vaccination / Shot / Immunization	Other 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 NCS
<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): _____ _____	_____ lb <input type="checkbox"/> Not done/ <u>Don't know</u>	_____ / _____ For example 120 / 80 <input type="checkbox"/> Not done/ <u>Don't know</u>	(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 NCS TELEPHONE CALLS AND VISITS.
SAVE ALL BOTTLES AND CONTAINERS OF MEDICINES AND BRING TO NCS VISITS & TELEPHONE CALLS:**

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- Vitamins, minerals, herbs, and any other supplements

Health Care Visit/Hospital Stay 2

Visit Date: ___ / ___ / _____ Month Day Year	Provider Number from Log: _____ _____	Name of Provider Seen: _____ Be sure to write this provider's contact information in the HEALTH CARE PROVIDER LOG too	Visit Location: _____
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HEALTH CARE VISITS AND OVERNIGHT HOSPITAL STAYS

1	2	3	4	5	6	7	8	9
Reason for visit	Weight	Blood Pressure	Pregnancy Care Procedures (Tests to check on the health of your baby)	Vaccination / Shot / Immunization	Other 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 NCS
<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): _____ _____	_____ lb <input type="checkbox"/> Not done/ <u>Don't know</u>	_____ / _____ For example 120 / 80 <input type="checkbox"/> Not done/ <u>Don't know</u>	(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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- Medicines (those prescribed by a health care provider and those bought 'over the counter')
- Vitamins, minerals, herbs, and any other supplements

Health Care Visit/Hospital Stay 3

Visit Date: ___ / ___ / ____ Month Day Year	Provider Number from Log: _____ _____	Name of Provider Seen: _____ Be sure to write this provider's contact information in the HEALTH CARE PROVIDER LOG too	Visit Location: _____
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HEALTH CARE VISITS AND OVERNIGHT HOSPITAL STAYS

1	2	3	4	5	6	7	8	9
Reason for visit	Weight	Blood Pressure	Pregnancy Care Procedures (Tests to check on the health of your baby)	Vaccination / Shot / Immunization	Other 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 NCS
<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): _____ _____	_____ lb <input type="checkbox"/> Not done/ <u>Don't know</u>	_____ / _____ For example 120 / 80 <input type="checkbox"/> Not done/ <u>Don't know</u>	(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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SAVE ALL BOTTLES AND CONTAINERS OF MEDICINES AND BRING TO NCS VISITS & TELEPHONE CALLS:**

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

Health Care Visit/Hospital Stay 4

Visit Date: ___ / ___ / _____ Month Day Year	Provider Number from Log: _____ _____	Name of Provider Seen: _____ Be sure to write this provider's contact information in the HEALTH CARE PROVIDER LOG too	Visit Location: _____
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HEALTH CARE VISITS AND OVERNIGHT HOSPITAL STAYS

1	2	3	4	5	6	7	8	9
Reason for visit	Weight	Blood Pressure	Pregnancy Care Procedures (Tests to check on the health of your baby)	Vaccination / Shot / Immunization	Other 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 NCS
<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): _____ _____	_____ lb <input type="checkbox"/> Not done/ <u>Don't know</u>	_____ / _____ For example 120 / 80 <input type="checkbox"/> Not done/ <u>Don't know</u>	(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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 SAVE ALL BOTTLES AND CONTAINERS OF MEDICINES AND BRING TO NCS VISITS & TELEPHONE CALLS:**

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

Health Care Visit/Hospital Stay 5

Visit Date: ___ / ___ / ____ Month Day Year	Provider Number from Log: _____ _____	Name of Provider Seen: _____ Be sure to write this provider's contact information in the HEALTH CARE PROVIDER LOG too	Visit Location: _____
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HEALTH CARE VISITS AND OVERNIGHT HOSPITAL STAYS

1	2	3	4	5	6	7	8	9
Reason for visit	Weight	Blood Pressure	Pregnancy Care Procedures (Tests to check on the health of your baby)	Vaccination / Shot / Immunization	Other 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 NCS
<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): _____ _____	_____ lb <input type="checkbox"/> Not done/ <u>Don't know</u>	_____ / _____ For example 120 / 80 <input type="checkbox"/> Not done/ <u>Don't know</u>	(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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- Medicines (those prescribed by a health care provider and those bought 'over the counter')
- Vitamins, minerals, herbs, and any other supplements

Health Care Visit/Hospital Stay 6

Visit Date: ___ / ___ / ____ Month Day Year	Provider Number from Log: _____ _____	Name of Provider Seen: _____ Be sure to write this provider's contact information in the HEALTH CARE PROVIDER LOG too	Visit Location: _____
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HEALTH CARE VISITS AND OVERNIGHT HOSPITAL STAYS

1	2	3	4	5	6	7	8	9
Reason for visit	Weight	Blood Pressure	Pregnancy Care Procedures (Tests to check on the health of your baby)	Vaccination / Shot / Immunization	Other 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 NCS
<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): _____ _____	_____ lb <input type="checkbox"/> Not done/ <u>Don't know</u>	_____ / _____ For example 120 / 80 <input type="checkbox"/> Not done/ <u>Don't know</u>	(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

Health Care Visit/Hospital Stay 7

Visit Date: ____ / ____ / ____ Month Day Year	Provider Number from Log: _____ _____	Name of Provider Seen: _____ Be sure to write this provider's contact information in the HEALTH CARE PROVIDER LOG too	Visit Location: _____
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HEALTH CARE VISITS AND OVERNIGHT HOSPITAL STAYS

1	2	3	4	5	6	7	8	9
Reason for visit	Weight	Blood Pressure	Pregnancy Care Procedures (Tests to check on the health of your baby)	Vaccination / Shot / Immunization	Other 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 NCS
<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): _____ _____	_____ lb <input type="checkbox"/> Not done/ <u>Don't know</u>	_____ / _____ For example 120 / 80 <input type="checkbox"/> Not done/ <u>Don't know</u>	(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 NCS TELEPHONE CALLS AND VISITS.
SAVE ALL BOTTLES AND CONTAINERS OF MEDICINES AND BRING TO NCS VISITS & TELEPHONE CALLS:**

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- Vitamins, minerals, herbs, and any other supplements

Health Care Visit/Hospital Stay 8

Visit Date: ____ / ____ / ____ Month Day Year	Provider Number from Log: _____ _____	Name of Provider Seen: _____ Be sure to write this provider's contact information in the HEALTH CARE PROVIDER LOG too	Visit Location: _____
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HEALTH CARE VISITS AND OVERNIGHT HOSPITAL STAYS

1	2	3	4	5	6	7	8	9
Reason for visit	Weight	Blood Pressure	Pregnancy Care Procedures (Tests to check on the health of your baby)	Vaccination / Shot / Immunization	Other 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 NCS
<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): _____ _____	_____ lb <input type="checkbox"/> Not done/ <u>Don't know</u>	_____ / _____ For example 120 / 80 <input type="checkbox"/> Not done/ <u>Don't know</u>	(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 NCS TELEPHONE CALLS AND VISITS.
SAVE ALL BOTTLES AND CONTAINERS OF MEDICINES AND BRING TO NCS VISITS & TELEPHONE CALLS:**

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

Health Care Visit/Hospital Stay 9

Visit Date: ___ / ___ / ____ Month Day Year	Provider Number from Log: _____ _____	Name of Provider Seen: _____ Be sure to write this provider's contact information in the HEALTH CARE PROVIDER LOG too	Visit Location: _____
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HEALTH CARE VISITS AND OVERNIGHT HOSPITAL STAYS

1	2	3	4	5	6	7	8	9
Reason for visit	Weight	Blood Pressure	Pregnancy Care Procedures (Tests to check on the health of your baby)	Vaccination / Shot / Immunization	Other 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 NCS
<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): _____ _____	_____ lb <input type="checkbox"/> Not done/ <u>Don't know</u>	_____ / _____ For example 120 / 80 <input type="checkbox"/> Not done/ <u>Don't know</u>	(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 NCS TELEPHONE CALLS AND VISITS.
SAVE ALL BOTTLES AND CONTAINERS OF MEDICINES AND BRING TO NCS VISITS & TELEPHONE CALLS:**

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

Health Care Visit/Hospital Stay 10

Visit Date: ____ / ____ / ____ Month Day Year	Provider Number from Log: _____ _____	Name of Provider Seen: _____ Be sure to write this provider's contact information in the HEALTH CARE PROVIDER LOG too	Visit Location: _____
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HEALTH CARE VISITS AND OVERNIGHT HOSPITAL STAYS

1	2	3	4	5	6	7	8	9
Reason for visit	Weight	Blood Pressure	Pregnancy Care Procedures (Tests to check on the health of your baby)	Vaccination / Shot / Immunization	Other 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 NCS
<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): _____ _____	_____ lb <input type="checkbox"/> Not done/ <u>Don't know</u>	_____ / _____ For example 120 / 80 <input type="checkbox"/> Not done/ <u>Don't know</u>	(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 NCS TELEPHONE CALLS AND VISITS.
SAVE ALL BOTTLES AND CONTAINERS OF MEDICINES AND BRING TO NCS VISITS & TELEPHONE CALLS:**

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

Health Care Visit/Hospital Stay 11

Visit Date: ____ / ____ / ____ Month Day Year	Provider Number from Log: _____ _____	Name of Provider Seen: _____ Be sure to write this provider's contact information in the HEALTH CARE PROVIDER LOG too	Visit Location: _____
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HEALTH CARE VISITS AND OVERNIGHT HOSPITAL STAYS

1	2	3	4	5	6	7	8	9
Reason for visit	Weight	Blood Pressure	Pregnancy Care Procedures (Tests to check on the health of your baby)	Vaccination / Shot / Immunization	Other 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 NCS
<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): _____ _____	_____ lb <input type="checkbox"/> Not done/ <u>Don't know</u>	_____ / _____ For example 120 / 80 <input type="checkbox"/> Not done/ <u>Don't know</u>	(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 NCS TELEPHONE CALLS AND VISITS.
SAVE ALL BOTTLES AND CONTAINERS OF MEDICINES AND BRING TO NCS VISITS & TELEPHONE CALLS:**

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

Health Care Visit/Hospital Stay 12

Visit Date: ___ / ___ / ____ Month Day Year	Provider Number from Log: _____ _____	Name of Provider Seen: _____ Be sure to write this provider's contact information in the HEALTH CARE PROVIDER LOG too	Visit Location: _____
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HEALTH CARE VISITS AND OVERNIGHT HOSPITAL STAYS

1	2	3	4	5	6	7	8	9
Reason for visit	Weight	Blood Pressure	Pregnancy Care Procedures (Tests to check on the health of your baby)	Vaccination / Shot / Immunization	Other 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 NCS
<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): _____ _____	_____ lb <input type="checkbox"/> Not done/ <u>Don't know</u>	_____ / _____ For example 120 / 80 <input type="checkbox"/> Not done/ <u>Don't know</u>	(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 NCS TELEPHONE CALLS AND VISITS.
SAVE ALL BOTTLES AND CONTAINERS OF MEDICINES AND BRING TO NCS VISITS & TELEPHONE CALLS:**

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

Health Care Visit/Hospital Stay 13

Visit Date: ___ / ___ / ____ Month Day Year	Provider Number from Log: _____ _____	Name of Provider Seen: _____ Be sure to write this provider's contact information in the HEALTH CARE PROVIDER LOG too	Visit Location: _____
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HEALTH CARE VISITS AND OVERNIGHT HOSPITAL STAYS

1	2	3	4	5	6	7	8	9
Reason for visit	Weight	Blood Pressure	Pregnancy Care Procedures (Tests to check on the health of your baby)	Vaccination / Shot / Immunization	Other 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 NCS
<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): _____ _____	_____ lb <input type="checkbox"/> Not done/ Don't know	_____ / _____ For example 120 / 80 <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 NCS TELEPHONE CALLS AND VISITS.
SAVE ALL BOTTLES AND CONTAINERS OF MEDICINES AND BRING TO NCS VISITS & TELEPHONE CALLS:**

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

Health Care Visit/Hospital Stay 14

Visit Date: ___ / ___ / _____ Month Day Year	Provider Number from Log: _____ _____	Name of Provider Seen: _____ Be sure to write this provider's contact information in the HEALTH CARE PROVIDER LOG too	Visit Location: _____
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HEALTH CARE VISITS AND OVERNIGHT HOSPITAL STAYS

1	2	3	4	5	6	7	8	9
Reason for visit	Weight	Blood Pressure	Pregnancy Care Procedures (Tests to check on the health of your baby)	Vaccination / Shot / Immunization	Other 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 NCS
<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): _____ _____	_____ lb <input type="checkbox"/> Not done/ <u>Don't know</u>	_____ / _____ For example 120 / 80 <input type="checkbox"/> Not done/ <u>Don't know</u>	(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 NCS TELEPHONE CALLS AND VISITS.
 SAVE ALL BOTTLES AND CONTAINERS OF MEDICINES AND BRING TO NCS VISITS & TELEPHONE CALLS:**

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

Health Care Visit/Hospital Stay 15

Visit Date: ___ / ___ / ____ Month Day Year	Provider Number from Log: _____ _____	Name of Provider Seen: _____ Be sure to write this provider's contact information in the HEALTH CARE PROVIDER LOG too	Visit Location: _____
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HEALTH CARE VISITS AND OVERNIGHT HOSPITAL STAYS

1	2	3	4	5	6	7	8	9
Reason for visit	Weight	Blood Pressure	Pregnancy Care Procedures (Tests to check on the health of your baby)	Vaccination / Shot / Immunization	Other 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 NCS
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**BRING THIS LOG TO ALL HEALTH CARE VISITS. USE THIS LOG FOR ALL NCS TELEPHONE CALLS AND VISITS.
SAVE ALL BOTTLES AND CONTAINERS OF MEDICINES AND BRING TO NCS VISITS & TELEPHONE CALLS:**

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

Health Care Visit/Hospital Stay 16

Visit Date: ___ / ___ / ____ Month Day Year	Provider Number from Log: _____ _____	Name of Provider Seen: _____ Be sure to write this provider's contact information in the HEALTH CARE PROVIDER LOG too	Visit Location: _____
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HEALTH CARE VISITS AND OVERNIGHT HOSPITAL STAYS

1	2	3	4	5	6	7	8	9
Reason for visit	Weight	Blood Pressure	Pregnancy Care Procedures (Tests to check on the health of your baby)	Vaccination / Shot / Immunization	Other 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 NCS
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SAVE ALL BOTTLES AND CONTAINERS OF MEDICINES AND BRING TO NCS VISITS & TELEPHONE CALLS:**

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

Health Care Visit/Hospital Stay 17

Visit Date: ___ / ___ / _____ Month Day Year	Provider Number from Log: _____ _____	Name of Provider Seen: _____ Be sure to write this provider's contact information in the HEALTH CARE PROVIDER LOG too	Visit Location: _____
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HEALTH CARE VISITS AND OVERNIGHT HOSPITAL STAYS

1	2	3	4	5	6	7	8	9
Reason for visit	Weight	Blood Pressure	Pregnancy Care Procedures (Tests to check on the health of your baby)	Vaccination / Shot / Immunization	Other 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 NCS
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**BRING THIS LOG TO ALL HEALTH CARE VISITS. USE THIS LOG FOR ALL NCS TELEPHONE CALLS AND VISITS.
SAVE ALL BOTTLES AND CONTAINERS OF MEDICINES AND BRING TO NCS VISITS & TELEPHONE CALLS:**

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



**BRING THIS LOG TO ALL HEALTH CARE VISITS. USE THIS LOG FOR ALL NCS TELEPHONE CALLS AND VISITS.
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- Medicines (those prescribed by a health care provider and those bought 'over the counter')
- Vitamins, minerals, herbs, and any other supplements