OMB #: 0925-0593 Expiration Date: 7/31/2013 Pregnancy Health Care Log, Phase 2e

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: _	

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.

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.
- Health Care Visits Log is for information about all your visits to your doctor, other health care provider, or emergency room. This <u>does</u> 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.

- 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- 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.

	·	HE	ALTH CARE PRO	VIDER LOG									
		Fill in ONLY if you HAVE NOT attached a business card											
1	2	3	4	5	6	7	8	9	10				
Health	Attach Health Care Provider	Name of	Provider Type	Type of Place	Street	City or	Stat	ZIP	Telephone				
Care Provider Number	Business Card	Health Care Provider			Number and Name	Town	е	Code	Number				
1		Dr. Robert Jones	X Obstetrician/ Gynecologist (OB/GYN) Family Physician Nurse/Midwife Another Type of Provider (specify):	X Doctor's office, clinic, or health center Emergency room Urgent care center Hospital for hospitalization Some other place (specify):	400 Main Street	Capit ol City	MN	560 87	937-889- 9275				

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

		HEALTH (CARE PROVIDE									
		Fill in ONLY if you HAVE NOT attached a business card 3 4 5 6 7 8 9										
1	2								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	Stat e	ZIP Code	Telephon e Number			
			☐ Obstetrician/ Gynecologist (OB/GYN) ☐ Family Physician ☐ Nurse/Midwife ☐ Another Type of Provider (specify):	□ Doctor's office, clinic, or health center □ Emergency room □ Urgent care center □ Hospital for hospitalization □ Some other place (specify):								
			☐ Obstetrician/ Gynecologist (OB/GYN) ☐ Family Physician ☐ Nurse/Midwife ☐ Another Type of Provider (specify): ————————————————————————————————————	□ Doctor's office, clinic, or health center □ Emergency room □ Urgent care center □ Hospital for hospitalization □ Some other place (specify):								
			☐ Obstetrician/ Gynecologist (OB/GYN) ☐ Family Physician ☐ Nurse/Midwife ☐ Another Type of Provider (specify):	□ Doctor's office, clinic, or health center □ Emergency room □ Urgent care center □ Hospital for								

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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

		hospitalization ☐ Some other place (specify):			

- 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	e of the visit	(month/day/year).
VISIL DULL	WILL LIFE GALL	of the visit	(IIIOIICII) aay, y cai j.

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

6

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

EXAMPLE

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		Н	IEALTH CARE	VISITS AND	OVERNIGHT H	OSPITAL STAY	5	
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
X Routine Pregnancy Care Illness or Injury Overnight hospital stay (Hospitalize d) How many nights? Some other reason (explain):	155_lb □ Not done/ Don't know	For example 120 /80 Not done/ Don't know	(Check all that apply) X Ultrasound or Sonogram Chorionic Villus Sampling (CVS) Amniocentesis Other tests to check on the health of your baby (describe below): Triple Screen Test	X No Yes (Specify type below. Check all that apply. Influenza Hepatitis B Hepatitis A Tetanus / Diphtheria (Td) Tetanus / Diphtheria Pertussis (Tdap) Meningococcal Pneumococcal Other:			Protein in Urine	X Office Self Date: 4/1/09

- 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

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Visit Date:	// :h Day Ye	 ear	Provider Number from Log:	Name of Provider S	een:	Vi	sit 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 Pressu	re Care Procedures	Vaccination / Shot / Immunization	Other Procedures ((Tests to check on YOUR health)	(For example, ove	Ĭ	Completed by Office or Self					
			(Tests to check on the health of your baby)		For example, lab tests (blood, urine, etc.)	the-counter or prescribed medications)		Date Reported to NCS					
□ Routine Pregnancy Care □ Illness or Injury □ Overnight hospital stay	lb	For example 120 / 80	(Check all that apply) Ultrasound or Sonogram Chorionic Villus	☐ No ☐ Yes (Specify type below. Check all that apply. ☐ Influenza ☐ Hepatitis B				□ Office □ Self					
How many nights? Some other reason (explain):	□ Not done/ Don't know	Don't know	Sampling (CVS) Amniocentesis Other tests to check on the health of your baby (describe below):	☐ Hepatitis B ☐ Hepatitis A ☐ Tetanus / Diphtheria (Td) ☐ Tetanus / Diphtheria Pertussis (Tdap) ☐ Meningococcal ☐ Pneumococcal ☐ Other:				Date:					

- 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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1 Reason for visit	2 Weight	3 Blood Pressure	Pregnancy Care Procedures (Tests to check on the health of your baby)	5 Vaccination / Shot / Immunization	6 Other Procedures ((Tests to check on YOUR health) For example, lab tests (blood, urine, etc.)	7 Medications/Ott Treatments (For example, over the-counter of prescribed medications)	/er-	9 Completed by Office or Self Date Reported to NCS
□ Routine Pregnancy Care □ Illness or Injury □ Overnight hospital stay (Hospitalized) How many nights? □ Some other reason (explain):	lb □ Not done/ □ Don't know	For example 120 / 80 Not done/ Don't know	(Check all that apply) Ultrasound or Sonogram Chorionic Villus Sampling (CVS) Amniocentesis Other tests to check on the health of your baby (describe below):	□ No □ Yes (Specify type below. Check all that apply. □ Influenza □ Hepatitis B □ Hepatitis A □ Tetanus / Diphtheria (Td) □ Tetanus / Diphtheria Pertussis (Tdap) □ Meningococcal □ Pneumococcal				□ Office □ Self Date:

- Medicines (those prescribed by a health care provider and those bought 'over the counter')
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			(Tests to check on the health of your baby)		For example, lab tests (blood, urine, etc.)	the-counter of prescribed medications		Date Reported to NCS
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			(Tests to check on the health of your baby)		For example, lab tests (blood, urine, etc.)	the-counter of prescribed medications		Date Reported to NCS			
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How many nights? Some other reason (explain):	□ Not done/ Don't know	Don't know	Sampling (CVS) Amniocentesis Other tests to check on the health of your baby (describe below):	☐ Hepatitis B ☐ Hepatitis A ☐ Tetanus / Diphtheria (Td) ☐ Tetanus / Diphtheria Pertussis (Tdap) ☐ Meningococcal ☐ Pneumococcal ☐ Other:				Date:			

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Reason for visit	Weight	Blood Pressu	re Care Procedures	Vaccination / Shot / Immunization	Other Procedures ((Tests to check on YOUR health)	(For example, o	s over-	by Office or Self
			(Tests to check on the health of your baby)		For example, lab tests (blood, urine, etc.)	the-counter of prescribed medications		Date Reported to NCS
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(Hospitalized) How many nights? —— Some other reason (explain):	□ Not done/ <u>Don't know</u>	Don't know	Sampling (CVS) Amniocentesis Other tests to check on the health of your baby (describe below):	☐ Hepatitis B ☐ Hepatitis A ☐ Tetanus / Diphtheria (Td) ☐ Tetanus / Diphtheria Pertussis (Tdap) ☐ Meningococcal ☐ Pneumococcal ☐ Other:				Date:

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Visit Date:			Provider Number	Name of Provider S	een.	7 10	Visit Location:	
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Reason for visit	Weight	Blood Pressur	, ,	Vaccination / Shot / Immunization	Other Procedures ((Tests to check on YOUR health) For example, lab tests (blood, urine, etc.)	Medications/O Treatments (For example, of the-counter of prescribed medications)	s over- or	Completed by Office or Self Date Reported to NCS
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reason (explain):			of your baby (describe below):	(Tdap) ☐ Meningococcal ☐ Pneumococcal ☐ Other:				

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Visit Date:// Month Day Year		Provider Number from Log:	Name of Provider S Be sure to write this	s provider's contact inf		Visit Location:		
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- Medicines (those prescribed by a health care provider and those bought 'over the counter')
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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/Oth Treatments (For example, ov the-counter or prescribed medications)	ver-	Completed by Office or Self Date Reported to NCS
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	-			Be sure to write this the HEALTH CARE P	s provider's contact inf ROVIDER LOG too	ormation in				
HEALTH CARE VISITS AND OVERNIGHT HOSPITAL STAYS										
1	2	3	4	5	6	7	8	9		
Reason for visit	Weight	Blood Pressu	,	Vaccination / Shot / Immunization	Other Procedures ((Tests to check on YOUR health) For example, lab	Medications/Othe Treatments (For example, over the-counter or	Ĭ	Completed by Office or Self Date		
			on the health of your baby)		tests (blood, urine, etc.)	prescribed medications)		Reported to NCS		
□ Routine Pregnancy Care □ Illness or Injury □ Overnight hospital stay	lb	For example 120 / 80	(Check all that apply) Ultrasound or Sonogram Chorionic Villus	☐ No ☐ Yes (Specify type below. Check all that apply. ☐ Influenza				□ Office □ Self		
How many nights? Some other reason (explain):	□ Not done/ Don't know	Don't know	Sampling (CVS) ☐ Amniocentesis ☐ Other tests to check on the health of your baby (describe below):	☐ Hepatitis B ☐ Hepatitis A ☐ Tetanus / Diphtheria (Td) ☐ Tetanus / Diphtheria Pertussis (Tdap) ☐ Meningococcal ☐ Pneumococcal ☐ Other:				Date:		

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

Visit Date:	//_ :h Day Ye	 ear	Provider Number from Log:	Name of Provider S	een:		Visit Location:		
Mont	ii Day Ye	ar		Be sure to write this provider's contact information in the HEALTH CARE PROVIDER LOG too					
		HE.	ALTH CARE VI	SITS AND O	ERNIGHT HO	SPITAL S	TAYS		
Reason for visit	Weight	3 Blood Pressur	, ,	Vaccination / Shot / Immunization	Other Procedures ((Tests to check on YOUR health) For example, lab tests (blood, urine, etc.)	7 Medications/Or Treatments (For example, or the-counter or prescribed medications)	over- or	9 Completed by Office or Self Date Reported to NCS	
□ Routine Pregnancy Care □ Illness or Injury □ Overnight hospital stay (Hospitalized) How many nights? □ Some other reason (explain):	□ Not done/ □ Don't know	For example 120 / 80	(Check all that apply) Ultrasound or Sonogram Chorionic Villus Sampling (CVS) Amniocentesis Other tests to check on the health of your baby (describe below):	□ No □ Yes (Specify type below. Check all that apply. □ Influenza □ Hepatitis B □ Hepatitis A □ Tetanus / Diphtheria (Td) □ Tetanus / Diphtheria Pertussis (Tdap) □ Meningococcal □ Pneumococcal □ Other:				□ Office □ Self Date:	

- Medicines (those prescribed by a health care provider and those bought 'over the counter')
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HEALTH CARE VISITS AND OVERNIGHT HOSPITAL STAYS										
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Reason for visit	Weight	Blood Pressui	Care Procedures (Tests to check	Vaccination / Shot / Immunization	Other Procedures ((Tests to check on YOUR health) For example, lab	Medications/Othe Treatments (For example, over the-counter or	Ĭ	Completed by Office or Self Date		
			on the health of your baby)		tests (blood, urine, etc.)	prescribed medications)		Reported to NCS		
□ Routine Pregnancy Care □ Illness or Injury □ Overnight hospital stay	lb	For example 120 / 80	(Check all that apply) Ultrasound or Sonogram Chorionic Villus	□ No □ Yes (Specify type below. Check all that apply. □ Influenza				□ Office □ Self		
How many nights? Some other reason (explain):	□ Not done/ Don't know	Don't know	Sampling (CVS) Amniocentesis Other tests to check on the health of your baby (describe below):	☐ Hepatitis B ☐ Hepatitis A ☐ Tetanus / Diphtheria (Td) ☐ Tetanus / Diphtheria Pertussis (Tdap) ☐ Meningococcal ☐ Pneumococcal ☐ Other:				Date:		

- Medicines (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 Log:	Name of Provider S Be sure to write this	s provider's contact inf		Visit Location:		
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Visit Date:// Month Day Year			Provider Number from Log:	Name of Provider S	een:	\	Visit Location:				
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Reason for visit	Weight	Blood Pressu	Care Procedures	Vaccination / Shot / Immunization	Other Procedures ((Tests to check on YOUR health)	(For example, ov	/er-	Completed by Office or Self			
			(Tests to check on the health of your baby)		For example, lab tests (blood, urine, etc.)	the-counter of prescribed medications)		Date Reported to NCS			
□ Routine Pregnancy Care □ Illness or Injury □ Overnight hospital stay	lb	For example 120 / 80	(Check all that apply) Ultrasound or Sonogram Chorionic Villus	□ No □ Yes (Specify type below. Check all that apply. □ Influenza □ Hepatitis B				□ Office □ Self			
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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



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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