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

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.

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 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***	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***	***Capitol City***	***MN***	***56087***	***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**

				_____ _					

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**
			☐ 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					

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): _____ _					

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

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 Log:**	**Name of Provider Seen:**	**Visit Location:**
0 3 / ***18*** / ***2 0 10*** **Month Day Year**	***1***	***Dr. Robert Jones*** Be sure to write this provider's contact information in the HEALTH CARE PROVIDER LOG too	***Dr. Robert Jones' office***

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
X Routine Pregnancy Care ☐ Illness or Injury ☐ Overnight hospital stay (Hospitalized) 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*

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.
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 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:** _____

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**
☐ 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 ☐ Other:_____				☐ Office ☐ 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 2

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

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**
☐ 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 ☐ Other:_____				☐ Office ☐ 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 3

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

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**
☐ 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 ☐ Other:_____				☐ Office ☐ 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 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:** _____

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**
☐ 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 ☐ Other:_____				☐ Office ☐ 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 5

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

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**
☐ 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 ☐ Other:_____				☐ Office ☐ 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 6

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

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**
☐ 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 ☐ Other:_____				☐ Office ☐ 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 7

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

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**
☐ 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 ☐ Other:_____				☐ Office ☐ 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 8

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

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**
☐ 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 ☐ Other:_____				☐ Office ☐ 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:** _____

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**
☐ 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 ☐ Other:_____				☐ Office ☐ 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:	Provider Number from Log:	Name of Provider Seen:	Visit Location:
__ __ / __ __ / __ __ __ __ Month Day Year	_____	_____ Be sure to write this provider's contact information in the HEALTH CARE PROVIDER LOG too	_____

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**
☐ 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 ☐ Other:_____				☐ Office ☐ 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:	Provider Number from Log:	Name of Provider Seen:	Visit Location:
__ __ / __ __ / __ __ __ __ Month Day Year	_____	_____ Be sure to write this provider's contact information in the HEALTH CARE PROVIDER LOG too	_____

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**
☐ 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 ☐ Other:_____				☐ Office ☐ 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:** _____

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**
☐ 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 ☐ Other:_____				☐ Office ☐ 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:	Provider Number from Log:	Name of Provider Seen:	Visit Location:
__ __ / __ __ / __ __ __ __ Month Day Year	_____	_____ Be sure to write this provider's contact information in the HEALTH CARE PROVIDER LOG too	_____

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**
☐ 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 ☐ Other:_____				☐ Office ☐ 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:	Provider Number from Log:	Name of Provider Seen:	Visit Location:
__ __ / __ __ / __ __ __ __ Month Day Year	_____	_____ Be sure to write this provider's contact information in the HEALTH CARE PROVIDER LOG too	_____

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**
☐ 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 ☐ Other:_____				☐ Office ☐ 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:	Provider Number from Log:	Name of Provider Seen:	Visit Location:
__ __ / __ __ / __ __ __ __ Month Day Year	_____	_____ Be sure to write this provider's contact information in the HEALTH CARE PROVIDER LOG too	_____

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**
☐ 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 ☐ Other:_____				☐ Office ☐ 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 16

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

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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- **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:** _____

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**
☐ 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 ☐ Other:_____				☐ Office ☐ Self Date: _____

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