

Pregnancy Health Care Log

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

Save all bottles and containers of medications.

Bring to Study visits and have available for telephone calls:

| • | Medicines | (those | prescribed | by a | a health | care | provider | and | those | bough | ١t |
|---|-----------|--------|------------|------|----------|-------|----------|-----|-------|-------|----|
| | | | C | ver- | the-cou | nter) | | | | | |

| | Vitamins, minerals, herbs, and any other supplements |
|------------|--|
| Last Name: | First Name: |

Public reporting for this collection of information is estimated to average 5 minutes per response including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. **An agency may not conduct or**

sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0593). Do not return the completed form to this address.

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



The log has two parts:

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

stay.

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

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

Health Care Provider Log Instructions

The health care provider is the person who cared for you at this visit (doctor, midwife, nurse, etc.)

Column 1 A number is listed for each health care

provider (for example, 1,2,3,4, etc). This number will be referred to on the Health Care Visits and Overnight Hospital Stays

log page.

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

Fill in columns 3–10 only if you have <u>not</u> attached the health care provider's business card.

Column 3 Write in the name of the health care provider.

Column 4 Check (✓) the box for the type of provider. If

it was "Another type of provider," write in

the type of health care provider.

Column 5 Check (✓) the box for the type of place where

you saw the provider. If it was "Some other place," write in the type of place where you

visited the health care provider.

Columns 6–9 Write in the address of the place including

city/town, state, and ZIP Code.

Column 10 Write in the telephone number of the

health care provider including area code.

See sample log on next page.

After you fill out the Health Care Provider Log, please fill out the Health Care Visits

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and Overnight Hospital Stavs Log.

The National Children's Pregnancy Health

Health Care Provider Log

| Tieattii | Care Provider Log | | Fill ii | n ONLY if you | HAVE NOT attac | hed a busin | ess card | | |
|-----------------------------------|---|------------------------------------|--|--|------------------------------|-----------------|----------|-------------|---------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Health Care Provider Number | Attach Health Care Provider Business Card | Name of Health Care Provider | Type of Health Care | Type of Place | Street Number and Name | City or Town | State | ZIP Code | Telephone Number |
| O (Sample) | | Dr. Robert Jones | Obstetrici an/ Gynecolog ist (OB/GYN) D Family physician D Nurse D Midwife D Another type of | Doctor's office, clinic, or health center D Emergency room D Urgent care center D Hospital for hospitalization D Some other place | 400Main Street | Capitol City | MN | 56087 | 937-889- 9275 |
| 1 | | | D Obstetrici an/ Gynecolog ist (OB/GYN) D Family physician D Nurse D Midwife D Another type of | D Doctor's office, clinic, or health center D Emergency room D Urgent care center D Hospital for hospitalizatio n D Some other place | | | | | |
| 2 | | | D Obstetrici an/ Gynecolog ist (OB/GYN) D Family physician D Nurse D Midwife D Another type of | D Doctor's office, clinic, or health center D Emergency room D Urgent care center D Hospital for hospitalizatio n D Some other place | | | | | |
| 3 | | | D Obstetrici an/ Gynecolog ist (OB/GYN) D Family physician D Nurse D Midwife D Another type of | D Doctor's office, clinic, or health center D Emergency room D Urgent care center D Hospital for hospitalizatio n D Some other place | | | | | |

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

• Medicines (those prescribed by a health care provider and those bought over-the-counter)

• Vitamins, minerals, herbs, and any other supplements

Please remember to fill out the Health Care Visits and Overnight



The National Children's Pregnancy Health

Health Care Provider Log

| Ticaicii | care i lovider Log | | Fill ii | ONLY if you | HAVE NOT attac | hed a busin | ess card | | |
|-----------------------------------|---|---------------------------------|--|--|------------------------------|-----------------|----------|-------------|---------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Health Care Provider Number | Attach Health Care Provider Business Card | Name of Health Care Provider | Type of Health Care | Type of Place | Street Number and Name | City or Town | State | ZIP Code | Telephone Number |
| 4 | | | D Obstetrici an/ Gynecolog ist (OB/GYN) D Family physician D Nurse D Midwife D Another type of | D Doctor's office, clinic, or health center D Emergency room D Urgent care center D Hospital for hospitalizatio n D Some other place | | | | | |
| 5 | | | D Obstetrici an/ Gynecolog ist (OB/GYN) D Family physician D Nurse D Midwife D Another type of | D Doctor's office, clinic, or health center D Emergency room D Urgent care center D Hospital for hospitalizatio n D Some other place | | | | | |
| 6 | | | D Obstetrici an/ Gynecolog ist (OB/GYN) D Family physician D Nurse D Midwife D Another type of | D Doctor's office, clinic, or health center D Emergency room D Urgent care center D Hospital for hospitalizatio n D Some other place | | | | | |
| 7 | | | D Obstetrici an/ Gynecolog ist (OB/GYN) D Family physician D Nurse D Midwife D Another type of | D Doctor's office, clinic, or health center D Emergency room D Urgent care center D Hospital for hospitalizatio n D Some other place | | | | | |

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• Vitamins, minerals, herbs, and any other supplements

Please remember to fill out the Health Care Visits and Overnight



The National Children's Pregnancy Health

Health Care Provider Log

| | Care i Tovider Log | | Fill ii | ONLY if you | HAVE NOT attac | hed a busin | ess card | | |
|-----------------------------------|---|---------------------------------|--|--|------------------------------|-----------------|----------|-------------|---------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Health Care Provider Number | Attach Health Care Provider Business Card | Name of Health Care Provider | Type of Health Care | Type of Place | Street Number and Name | City or Town | State | ZIP Code | Telephone Number |
| 8 | | | D Obstetrici an/ Gynecolog ist (OB/GYN) D Family physician D Nurse D Midwife D Another type of | D Doctor's office, clinic, or health center D Emergency room D Urgent care center D Hospital for hospitalizatio n D Some other place | | | | | |
| 9 | | | D Obstetrici an/ Gynecolog ist (OB/GYN) D Family physician D Nurse D Midwife D Another type of | D Doctor's office, clinic, or health center D Emergency room D Urgent care center D Hospital for hospitalizatio n D Some other place | | | | | |
| 1 0 | | | D Obstetrici an/ Gynecolog ist (OB/GYN) D Family physician D Nurse D Midwife D Another type of | D Doctor's office, clinic, or health center D Emergency room D Urgent care center D Hospital for hospitalizatio n D Some other place | | | | | |
| 1 1 | | | D Obstetrici an/ Gynecolog ist (OB/GYN) D Family physician D Nurse D Midwife D Another type of | D Doctor's office, clinic, or health center D Emergency room D Urgent care center D Hospital for hospitalizatio n D Some other place | | | | | |

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

• Medicines (those prescribed by a health care provider and those bought over-the-counter)

• Vitamins, minerals, herbs, and any other supplements

Please remember to fill out the Health Care Visits and Overnight





Health Care Visits and Overnight Hospital Stays Log Instructions:

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

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

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

completed the log. After you report the visit to the National Children's Study staff, write in the date reported.

Health Care Visits and Overnight Hospital Stays

Sample Log

| h | Visit 03 / 18 / 2010 Date: Month Day Year Provider Number from Health Care Provider Log: | 0 |
|---|---|---|
| | Name of Provider Dr. Robert Jones | |
| | Seen: | |

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

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
|---|-----------------------------------|-------------------|--|--|---|--|--|--|
| Reason for Visit | Weight | Blood Pressure | Pregnancy Care Procedures (tests to check on your baby's health) | Vaccination/ Shot/ Immunization | Other Tests and Procedures (tests to check on YOUR health) (For example, lab tests (blood, urine, etc.)) | Medication s/ Other Treatments (For example, over-the- counter or prescribed | Diagnoses | Completed by Office or Self Date Reported to National |
| D Routine pregnancy care D Illness or injury D Overnight hospital stay (hospitalized) How many nights? | 155 Ib D Not done/ don't know | 120 /_80 _ | (Check all that apply) D Ultrasound or Sonogram Chorionic Villus Sampling (CVS) D Amniocentesis D Other tests to check on the health of your | D No D Yes (Specify type below. Check all that apply). D Influenza D Hepatitis | Urine test Glucose tolerance test Blood test Ankle x- | Tylenol Amoxicillin Folic Acid RhoGAM injection | Protein in urine Urinary tract infection | D Office D Self |

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

• Medications (those prescribed by a health care provider and those bought over-the-counter)

• Vitamins, minerals, herbs, and any other supplements



| D Some other reason (explain): | baby (describe below): | В | D | ray | Physical therapy | Sprained ankle | Date: 4/1/10 |
|--------------------------------|------------------------------|----------------------------|----------------------|-----|---------------------|----------------|-----------------|
| (CAPILITY) | Triple Screen Test | Hepatiti A | b D | | | | 7/1/10 |
| | 1030 | | s / theria ſd) | | | | |
| | | D Tetar Dipht Pertus | heria | | | | |







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Health Care Visits and Overnight Health Care Visit/Hospital Stay 1

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
|--|---------------------------|---------------------------|--|----------------------------------|--|-------------------------------------|-----------|---------------------------------|
| 1 | 2 | 3 | 4 | 3 | 0 | / Medications/ | • | |
| Reason for Visit | Weight | Blood Pressure | Pregnancy Care Procedures | Vaccination/ Shot/ | Other Tests and Procedures (tests to check on YOUR health) | Other Treatments (For | Diagnoses | by Office or Self |
| | | | (tests to check on your baby's health) | Immunization | (For example, lab tests (blood, urine, etc.)) | example, over-the- counter or | | Date Reported to National |
| D Routine | - <u>Ib</u> | | (Check all that | D | | | | D Office |
| pregnancy care | 15 | / | apply) | No | | | | D Self |
| D Illness or injury | D Not done | | D Ultrasound or Sonogram | D Yes (Specify type below. | | | | |
| D Overnight hospital stay (hospitalized) | D Not done/ don't know | D Not done/ don't know | D Chorionic Villus Sampling (CVS) | Check all that apply). | | | | |
| How many | | | D Amniocentesis | D Influenza | | | | |
| nights? | | | D Other tests to check on the | D | | | | |
| D Some other | | | health of your baby | Hepatitis | | | | |
| reason (explain): | | | (describe below): | B D | | | | Date: |
| | | | | Hepatitis | | | | |
| | | | | A D | | | | |
| | | | | Tetanus / Diphtheria (Td) | | | | |
| | | | | D Tetanus / Diphtheria Pertussis | | | | |

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

• Medications (those prescribed by a health care provider and those bought over-the-counter)

• Vitamins, minerals, herbs, and any other supplements



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Provider Number from Health Care Provider Log: _

Name of Provider Seen: _

Be sure to also write this provider's contact information in the

Health Care Visits and Overnight

Health Care Visit/Hospital Stay 2

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
|---------------------|-------------|-------------------|---|---------------------------------------|---|--|-----------|--|
| Reason for Visit | Weight | Blood Pressure | Pregnancy Care Procedures (tests to check on your baby's health) | Vaccination/ Shot/ Immunization | Other Tests and Procedures (tests to check on YOUR health) (For example, lab tests (blood, urine, etc.)) | Medications/ Other Treatments (For example, over-the- counter or | Diagnoses | Completed by Office or Self Date Reported to National |
| D Routine | | | (Check all that | D | | | | D Office |
| pregnancy | lb | / | apply) | No | | | | D Self |
| care | | | D Ultrasound or | D Yes (Specify | | | | D Sell |
| D Illness or injury | D Not done/ | | Sonogram | type below. Check | | | | |
| D Overnight | don't know | D Not done/ | D Chorionic Villus | all that | | | | |
| hospital stay | | don't know | Sampling (CVS) | apply). | | | | |
| (hospitalized) | | | D Amniocentesis | D | | | | |
| How many | | | D Other tests to | Influenza | | | | |
| nights? | | | check on the | D | | | | |
| D.Como othor | | | health of your baby | Hepatitis | | | | |
| D Some other reason | | | (describe | B D | | | | Data |
| (explain): | | | below): | | | | | Date: |
| | | | | Hepatitis | | | | |
| | | | | A D | | | | |
| | | | | Tetanus / | | | | |
| | | | | Diphtheria (Td) | | | | |
| | | | | D Tetanus / | | | | |
| | | | | Diphtheria Pertussis | | | | |



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

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Provider Number from Health Care Provider Log: _

Name of Provider Seen: _

Be sure to also write this provider's contact information in the

Health Care Visits and Overnight

Health Care Visit/Hospital Stay 3

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
|---------------------|-------------|-------------------|---|---------------------------------------|---|--|-----------|--|
| Reason for Visit | Weight | Blood Pressure | Pregnancy Care Procedures (tests to check on your baby's health) | Vaccination/ Shot/ Immunization | Other Tests and Procedures (tests to check on YOUR health) (For example, lab tests (blood, urine, etc.)) | Medications/ Other Treatments (For example, over-the- counter or | Diagnoses | Completed by Office or Self Date Reported to National |
| D Routine | | | (Check all that | D | | | | D Office |
| pregnancy | lb | / | apply) | No | | | | D Self |
| care | | | D Ultrasound or | D Yes (Specify | | | | D Sell |
| D Illness or injury | D Not done/ | | Sonogram | type below. Check | | | | |
| D Overnight | don't know | D Not done/ | D Chorionic Villus | all that | | | | |
| hospital stay | | don't know | Sampling (CVS) | apply). | | | | |
| (hospitalized) | | | D Amniocentesis | D | | | | |
| How many | | | D Other tests to | Influenza | | | | |
| nights? | | | check on the | D | | | | |
| D. Como o otheru | | | health of your baby | Hepatitis | | | | |
| D Some other reason | | | (describe | B D | | | | Data |
| (explain): | | | below): | | | | | Date: |
| _ | | | | Hepatitis | | | | |
| | | | | A D | | | | |
| | | | | Tetanus / | | | | |
| | | | | Diphtheria (Td) | | | | |
| | | | | D Tetanus / | | | | |
| | | | | Diphtheria Pertussis | | | | |



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

Provider Number from Health Care Provider Log: _

Name of Provider Seen:

Be sure to also write this provider's contact information in the

Health Care Visits and Overnight

Health Care Visit/Hospital Stay 4

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



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

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Provider Number from Health Care Provider Log: _

Name of Provider Seen: _

Be sure to also write this provider's contact information in the

Health Care Visits and Overnight

Health Care Visit/Hospital Stay 5

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
|---------------------|-------------|-------------------|---|---------------------------------------|---|--|-----------|--|
| Reason for Visit | Weight | Blood Pressure | Pregnancy Care Procedures (tests to check on your baby's health) | Vaccination/ Shot/ Immunization | Other Tests and Procedures (tests to check on YOUR health) (For example, lab tests (blood, urine, etc.)) | Medications/ Other Treatments (For example, over-the- counter or | Diagnoses | Completed by Office or Self Date Reported to National |
| D Routine | | | (Check all that | D | | | | D Office |
| pregnancy | lb | / | apply) | No | | | | D Self |
| care | | | D Ultrasound or | D Yes (Specify | | | | D Sell |
| D Illness or injury | D Not done/ | | Sonogram | type below. Check | | | | |
| D Overnight | don't know | D Not done/ | D Chorionic Villus | all that | | | | |
| hospital stay | | don't know | Sampling (CVS) | apply). | | | | |
| (hospitalized) | | | D Amniocentesis | D | | | | |
| How many | | | D Other tests to | Influenza | | | | |
| nights? | | | check on the | D | | | | |
| D. Como o otheru | | | health of your baby | Hepatitis | | | | |
| D Some other reason | | | (describe | B D | | | | Data |
| (explain): | | | below): | | | | | Date: |
| _ | | | | Hepatitis | | | | |
| | | | | A D | | | | |
| | | | | Tetanus / | | | | |
| | | | | Diphtheria (Td) | | | | |
| | | | | D Tetanus / | | | | |
| | | | | Diphtheria Pertussis | | | | |



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

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Provider Number from Health Care Provider Log: _

Name of Provider Seen: _

Be sure to also write this provider's contact information in the

Health Care Visits and Overnight

Health Care Visit/Hospital Stay 6

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
|---------------------|-------------|-------------------|---|---------------------------------------|---|--|-----------|--|
| Reason for Visit | Weight | Blood Pressure | Pregnancy Care Procedures (tests to check on your baby's health) | Vaccination/ Shot/ Immunization | Other Tests and Procedures (tests to check on YOUR health) (For example, lab tests (blood, urine, etc.)) | Medications/ Other Treatments (For example, over-the- counter or | Diagnoses | Completed by Office or Self Date Reported to National |
| D Routine | | | (Check all that | D | | | | D Office |
| pregnancy | lb | / | apply) | No | | | | D Self |
| care | | | D Ultrasound or | D Yes (Specify | | | | D Sell |
| D Illness or injury | D Not done/ | | Sonogram | type below. Check | | | | |
| D Overnight | don't know | D Not done/ | D Chorionic Villus | all that | | | | |
| hospital stay | | don't know | Sampling (CVS) | apply). | | | | |
| (hospitalized) | | | D Amniocentesis | D | | | | |
| How many | | | D Other tests to | Influenza | | | | |
| nights? | | | check on the | D | | | | |
| 5.6 | | | health of your baby | Hepatitis | | | | |
| D Some other reason | | | (describe | B D | | | | |
| (explain): | | | below): | | | | | Date: |
| | | | | Hepatitis | | | | |
| | | | | A D | | | | |
| | | | | Tetanus / | | | | |
| | | | | Diphtheria (Td) | | | | |
| | | | | D Tetanus / | | | | |
| | | | | Diphtheria Pertussis | | | | |



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

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Provider Number from Health Care Provider Log: _

Name of Provider Seen: _

Be sure to also write this provider's contact information in the

Health Care Visits and Overnight

Health Care Visit/Hospital Stay 7

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
|---------------------|-------------|-------------------|---|---------------------------------------|---|--|-----------|--|
| Reason for Visit | Weight | Blood Pressure | Pregnancy Care Procedures (tests to check on your baby's health) | Vaccination/ Shot/ Immunization | Other Tests and Procedures (tests to check on YOUR health) (For example, lab tests (blood, urine, etc.)) | Medications/ Other Treatments (For example, over-the- counter or | Diagnoses | Completed by Office or Self Date Reported to National |
| D Routine | | | (Check all that | D | | | | D Office |
| pregnancy | lb | / | apply) | No | | | | D Self |
| care | | | D Ultrasound or | D Yes (Specify | | | | D Sell |
| D Illness or injury | D Not done/ | | Sonogram | type below. Check | | | | |
| D Overnight | don't know | D Not done/ | D Chorionic Villus | all that | | | | |
| hospital stay | | don't know | Sampling (CVS) | apply). | | | | |
| (hospitalized) | | | D Amniocentesis | D | | | | |
| How many | | | D Other tests to | Influenza | | | | |
| nights? | | | check on the | D | | | | |
| D.Como othor | | | health of your baby | Hepatitis | | | | |
| D Some other reason | | | (describe | B D | | | | Data |
| (explain): | | | below): | | | | | Date: |
| | | | | Hepatitis | | | | |
| | | | | A D | | | | |
| | | | | Tetanus / | | | | |
| | | | | Diphtheria (Td) | | | | |
| | | | | D Tetanus / | | | | |
| | | | | Diphtheria Pertussis | | | | |



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

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Provider Number from Health Care Provider Log: _

Name of Provider Seen: _

Be sure to also write this provider's contact information in the

Health Care Visits and Overnight

Health Care Visit/Hospital Stay 8

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

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

• Medications (those prescribed by a health care provider and those bought over-the-counter)

• Vitamins, minerals, herbs, and any other supplements



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Provider Number from Health Care Provider Log: _

Name of Provider Seen: _

Be sure to also write this provider's contact information in the

Health Care Visits and Overnight

Health Care Visit/Hospital Stay 9

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



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

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Provider Number from Health Care Provider Log: _

Name of Provider Seen: _

Be sure to also write this provider's contact information in the

Health Care Visits and Overnight

Health Care Visit/Hospital Stay 10

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
|---------------------------------|-------------|-------------------|---|---------------------------------------|---|--|-----------|--|
| Reason for Visit | Weight | Blood Pressure | Pregnancy Care Procedures (tests to check on your baby's health) | Vaccination/ Shot/ Immunization | Other Tests and Procedures (tests to check on YOUR health) (For example, lab tests (blood, urine, etc.)) | Medications/ Other Treatments (For example, over-the- counter or | Diagnoses | Completed by Office or Self Date Reported to National |
| D Routine | | | (Check all that | D | | | | D Office |
| pregnancy | lb | / | apply) | No | | | | D Self |
| care | | | D Ultrasound or | D Yes (Specify | | | | D Jen |
| D Illness or injury | D Not done/ | | Sonogram | type below. Check | | | | |
| D Overnight | don't know | D Not done/ | D Chorionic Villus | all that | | | | |
| hospital stay (hospitalized) | | don't know | Sampling (CVS) | apply). | | | | |
| (nospitalizeu) | | | D Amniocentesis | D | | | | |
| How many nights? | | | D Other tests to | Influenza | | | | |
| nights: | | | check on the | D | | | | |
| D Some other | | | health of your baby | Hepatitis | | | | |
| - reason | | | (describe | В D | | | | Date: |
| (explain): | | | below): | Hepatitis | | | | Date. |
| | | | | • | | | | |
| | | | | A D | | | | |
| | | | | Tetanus / | | | | |
| | | | | Diphtheria (Td) | | | | |
| | | | | D Tetanus / | | | | |
| | | | | Diphtheria Pertussis | | | | |



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

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Provider Number from Health Care Provider Log: _

Name of Provider Seen: _

Be sure to also write this provider's contact information in the

Health Care Visits and Overnight

Health Care Visit/Hospital Stay 11

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
|---------------------|-------------|-------------------|---|---------------------------------------|---|--|-----------|--|
| Reason for Visit | Weight | Blood Pressure | Pregnancy Care Procedures (tests to check on your baby's health) | Vaccination/ Shot/ Immunization | Other Tests and Procedures (tests to check on YOUR health) (For example, lab tests (blood, urine, etc.)) | Medications/ Other Treatments (For example, over-the- counter or | Diagnoses | Completed by Office or Self Date Reported to National |
| D Routine | | | (Check all that | D | | | | D Office |
| pregnancy | lb | / | apply) | No | | | | D Self |
| care | | | D Ultrasound or | D Yes (Specify | | | | D Sell |
| D Illness or injury | D Not done/ | | Sonogram | type below. Check | | | | |
| D Overnight | don't know | D Not done/ | D Chorionic Villus | all that | | | | |
| hospital stay | | don't know | Sampling (CVS) | apply). | | | | |
| (hospitalized) | | | D Amniocentesis | D | | | | |
| How many | | | D Other tests to | Influenza | | | | |
| nights? | | | check on the | D | | | | |
| D.Como othor | | | health of your baby | Hepatitis | | | | |
| D Some other reason | | | (describe | B D | | | | Data |
| (explain): | | | below): | | | | | Date: |
| | | | | Hepatitis | | | | |
| | | | | A D | | | | |
| | | | | Tetanus / | | | | |
| | | | | Diphtheria (Td) | | | | |
| | | | | D Tetanus / | | | | |
| | | | | Diphtheria Pertussis | | | | |



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

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Provider Number from Health Care Provider Log: _

Name of Provider Seen: _

Be sure to also write this provider's contact information in the

Health Care Visits and Overnight

Health Care Visit/Hospital Stay 12

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
|---------------------|-------------|-------------------|---|---------------------------------------|---|--|-----------|--|
| Reason for Visit | Weight | Blood Pressure | Pregnancy Care Procedures (tests to check on your baby's health) | Vaccination/ Shot/ Immunization | Other Tests and Procedures (tests to check on YOUR health) (For example, lab tests (blood, urine, etc.)) | Medications/ Other Treatments (For example, over-the- counter or | Diagnoses | Completed by Office or Self Date Reported to National |
| D Routine | | | (Check all that | D | | | | D Office |
| pregnancy | lb | / | apply) | No | | | | D Self |
| care | | | D Ultrasound or | D Yes (Specify | | | | D Sell |
| D Illness or injury | D Not done/ | | Sonogram | type below. Check | | | | |
| D Overnight | don't know | D Not done/ | D Chorionic Villus | all that | | | | |
| hospital stay | | don't know | Sampling (CVS) | apply). | | | | |
| (hospitalized) | | | D Amniocentesis | D | | | | |
| How many | | | D Other tests to | Influenza | | | | |
| nights? | | | check on the | D | | | | |
| D.Como othor | | | health of your baby | Hepatitis | | | | |
| D Some other reason | | | (describe | B D | | | | Data |
| (explain): | | | below): | | | | | Date: |
| | | | | Hepatitis | | | | |
| | | | | A D | | | | |
| | | | | Tetanus / | | | | |
| | | | | Diphtheria (Td) | | | | |
| | | | | D Tetanus / | | | | |
| | | | | Diphtheria Pertussis | | | | |



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

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Provider Number from Health Care Provider Log: _

Name of Provider Seen: _

Be sure to also write this provider's contact information in the

Health Care Visits and Overnight

Health Care Visit/Hospital Stay 13

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
|---------------------------------|-------------|-------------------|--|---------------------------------------|---|--|-----------|--|
| Reason for Visit | Weight | Blood Pressure | Pregnancy Care Procedures (tests to check on your baby's health) | Vaccination/ Shot/ Immunization | Other Tests and Procedures (tests to check on YOUR health) (For example, lab tests (blood, urine, etc.)) | Medications/ Other Treatments (For example, over-the- counter or | Diagnoses | Completed by Office or Self Date Reported to National |
| D Routine | | | (Check all that | D | | | | D Office |
| pregnancy | Ib | / | apply) | No | | | | D Self |
| care | | | D Ultrasound or | D Yes (Specify | | | | D Sell |
| D Illness or injury | D Not done/ | | Sonogram | type below. Check | | | | |
| D Overnight | don't know | D Not done/ | D Chorionic Villus | all that | | | | |
| hospital stay (hospitalized) | | don't know | Sampling (CVS) | apply). | | | | |
| - | | | D Amniocentesis | D Influenza | | | | |
| <u>How m</u> any nights? | | | D Other tests to | | | | | |
| J | | | check on the health of your | D | | | | |
| D Some other | | | baby | Hepatitis | | | | |
| reason (explain): | | | (describe below): | B D | | | | Date: |
| (explain). | | | , | Hepatitis | | | | |
| | | | | A D | | | | |
| | | | | Tetanus / | | | | |
| | | | | Diphtheria (Td) | | | | |
| | | | | D Tetanus / | | | | |
| | | | | Diphtheria Pertussis | | | | |



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

Provider Number from Health Care Provider Log: _

Name of Provider Seen: _

Be sure to also write this provider's contact information in the

Health Care Visits and Overnight

Health Care Visit/Hospital Stay 14

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
|---------------------|-------------|-------------------|---|---------------------------------------|---|--|-----------|--|
| Reason for Visit | Weight | Blood Pressure | Pregnancy Care Procedures (tests to check on your baby's health) | Vaccination/ Shot/ Immunization | Other Tests and Procedures (tests to check on YOUR health) (For example, lab tests (blood, urine, etc.)) | Medications/ Other Treatments (For example, over-the- counter or | Diagnoses | Completed by Office or Self Date Reported to National |
| D Routine | | | (Check all that | D | | | | D Office |
| pregnancy | lb | / | apply) | No | | | | D Self |
| care | | | D Ultrasound or | D Yes (Specify | | | | D Sell |
| D Illness or injury | D Not done/ | | Sonogram | type below. Check | | | | |
| D Overnight | don't know | D Not done/ | D Chorionic Villus | all that | | | | |
| hospital stay | | don't know | Sampling (CVS) | apply). | | | | |
| (hospitalized) | | | D Amniocentesis | D | | | | |
| How many | | | D Other tests to | Influenza | | | | |
| nights? | | | check on the | D | | | | |
| D.Como othor | | | health of your baby | Hepatitis | | | | |
| D Some other reason | | | (describe | B D | | | | Data |
| (explain): | | | below): | | | | | Date: |
| | | | | Hepatitis | | | | |
| | | | | A D | | | | |
| | | | | Tetanus / | | | | |
| | | | | Diphtheria (Td) | | | | |
| | | | | D Tetanus / | | | | |
| | | | | Diphtheria Pertussis | | | | |



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

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Provider Number from Health Care Provider Log: _

Name of Provider Seen: _

Be sure to also write this provider's contact information in the

Health Care Visits and Overnight

Health Care Visit/Hospital Stay 15

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
|---------------------|-------------|-------------------|---|---------------------------------------|---|--|-----------|--|
| Reason for Visit | Weight | Blood Pressure | Pregnancy Care Procedures (tests to check on your baby's health) | Vaccination/ Shot/ Immunization | Other Tests and Procedures (tests to check on YOUR health) (For example, lab tests (blood, urine, etc.)) | Medications/ Other Treatments (For example, over-the- counter or | Diagnoses | Completed by Office or Self Date Reported to National |
| D Routine | | | (Check all that | D | | | | D Office |
| pregnancy | lb | / | apply) | No | | | | D Self |
| care | | | D Ultrasound or | D Yes (Specify | | | | D Sell |
| D Illness or injury | D Not done/ | | Sonogram | type below. Check | | | | |
| D Overnight | don't know | D Not done/ | D Chorionic Villus | all that | | | | |
| hospital stay | | don't know | Sampling (CVS) | apply). | | | | |
| (hospitalized) | | | D Amniocentesis | D | | | | |
| How many | | | D Other tests to | Influenza | | | | |
| nights? | | | check on the | D | | | | |
| D. Como o otheru | | | health of your baby | Hepatitis | | | | |
| D Some other reason | | | (describe | B D | | | | Date |
| (explain): | | | below): | | | | | Date: |
| | | | | Hepatitis | | | | - |
| | | | | A D | | | | |
| | | | | Tetanus / | | | | |
| | | | | Diphtheria (Td) | | | | |
| | | | | D Tetanus / | | | | |
| | | | | Diphtheria Pertussis | | | | |



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

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Provider Number from Health Care Provider Log: _

Name of Provider Seen: _

Be sure to also write this provider's contact information in the

Health Care Visits and Overnight

Health Care Visit/Hospital Stay 16

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



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

Provider Number from Health Care Provider Log: _

Name of Provider Seen: _

Be sure to also write this provider's contact information in the

Health Care Visits and Overnight

Health Care Visit/Hospital Stay 17

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
|---------------------|-------------|-------------------|---|---------------------------------------|---|--|-----------|--|
| Reason for Visit | Weight | Blood Pressure | Pregnancy Care Procedures (tests to check on your baby's health) | Vaccination/ Shot/ Immunization | Other Tests and Procedures (tests to check on YOUR health) (For example, lab tests (blood, urine, etc.)) | Medications/ Other Treatments (For example, over-the- counter or | Diagnoses | Completed by Office or Self Date Reported to National |
| D Routine | | | (Check all that | D | | | | D Office |
| pregnancy | lb | / | apply) | No | | | | D Self |
| care | | | D Ultrasound or | D Yes (Specify | | | | D Sell |
| D Illness or injury | D Not done/ | | Sonogram | type below. Check | | | | |
| D Overnight | don't know | D Not done/ | D Chorionic Villus | all that | | | | |
| hospital stay | | don't know | Sampling (CVS) | apply). | | | | |
| (hospitalized) | | | D Amniocentesis | D | | | | |
| How many | | | D Other tests to | Influenza | | | | |
| nights? | | | check on the | D | | | | |
| D.Como othor | | | health of your baby | Hepatitis | | | | |
| D Some other reason | | | (describe | B D | | | | Data |
| (explain): | | | below): | | | | | Date: |
| | | | | Hepatitis | | | | |
| | | | | A D | | | | |
| | | | | Tetanus / | | | | |
| | | | | Diphtheria (Td) | | | | |
| | | | | D Tetanus / | | | | |
| | | | | Diphtheria Pertussis | | | | |



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

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Centers for Disease Control and Prevention

U.S. ENVIRONMENTAL PROTECTION AGENCY