



**828.252.1050**

**Our Doctors:**

**Dr. David Cobb, Jr. | Dr. Logan Lechner | Dr. Danica McAden | Dr. Jennifer Paltzer | Dr. Rebecca Seay**

We are located directly behind Taqueria Muñoz – ½ mile south of Biltmore Village

- PLEASE ARRIVE 15 MINUTES PRIOR TO YOUR APPOINTMENT TIME.
- PLEASE BRING COMPLETED PAPERWORK, PICTURE ID, AND YOUR INSURANCE CARD(S) TO YOUR APPOINTMENT.
- COPAYS AND PAYMENTS ARE DUE AT THE TIME OF SERVICE.
- DO NOT MAIL PAPERWORK BACK TO US. PLEASE BRING IT TO YOUR VISIT.
- IF YOU ARE MORE THAN 15 MINUTES LATE FOR YOUR SCHEDULED APPOINTMENT, YOU WILL BE ASKED TO RESCHEDULE. THIS IS IN CONSIDERATION OF OUR PATIENTS AS WELL AS OUR PHYSICIANS.
- IN THE EVENT THAT OUR PATIENT PARKING LOT IS FULL, THERE IS ADDITIONAL PARKING IN THE EMPLOYEE PARKING DECK BELOW OUR BUILDING.



GRACE OBGYN, PA
PATIENT INFORMATION

In order to comply with new national standards, meeting meaningful use, we must have answers to the following questions.

ACCOUNT # \_\_\_\_\_ DATE \_\_\_\_\_
PATIENT'S LEGAL NAME \_\_\_\_\_ RACE \_\_\_\_\_ ETHNICITY \_\_\_\_\_
SOCIAL SECURITY # \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_
MAILING ADDRESS \_\_\_\_\_
HOME ADDRESS (if different) \_\_\_\_\_
HOME PHONE \_\_\_\_\_ CELL \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_
EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_
OCCUPATION \_\_\_\_\_ EMAIL \_\_\_\_\_
NAME OF POLICYHOLDER \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_
SSN# OF POLICYHOLDER \_\_\_\_\_
EMPLOYER OF POLICYHOLDER \_\_\_\_\_
NAME OF CLOSEST LIVING RELATIVE/SPOUSE \_\_\_\_\_ PHONE \_\_\_\_\_
IN CASE OF EMERGENCY, NOTIFY \_\_\_\_\_ PHONE \_\_\_\_\_
NAME OF PRIMARY CARE PHYSICIAN \_\_\_\_\_ (We must have this information.)
HOW DID YOU HEAR ABOUT OUR PRACTICE? \_\_\_\_\_

INSURANCE POLICY HOLDERS DOB \_\_\_\_\_
(We must have this information in order to file your visit today.)

Lifetime Insurance Authorization: I hereby authorize the undersigned physician to release any information acquired in the course of my examination or treatment to the social security administration, or its intermediaries, or carriers involved in processing and collection of a claim. I understand that I am financially responsible for the charges not covered by this authorization.

Signature \_\_\_\_\_ Date \_\_\_\_\_

IF PATIENT IS A MINOR, PLEASE COMPLETE:

I, \_\_\_\_\_, give permission to \_\_\_\_\_ to examine my daughter \_\_\_\_\_.

Patient or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Witness \_\_\_\_\_ Date: \_\_\_\_\_



**Thank you for choosing Grace OBGYN for your obstetrical care!**

**Please complete ALL ENCLOSED FORMS and BRING THEM WITH YOU, along with the following, to your initial OB appointment:**

1. Insurance Card
2. Paperwork Completed
3. A list of all medications (prescription and over-the-counter), including vitamins and supplements

**Precertification:**

1. Call your insurance company to inquire about any deductible or co-insurance amount for which you will be responsible regarding your pregnancy.
2. During this phone call, please inquire about precertification for your delivery and approval for 48-hour vaginal delivery and/or 96-hour Cesarean Section.

We are happy to share this experience with you and look forward to taking care of you and your baby!

Sincerely,

The Physicians and Staff at Grace OBGYN

# PRENATAL GENETIC SCREEN

NAME \_\_\_\_\_ DOB \_\_\_\_\_ DATE \_\_\_\_\_

1. Will you be 35 years or older when your baby is due? Yes \_\_\_\_\_ No \_\_\_\_\_

2. Are either you or the baby's father adopted? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, which of you? \_\_\_\_\_

Is the birth family's medical history available? Yes \_\_\_\_\_ No \_\_\_\_\_

3. Do you or the baby's father have a birth defect? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, which of you? \_\_\_\_\_

What type of defect? \_\_\_\_\_

4. Have you, the baby's father or anyone in either of your close families ever had any of the following:

- |  |           |          |
|--|-----------|----------|
| • Down Syndrome (Mongolism)                                    | Yes _____ | No _____ |
| • Cystic Fibrosis  | Yes _____ | No _____ |
| • Hemophilia   | Yes _____ | No _____ |
| • Muscular Dystrophy   | Yes _____ | No _____ |
| • Other chromosomal abnormality                                | Yes _____ | No _____ |
| • Neural Tube Defect, Spina Bifida (open spine) or Anencephaly | Yes _____ | No _____ |
| • Fragile X Syndrome   | Yes _____ | No _____ |
| • Phenylketonuria  | Yes _____ | No _____ |
| • Any other type of mental retardation (indicate below)        | Yes _____ | No _____ |
| • Any other family disorder (indicate below)                   | Yes _____ | No _____ |
| • Any other type of birth defect (indicate below)              | Yes _____ | No _____ |

If yes, indicate the relationship to you or the baby's father: \_\_\_\_\_

Indicate the cause, if known: \_\_\_\_\_

5. In any previous marriage or relationship, have you or the baby's father had a child born, either alive or stillborn, with any birth defect not listed above? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what type of defect and who has it? \_\_\_\_\_

6. In any previous marriage or relationship, have you or the baby's father had a stillborn child or three or more first-trimester miscarriages? Yes \_\_\_\_\_ No \_\_\_\_\_

Have either of you had a chromosomal study? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, indicate who and the results: \_\_\_\_\_

7. Certain ethnic groups have increased risk of specific medical problems. If either you or the baby's father are any of the backgrounds listed below, please indicate if you have been tested for the specified problem and give the results.

- |  |           |              |              |              |
|--|-----------|--------------|--------------|--------------|
| • African American: Sickle Cell Anemia           | You _____ | Result _____ | Father _____ | Result _____ |
| • Jewish: Tay-Sachs Disease                      | You _____ | Result _____ | Father _____ | Result _____ |
| • Italian, Greek or Mediterranean: B-Thalassemia | You _____ | Result _____ | Father _____ | Result _____ |
| • Philippine or Southeast Asian: A-Thalassemia   | You _____ | Result _____ | Father _____ | Result _____ |
| • Not Applicable                                 | _____     |              |              |              |

8. Have you ever had any unusual craving for any substance other than food, such as clay, laundry starch, dirt, ashes, etc. during this pregnancy or at any other time? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what substance? \_\_\_\_\_

9. Excluding your prenatal vitamins and iron, have you taken any medication, prescription or over-the-counter, herbs or minerals, or used any recreational drugs or alcohol since becoming pregnant or since your last menstrual period?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, give name of medication or substance and time taken during pregnancy: \_\_\_\_\_

\_\_\_\_\_

**PLEASE COMPLETE ALL HISTORY INFORMATION AS IT PERTAINS TO YOU, THE PATIENT.**

NAME: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

PAST MEDICAL HISTORY			
Major Illness	If Yes, Date	Major Illness	If Yes, Date
Anemia		Hepatitis / Yellow Jaundice	
Arthritis		High Blood Pressure	
Asthma		High Cholesterol	
Back Problems		HIV / AIDS	
Blood Clots in Lungs or Legs		Irritable Bowel Syndrome	
Blood Clotting Disorders		Kidney Disease / Problems	
Blood Transfusions		Kidney Infections / Stones	
Broken Bones		Liver Disease	
Cancer		Migraines: [ ] w/aura [ ] w/o aura	
Chickenpox		Pneumonia / Lung Disease	
Colitis		Reflux / Hiatal Hernia / Ulcers	
Collagen Vascular Disease (Lupus)		Rheumatic Fever	
Depression or Anxiety (circle)		Seizures / Convulsions / Epilepsy	
Diabetes		Stroke	
Eating Disorders		Thyroid Disease	
Gallbladder Disease		Tuberculosis	
Glaucoma		Other:	
Heart Disease			

GYNECOLOGICAL HISTORY					
Problem	Yes	No	Problem	Yes	No
Abnormal Bleeding			Infertility		
Abnormal Hair Growth			Lichen Sclerosis		
Abnormal Pap Smear / Dysplasia			Osteoporosis		
Bartholin's Cyst / Abscess			Sexual Problems		
Breast Problems			Sexually Active / # of partners in last yr: _____		
DES Exposure			Sexually Transmitted Disease		
Endometriosis			Uterine Abnormality		
Fibroid Uterus			Urinary Leakage		

GYNECOLOGICAL SURGERIES			
Surgery	Yes	No	Date / Comments
Abdominal Surgery			
C/Section			
Dilation & Curettage (D&C)			
Hysterectomy [ ] Vaginal [ ] Abd. [ ] Lap.			
Hysteroscopy			
Laparoscopy			
Urinary Incontinence Surgery / Sling			
Vaginal Surgery			

OTHER OPERATIONS / HOSPITALIZATIONS			
Date	Diagnosis	Procedure	Findings

**PLEASE COMPLETE ALL HISTORY INFORMATION AS IT PERTAINS TO YOU, THE PATIENT.**

NAME: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

FAMILY HISTORY									
Illness	Mother	Father	Brother/ Sister	Child	Grandmother		Grandfather		Other
					Maternal	Paternal	Maternal	Paternal	
Alcohol									
Alzheimer's Disease									
Birth Defect									
Blood Clots in Lungs or Legs									
Blood Clotting Disorders									
Breast Cancer									
Colon Cancer									
Depression									
Diabetes									
Endometriosis									
Fibroid									
Heart Disease									
High Blood Pressure									
High Cholesterol									
Mental Illness									
Osteoporosis									
Ovarian Cancer									
Stroke									
Thyroid Disease									
Other:									

SOCIAL HISTORY	
Preferred Name:	Primary Physician:
Occupation:	Number of People in Household:
Marital Status (Circle one) Single Married Widowed Divorced Separated Living w/Partner	Name of Significant Other:
Education (Last Grade Completed):	How many days per week do you exercise?
Seat Belt Use (Circle one) Always Frequently Occasionally Never	Occupational Risk (Circle all that apply) None Bio-hazard Chemical Physical Labor
How many caffeinated beverages do you consume per day?	How many times per week do you drink alcohol?
Do you smoke? If yes, how many per day? Yes No	Do you use any of the following? (Circle all that apply) Cocaine Hallucinogens Marijuana Narcotics
Have you ever been or are you currently being physically, verbally or sexually abused?	Other Social History that you feel is important:

ANNUAL CARE	Yes	No	WHEN WAS YOUR LAST ...	Year
Do you examine your breasts?			Bone Density?	
Do you get 1200 – 1500 mg of calcium per day?			Colonoscopy?	
Have you seen your Primary Care MD in the last year?			Mammogram?	
Do you currently use contraception?				
If yes, what type of contraception do you use?				

**PLEASE COMPLETE ALL HISTORY INFORMATION AS IT PERTAINS TO YOU, THE PATIENT.**

NAME: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

OBSTETRICAL HISTORY						
	Full Term	Preterm ( < 20 wks)	Miscarriage	Abortion	Ectopic	
Number of times you have been pregnant:						
Number of children living:						
Number of adopted / stepchildren in the home:						
Pregnancy #	1	2	3	4	5	6
Pregnancy Outcome T = Full Term P = Premature M = Miscarriage						
Delivery Date						
Weeks at Delivery						
Number of Hours in Labor						
Epidural / Anesthesia						
Delivery Type V = Vaginal C = C/Section VE = Vacuum Ex.						
Did you have preterm labor?						
Delivery Location						
Who delivered your baby?						
Baby's Weight						
Baby's Sex						
Baby's Name						
<b>COMPLICATIONS (Check all that apply)</b>	1	2	3	4	5	6
4 <sup>th</sup> Degree Tear						
Gestational Diabetes / Insulin						
Infection / Separation of C/Section Incision						
Macrosomia (> 9 lbs)						
Multiple Gestation						
Post Dates (> 41 wks)						
Postpartum Hemorrhage						
Preeclampsia						
Preterm Delivery						

# CURRENT MEDICATION LIST

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Preferred Pharmacy & Location: (ABC Drugs, Patton Ave.) \_\_\_\_\_

Please TYPE or PRINT each medication you are taking, dosage (amount you take), frequency and prescribing MD. Also include any over-the-counter medications, vitamins and herbal supplements that you take frequently as well as medication allergies in the spaces provided.

	<b>MEDICATION NAME</b>	<b>DOSAGE</b>	<b>FREQUENCY</b>	<b>PRESCRIBING MD</b>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____
7.	_____	_____	_____	_____
8.	_____	_____	_____	_____

## **OVER-THE-COUNTER MEDICATIONS**

1.	_____	3.	_____
2.	_____	4.	_____

## **VITAMINS / HERBAL SUPPLEMENTS**

1.	_____	4.	_____
2.	_____	5.	_____
3.	_____	6.	_____

## **ALLERGIES TO MEDICATIONS**

<b>MEDICATION NAME</b>	<b>REACTION</b>
_____	_____
_____	_____
_____	_____

# Grace OBGYN

2 Yorkshire Street | Asheville, NC 28803  
(p) 828.252.1050 | (f) 828.253.0457

## Patient Release of Medical and/or Financial Information Authorization

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ MRN: \_\_\_\_\_

**\*\* PLEASE NOTE, IF YOU ARE 18 OR OLDER, BUT ARE STILL BEING SUPPORTED BY YOUR GUARDIANS/PARENTS YOU MUST SIGN FOR CONSENT REGARDING FINANCIAL INFORMATION. We cannot speak with your guardian/guarantor/parent about any bills, insurance information or payments unless you give financial consent.**

I, \_\_\_\_\_, give consent to Grace OBGYN to provide medical record information and/or financial information to the person(s) named below:

- |          |                     |
|----------|---------------------|
| 1. _____ | Relationship: _____ |
| 2. _____ | Relationship: _____ |
| 3. _____ | Relationship: _____ |
| 4. _____ | Relationship: _____ |
| 5. _____ | Relationship: _____ |

### Phone Calls and Voice Mail Preferences

May we leave messages on your voice mail regarding appointment reminders, return call messages, etc?

Home Phone:    Yes    No                      With Family Members:    Yes    No  
Cell Phone:    Yes    No

Please list any other specific instructions regarding phone calls and messages:

\_\_\_\_\_  
\_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Grace OBGYN Obstetrical Patient Financial Policy

We understand how confusing health care and insurance can be; therefore, in an effort to help you understand better, we have written a brief synopsis of how your pregnancy will be billed and paid.

Obstetrical fees are referred to as **GLOBAL** (a lump sum of services). Per your insurance company, the global fees are based on *routine pregnancy care*. Any services outside the scope of the defined global fee will incur an additional charge. These charges are typically your deductible and co-insurance amounts. Other charges include, but are not limited to lab work, ultrasounds, non-routine/non-pregnancy related office visits, other monitoring or tested as ordered by our physicians.

We contact your insurance company to verify all of your maternity benefits at the beginning of your pregnancy and encourage you to do the same. If you have any insurance changes during your pregnancy, please let us know as soon as possible to ensure proper billing.

Our Obstetrical Financial Policy requires that you pay a global co-insurance fee during the first four (4) months of your pregnancy. The first payment is due either at your initial or 2<sup>nd</sup> OB visit, with three (3) consecutive monthly payments to follow. Any remaining fees or additional charges will be paid based on your specific maternity benefits and are *in addition to your prepayment*. If you transfer to another practice during your pregnancy, your account will be billed for the time you were a patient in our practice.

All self-pay patients will be required to set up a payment plan to allow for your account to be paid in full within the first six (6) months of your pregnancy. Financial arrangements are made in our office.

### **FMLA/Disability**

- All FMLA and short-term disability forms, including any forms for your spouse, need to be submitted to our office *at least two (2) weeks* before they are due to your employer or insurance company.
- It is important that you sign the forms where your signature is required.
- Please make sure the patient's name is on the form.
- We need the information where the completed forms should be sent.
- If you know the time the doctor has taken you out of work, please indicate that on the form.
- As of January 2023, we will charge a administrative fee of \$25.00 for initial forms, and \$5.00/per additional forms.

### **Please Note:**

- Grace OBGYN does NOT accept Medicaid as primary or secondary; however, you may be eligible to use it for hospital and/or lab charges. If you have Medicaid (for hospital charges) and you wish to have a tubal ligation, you must inform us 60 DAYS PRIOR to the procedure to complete the mandatory forms for this procedure.
- We accept payment in the form of cash, check, Visa, MasterCard, Discover and CareCredit.

During your OB care at Grace OBGYN, the front staff are available at each visit to help you with any billing questions. If you need to contact someone directly you can send a portal message through Athena, email Kelsey Alexander at [Kelsey.alexander@unifiedhc.com](mailto:Kelsey.alexander@unifiedhc.com) or by calling the office at 828.252.1050.

# PREGNANCY . . . WHAT TO EXPECT

**CONGRATULATIONS!!** You are beginning a time of your life filled with excitement and questions. This information sheet is intended to be useful throughout your pregnancy. PLEASE READ it carefully before your first visit and KEEP IT HANDY for future reference.

## ROUTINE PRENATAL OFFICE VISITS

Your first office visit has been scheduled for \_\_\_\_\_ at \_\_\_\_\_ with

Dr. \_\_\_\_\_. This visit will last approximately three (3) hours.

After seeing the doctor, you will meet with a registered nurse who will discuss your medical history, give you information about nutrition, exercise, and laboratory tests, and answer any specific questions you may have. Please bring a list of any medications, vitamins, or herbal therapies you may use.

Your examination by your doctor will include a PAP smear if you have not had one in the past year and a vaginal probe ultrasound to confirm your baby's due date.

## LABORATORY TESTS

Labs are drawn in our office Monday through Friday between 8:15 am and 4:00pm. An appointment can be made to avoid excessive wait time if necessary.

Routine lab tests done at your first visit include:

Blood type	Hepatitis B	RH and antibody screen
Complete blood count	HIV	RPR
Urine Culture	Urine Drug Screen	Rubella titer

Other tests may be done to accommodate individual problems. As of November 1, 2007, NC state law requires HIV testing of all pregnant women unless a signed refusal is obtained. If a woman's HIV status is not known at the time of delivery, the infant will be tested within 12 hours of birth using a rapid HIV test. NC state law also requires a test for gonorrhea and chlamydia for all pregnant women.

Other lab tests performed during the course of your pregnancy include a hemoglobin, and one-hour glucola screen for gestational diabetes (done at 28 weeks), Group B Strep culture of the vagina/rectum (done at 36 weeks) Other optional tests may be offered, including a maternal serum quad screen and testing specific to any medical condition for which you may be treated. **Please read** any handouts given to you about these tests.

At your 12-week visit, you will be given additional information about the 2<sup>nd</sup> trimester of pregnancy by a registered nurse. At your 28-week visit, you will meet with a nurse and be given additional information about the 3<sup>rd</sup> trimester.

We will also discuss hospital admission forms, childbirth classes, and other available classes. This visit will last approximately 1.5 hours.

# GENERAL INFORMATION

## TELEPHONE CALL POLICY

Grace OBGYN Office Telephone Number: 828.252.1050,

Option 5 RN line, then....

**Option 1 URGENT ONLY**

**Option 2 financial**

**Option 3 all other concerns**

Any questions or problems should be brought to our attention as soon as possible.

If you notice or develop any health problems during your pregnancy, please notify our office and we will help you determine if you should see our doctor or be referred to another physician for the problem.

If you have problems or questions that you feel need immediate attention, call the office as early in the morning as possible (office phone hours begin at 8:30am). Please briefly tell the receptionist the nature of the problem and give a phone number where you can be reached during the day. The nurse attempts to return all calls **on the basis of urgency** and as soon as possible.

**AFTER HOURS CALLS** should be restricted to URGENT calls only. Please call our office number and your call will be directed to our answering service. They will page the on-call physician who will return your call as quickly as possible. Please make sure to keep your phone line open for the physician's return call and do not 'screen' your call to avoid a delay in responding to you. Please have your pharmacy telephone number available.

**Please Note: Telephone numbers with Caller ID or blocked numbers often cannot be returned. Please check your telephone number and remove this feature if you are awaiting a return call from our office or one of our physicians.**

## EDUCATIONAL MATERIALS

Learning about your pregnancy, labor and delivery, and your baby will relieve many of your fears and make this very important and exciting event easier for you. At your first office visit (and throughout your pregnancy), the nurse will provide a variety of information sources and handouts written specifically for our pregnant patients that will answer

many of your questions about pregnancy. If other questions come to mind as you read, please write them down and ask your doctor at your next office visit.

Although the internet can provide much information, sometimes it can be an overabundance and difficult to sift through.

Here are two websites which may be useful: [www.whattoexpect.com](http://www.whattoexpect.com) [www.strongmoms.com](http://www.strongmoms.com)

## FREQUENTLY ASKED QUESTIONS / PROBLEMS IN EARLY PREGNANCY

**BACKACHE** is very common during all stages of pregnancy. Simple backache can be helped by a firm mattress, good posture, and a heating pad (low setting). Any backache associated with cramping or contractions, bleeding or painful urination should be reported to the office.

**BLEEDING during the first trimester (12 weeks) is suggestive of a threatened miscarriage and should be reported immediately.** Bleeding may occur after a pelvic examination or intercourse. This is usually only spotting and should stop spontaneously. If it continues, notify the office.

**DENTAL PROBLEMS** can usually be handled by your dentist during pregnancy. Tell your dentist / hygienist that you are pregnant. General anesthesia should be avoided. Novocain is allowed. Avoid extractions during early pregnancy, if possible. Your abdomen should be shielded if X-rays are necessary.

**DIZZINESS** or "feeling faint" is a common symptom and is usually related to the normal lowering of blood pressure. Lying on your left side for 10-15 minutes when you feel lightheaded will usually correct the problem. Avoid becoming overheated or standing rapidly. Occasional dizziness may be secondary to anemia so recurrent problems should be brought to our attention at your routine visits.

**EXERCISE** is encouraged but **avoid** high-impact exercise. Walking (1-2 miles, 3 to 4 times per week), swimming and stationary bicycling are the best activities. Aerobic exercises should be low impact or specifically designed for pregnancy. Do not get overheated, over-tired, or allow your pulse to exceed 140 beats per minute. Consume additional water when you exercise. Prenatal yoga classes are available through Mission Hospital.

**SEXUAL INTERCOURSE** may be continued throughout pregnancy unless there are complications of bleeding, cramping, vaginal infections, preterm labor, or ruptured membranes. Spotting and temporary mild contractions occasionally occur after intercourse. Bleeding as heavy as a menstrual period or contractions continuing longer than an hour should be reported to your physician. After delivery, do not resume intercourse for four (4) weeks.

**LEG CRAMPS** are common during pregnancy. Adequate fluids, calcium and circulatory exercises will decrease the frequency of leg cramps. Avoid “pointing” your toes.

### **MEDICATIONS**

Please report any medications, vitamins, or herbal supplements you are currently taking. (See the medication list included in this packet in reference to over-the-counter medications.)

**NAUSEA AND VOMITING** are common in the first and third trimesters and can occur at any time during the day or night. Some practices to help minimize nausea and vomiting are small, frequent, high carbohydrate meals; popsicles; ginger ale; eating a few crackers before you get out of bed; getting up slowly and without making sudden movements. (You may also refer to the “Helpful Hints for Nausea and Vomiting During Pregnancy” handout included in this packet.)

Dehydration may result from prolonged vomiting. Call the office ASAP if you have not been able to keep down fluids for 24 hours or if you are not urinating several times a day.

**NUTRITION** is extremely important during pregnancy. You are eating for two, but that doesn't mean you need to eat twice as much. Your individual needs, habits and weight gain will be evaluated during your first visit with the nurse. Start by reducing your caffeine intake (sodas, coffee, tea). Do not consume decaffeinated products or artificial sweeteners.

Check labels for artificial sweeteners (aspartame, saccharine). Lean meats, fresh fruits and vegetables should be the staple of your diet. Limit seafood, fish, fried foods and other fats, and sweets (including cookies, candy and pastries).

### **ALL ALCOHOL SHOULD BE COMPLETELY AVOIDED!**

This includes beer and wine.

**SMOKING AND USE OF ALL TOBACCO PRODUCTS** is strongly discouraged during pregnancy. Serious fetal developmental problems have resulted from smoking. Miscarriage and premature delivery are also complications. We have information to help you stop smoking. We will discuss this with you during your first appointment. If you have not been able to completely quit smoking before your new OB appointment, begin to decrease your tobacco intake.

**TRAVEL** may be continued during an uncomplicated pregnancy. Automobile, train, cruise ship and airline travel is permitted. Cramping, bleeding issues or preterm labor will require limitation of travel. Vacations will likely be most enjoyable when taken during the second trimester (14-28 weeks). Trips requiring more than an hour should not be taken in the last month of pregnancy.

**WORKING** may be continued during pregnancy. **You will only be taken out of work for medical complications.** Employers usually do not recognize nausea, swelling, backache and other common discomforts of pregnancy as medical disabilities or complications. All work notes must be approved and signed by physician.

We hope this information answers some of your questions. Please make a list of any other questions you may have and write them down to discuss them with your doctor or nurse during any of your office visits. Urgent questions will be answered by phone according to our Telephone Call Policy.

**Thank you** again for choosing Grace OBGYN for your obstetrical care. We are happy to share this experience with you!

## **HELPFUL HINTS FOR NAUSEA AND VOMITING DURING PREGNANCY**

Eat small amounts of food every two (2) hours. Combinations that work will vary from person to person so experiment until you find what works for you. Some examples you can try:

- Carbohydrates with salt and high protein
- Potato chips and lemonade
- Pickles (Yes, PICKLES!)
- Mexican food (nachos and cheese)
- Potatoes, rice or pasta

If you become dehydrated, you will become more nauseated. **Drink fluids every hour.**

Sip – do not gulp. Fluids may be hot or cold. **ANY** fluid is allowed if it does not contain any alcohol. (Yes, Coke or Pepsi is even acceptable in this instance.)

If you cannot keep fluids down for 24 hours or you are not urinating at least 3-4 times per day, **please call the office.**

## **ACCEPTABLE OVER THE COUNTER MEDICATIONS FOR NAUSEA**

### **FIRST CHOICE**

- Vitamin B-6 – 25mg tablets three times a day (am, mid-day, bedtime)  
\*\*MAY ADD Unisom. NOTE: Unisom will cause drowsiness.
- Unisom sleep tabs – Doxylamine 12.5mg dose (you will need to cut 25mg tab in half)  
\*\* If you have trouble sleeping, you may take a whole Unisom (25mg) at the nighttime dose.
- It may take 2-3 days for this to work.

### **OTHER OTC OPTIONS**

\*\* You may use generic or pharmacy brands.

- Dramamine Less Drowsy (Meclizine)  
Use as package directs
- Dramamine (Dimenhydrinate)  
Use as package directs
- Emetrol (Dextrose, Fructose and phosphoric acid)  
Do not dilute or take with liquids.  
Do not use if you are diabetic.
- Ginger capsules, tablets, or wafers (found at natural food stores or pharmacies)  
\*\* Do not take more than one (1) Gram or 1000mg TOTAL of ginger in one day.
- Ginger ale or Ginger tea.
- Sea Bands (acupressure wrist bands) may also be helpful

These can be found at most local pharmacies.

If you have tried any/all of the above and have not experienced relief from your nausea, call the office and ask for a nurse to return your call.

## **MEDICATIONS DURING PREGNANCY**

Medications should be avoided throughout pregnancy, if possible, especially during the first trimester (the first 14 weeks). If you are taking a prescription medication prescribed by another physician, please call our office to discuss it with our Registered Nurse. Most herbal and homeopathic remedies have not been studied for the safety of use during pregnancy and should be avoided.

For more information on safety of medication and other environmental exposures, visit the Organization of Teratology Information Specialists website at [www.mothersbaby.org](http://www.mothersbaby.org).

### **OVER-THE-COUNTER MEDICATIONS / INGREDIENTS TO AVOID**

Afrin	Naproxen (Aleve)
Aspirin	Neo-Synephrine
Brompheniramine	Pepto Bismol
Ethanol (Alcohol- in many cough meds)	Phenylephrine (Sudafed PE)
Excedrin Migraine	Vitamin A
Ibuprofen (Advil, Motrin)	Zinc Preparations (Zi-Cam)
Kaopectate	Combination products that contain any of the above ingredients

### **COMMON SYMPTOMS AND SAFE MEDICATIONS TO USE DURING PREGNANCY**

The following over-the-counter medications MAY be used during pregnancy and are generally felt to be safe if taken as directed. ONLY take medications as/if needed.

#### **Allergies:**

- Claritin (Loratidine) – Take as directed
- Benadryl (Diphenhydramine) – 25mg every 12 hours
- Chlor-Trimeton (Chlorphenamine) – Take as directed
- Flonase (Fluticasone) – Take as directed
- Zyrtec (Cetirizine)

#### **Cold, Sinus or Flu:**

These conditions are treated according to symptoms. These illnesses are usually caused by viruses and are not treated with antibiotics. Call the office if your temperature exceeds 101°F or your nasal drainage is consistently green/brown for 2 or more days.

- Rest and drink extra fluids, especially water
- Use a cool mist humidifier (cleaned every 2 days with weak bleach/water solution, rinse well)
- For nasal stuffiness, use saline nasal spray. (Nettie-Pot, Saline Nasal Spray, Vicks VapoRub)
- Chlorpheniramine (Chlor-Trimeton)
- For cough, thick mucus or sinus congestion: Guaifenesin (Mucinex, Mucinex DM), or Dextromethorphan (Robitussin Plain, Robitussin DM) \*\*\* NOTE: Dextromethorphan may cause drowsiness.

#### **Constipation:**

- Drink 64oz of water
- Eat 3 servings of fruits and whole grain cereals/bran each day
- Eat prunes - Drink warm prune juice with 1 Tbsp melted butter mixed in
- Stool Softeners: Citrucel, Colace (Docusate), Metamucil
- Laxatives (only if necessary): Correctol, Milk of Magnesia, Miralax, Peri-colace, Senakot

**Diarrhea:**

- Immodium A-D (Loperamide) – Take as directed
- Lomotil (Diphenoxylate/Atropine) – Take as directed

**Gas:**

- Mylicon, Gas-X (Simethicone) – Take as directed

**Hemorrhoids:**

- To keep stools soft: Drink eight-- 8oz glasses of fluids each day; Eat fruit, bran/whole grain cereals
- Approved medications (if necessary): Anusol-HC, Preparation H, Tucks

**Headache:**

- Tylenol (Acetaminophen) – Take as directed
- Ice pack / Massage to the back of the head and neck

**Indigestion / Heartburn:**

- Maalox, Mylanta, Pepcid (famotidine), Tagamet (cimetidine), Tums

**Insect Bites / Rash / Sunburn:**

- 1% Hydrocortisone cream (in small amounts), Aloe Gel, Benadryl Cream, Caladryl Lotion, Oatmeal bath, Solarcaine, Sunscreen without PABA

**Leg Cramps:**

- Tums, Viactive Chewable Calcium

**Nausea / Vomiting:**

See “Helpful Hints for Nausea and Vomiting During Pregnancy” handout included in this packet. Call the office at 828.252.1050 (option 5, then option 3) if you have not been able to keep fluids down for 24 hours or if you are not urinating several times a day.

**Pain / Fever:**

- Tylenol (Acetaminophen) – 325mg (take 2 tablets every 6 hours as needed)  
500mg (take 1 tablet every 4 hours as needed)  
Do NOT exceed 3000 mg in 24 hours

**Sleeplessness:**

- Take a long, warm bath before going to bed.
- Drink warm milk. Warming milk releases tryptophan – a natural relaxant. (May use a minimal amount of chocolate, if desired.)
- Tylenol PM or Unisom may be used on occasion.

**Sore Throat:**

If your sore throat lasts longer than 2 days or is accompanied by a fever, call your primary care provider, and make an appointment to have a strep test.

- Alcohol-free Chloraseptic spray
- Cepacol lozenges
- Hall's cough drops (Zinc-free drops only)
- Warm saltwater gargle

**Yeast Infections:**

If you have treated a yeast infection once and still have symptoms, please call the nurse.

- Monistat