

Upload Letterhead, Design, Picture

**FOGSI Sampoorna**  
**PREGNANCY**  
**PASSPORT**

Upload Logo and Address

**Patient Name**

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**Age**

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**Contact Details**

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**Date of Passport**

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**Summary**

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## Current Information

Click any one box

Are you Pregnant?

Yes  No  Not Sure

Not Pregnant or Planning a Baby

Yes  No  Not Sure

## Previous Pregnancy details

Have you had any previous pregnancies?  Yes  No  Not Sure (If No, go to page 3)

If yes, how many?

.....

If ART, specify date of ET (embryo transfer)

.....

Specify Outcome(s) (e.g., live birth, miscarriage, complications)

.....

Did you have a vaginal or caesarean birth

.....

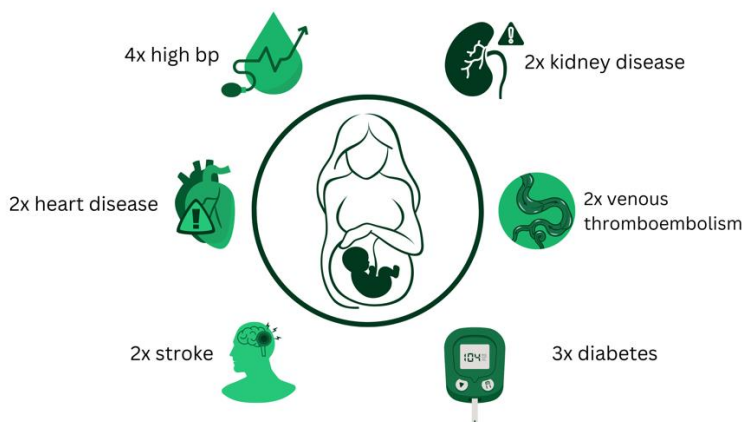
## Risk indicators-Previous Pregnancy

Have you had any pregnancy-related risk factors for diabetes and heart disease?

- Preeclampsia  Yes  No  Not Sure
- Gestational hypertension  Yes  No  Not Sure
- Gestational diabetes  Yes  No  Not Sure
- Placental abruption  Yes  No  Not Sure
- Preterm birth (<37 weeks)  Yes  No  Not Sure
- Fetal growth restriction  Yes  No  Not Sure
- Stillbirth/intrauterine death  Yes  No  Not Sure



## Women with high blood pressure & Gestational diabetes during pregnancy are at higher risk of future health events



### Did you know?

A history of high blood pressure and gestational diabetes in pregnancy does not mean you will definitely develop heart and diabetes problems, but you should have your current and future heart health and blood sugars monitored to reduce such risk.

## Your Medical History

Page 3

### BP/Sugar Before Pregnancy

- Did you have high blood pressure before pregnancy?  Yes  No  Not sure
- Did you have diabetes before pregnancy?  Yes  No  Not sure

### Chronic Disease

- Diabetes  Yes  No  Not sure
- High Blood Pressure  Yes  No  Not sure
- Thyroid issues  Yes  No  Not sure
- Heart disease  Yes  No  Not sure
- Obesity (BMI >30)  Yes  No  Not sure
- Underweight (BMI <18.5)  Yes  No  Not sure
- Endometriosis  Yes  No  Not sure
- Polycystic Ovary Syndrome (PCOS)  Yes  No  Not sure

Other: Specify \_\_\_\_\_

### Past Medical Conditions

- Have you had a heart attack or stroke?  Yes  No  Not sure
- Have you ever had any surgery?  Yes  No  Not sure

Specify Disease \_\_\_\_\_

### Transmissible diseases. Specify (Approx yrs of age) (And if Vaccinated)

- Tuberculosis: Specify (\_\_\_\_Age\_\_\_\_Vaccinated)  Yes  No  Not sure
- Rubella: Specify (\_\_\_\_Age\_\_\_\_Vaccinated)  Yes  No  Not sure
- Measles: Specify (\_\_\_\_Age\_\_\_\_Vaccinated)  Yes  No  Not sure
- Chicken Pox: Specify (\_\_\_\_Age\_\_\_\_Vaccinated)  Yes  No  Not sure

### Others

- Do you take any prescription medicines? Specify  Yes  No  Not sure
- Any Physical Disabilities - Specify  Yes  No  Not sure
- Any Psychiatric Illness - Specify  Yes  No  Not sure

### For those not Yet Pregnant

- Are your periods Regular  Yes  No  Not sure
- Have you been keeping track of ovulation cycle?  Yes  No  Not sure

## What you can do to reduce risks



Discuss with your Doctor



Test regularly



Take medications regularly



Exercise regularly

### Did you know?

All medical conditions are best treated before pregnancy. In pregnancy, many medications are not advised in pregnancy, so it's challenging to control them.



## Your Family History

### Family Medical History

- Has your mother or sister(s) had high BP or preeclampsia during pregnancy?  Yes  No  Not sure
- Does your mother, father or any sibling have high blood pressure?  Yes  No  Not sure
- Does your mother, father or any sibling have diabetes?  Yes  No  Not sure
- Has your mother, father or any sibling ever had a heart attack or stroke?  Yes  No  Not sure

### Genetic Medical History

- Were you and your husband related before you got married? (Consanguinity)  Yes  No  Not sure
- Any Genetic Conditions of family  Yes  No  Not sure

### Husband Medical History

- Does husband have any health problems? If 'Yes', what problem  Yes  No  Not sure
- Does husband drink alcohol? (\_\_\_\_\_glasses per day)  Yes  No  Not sure
- Does husband smoke? (\_\_\_\_\_cigarettes per day)  Yes  No  Not sure

## Lifestyle and Habits

### Weight & Height

Weight: \_\_\_\_\_ kg Height: \_\_\_\_\_

### Smoking

- Do you smoke?  Yes  No  Sometimes
- If yes, how many cigarettes per day? \_\_\_\_\_ per day

### Alcohol

- Do you consume alcohol?  Yes  No  Sometimes
- If yes, how often \_\_\_\_\_ drinks per week

### Exercise

- Do you exercise regularly?  Yes  No  Sometimes
- If yes, how many times per week? \_\_\_\_\_
- Type of exercise: \_\_\_\_\_

### Dietary habits

- Do you follow any specific diet or have any food restrictions  Yes  No  Sometimes
- e.g. vegetarian, low-carb, gluten-free
- If yes, please describe: \_\_\_\_\_

## What you can do to reduce risks



Couples must talk openly to Doctor



No Smoking/Drinking



Control body weight



Lifestyle changes may be needed

### Did you know?

Family History is important for Doctor to assess future complications. A good clean lifestyle helps both you and your child in a healthy pregnancy with less chances of complications

## Nutrition & Diet

### General Eating Habits

How many meals do you eat/day? \_\_\_\_\_

How much water do you drink daily? \_\_\_\_\_

### Digestive Issues & Dietary Concerns

Do you experience digestive issues like bloating, heartburn, or constipation? \_\_\_\_\_

### Nutritional Intake

Choose one option for food based on your regular consumption	Large quantities	Small quantities	Not regularly	Never
1. Fruits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Vegetables	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Dairy (milk, paneer, yogurt, cheese, chhaas)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Oils & Ghee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Rice, wheat (chapati, bread)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Pulses & Legumes (moong, toor, masoor, chana dal, rajma)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Eggs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Chicken	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Red Meat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Nuts & Seeds (cashews, almonds, peanuts, sesame, flaxseeds)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Any Medications, Supplements & Vitamins prescribed by a Doctor? \_\_\_\_\_

## Fitness & Exercise

Do you sit for a very long time during the day (at work or home)?  Yes  No \_\_\_\_\_

Do you have any medical conditions or injuries that restrict physical activity? \_\_\_\_\_

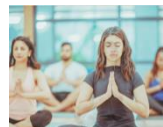
Choose one option	3/4 times/wk or More	Occasionally	Rare/ Never
1. Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Yoga	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Swimming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Gym	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Workouts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Dancing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Household chores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Strenuous physical activities (Specify _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Body needs  
7 - 8 hours of sleep



A diverse, rich, colourful  
diet throughout  
pregnancy helps



Most women need to  
do basic exercise as  
per Doctor's advise

### Did you know?

Good nutrition, diet and fitness before pregnancy helps avoid many possible complications for both, you and your baby



## Pregnancy Screening & Tests Records

LMP \_\_\_\_\_ Est. Due Date \_\_\_\_\_

<b>Date of visit</b>						
<b>No.wks pregnant</b>						
<b>Regular Checkup</b>						
Blood pressure <sup>†</sup> (mmHg)						
Weight (Kg)						
<b>Patient Examination</b> Medical conditions related to pregnancy (Bleeding, Pain)						
<b>Baby Track</b>						
Ultrasound results (measurements of fetal growth, anatomy scans, heart rate)						
<b>Tests</b>						
Haemoglobin (g/dL)						
TLC (Total Leucocyte Count test, wbc)						
Platelets (These cells help prevent bleeding)						
FBS (Fasting Blood Sugar)						
PLBS (Post Lunch Blood Sugar)						
RBS (random blood sugar)						
DIPSI (screening for gestational diabetes)						
HbA1C (blood test measuring avg sugar)						
TSH (A thyroid stimulating hormone )						
Urine R/M						
Hb electrophoresis (Hemoglobin electrophoresis)						
OTHERS						

### Never miss your health check-ups and tests

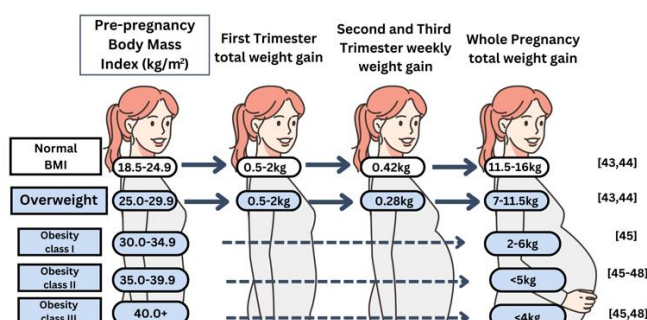
- ◇ Tracking your blood pressure is important to manage your heart health risk after pregnancy
- ◇ Body weight, body mass index, and waist circumference show overall picture of your health
- ◇ Urine analysis for proteinuria is a test of your urine used to detect and manage kidney disease and diabetes
- ◇ A low hemoglobin indicates that you have anemia and need treatment
- ◇ DIPSI is specifically to test Gestational Diabetes during Pregnancy
- ◇ HbA1c reflects your average blood sugar levels over the past 3 months
- ◇ Each case is unique and your Doctor knows your case the best, so always consult your Doctor and follow their advice fully
- ◇ Strictly Follow the schedule of visits and tests given by your Doctor
- ◇ Don't rely on hearsay or untrusted sources on the internet. TALK OPENLY TO YOUR DOCTOR

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Hb electrophoresis (Hemoglobin electrophoresis)						
OTHERS						

**Guidance on gestational weight gain for singleton pregnancy based on pregnancy BMI**



### Did you know?

Weight gain during pregnancy differs from person to person. Average indicators are not always appropriate. Your Doctor knows best

## Notes

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Dr. Name here

Address

Hospital Name1

Hospital Name2

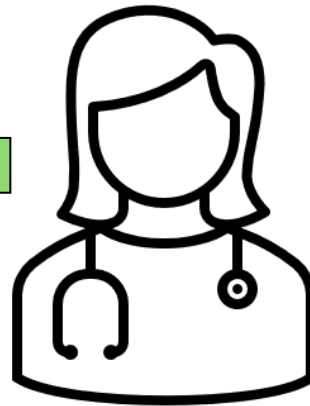
Nursing Home

Chairperson, Committee

HOD, College of

Contact No

Editable Doctor Credentials Box



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Promotion Committee

