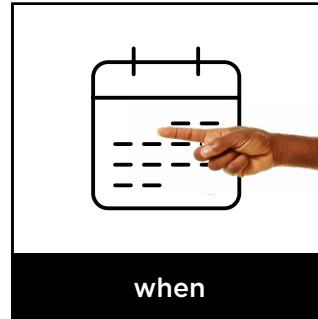
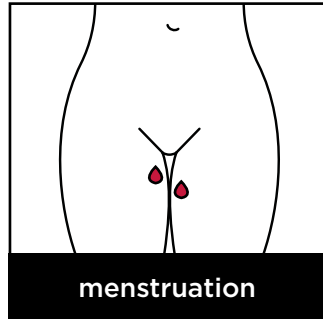
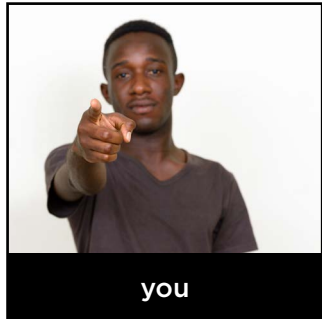


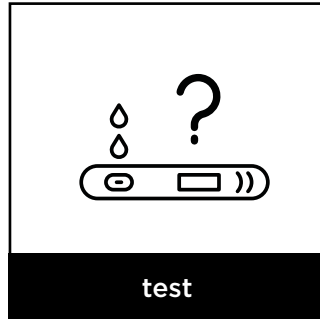
Prenatal Care

When was your last menstruation?

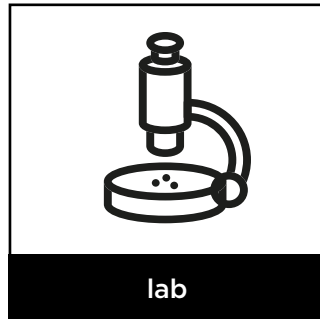
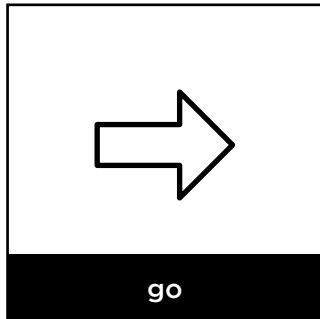


| | | | | | | | | | | | |
|---------|----------|-----------|---------|----------|----------|----|----|----|----|----|----|
| January | February | March | April | May | June | | | | | | |
| July | August | September | October | November | December | | | | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 |
| 25 | 26 | 27 | 28 | 29 | 30 | 31 | | | | | |

I need to test for pregnancy.



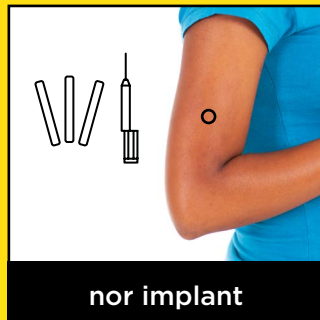
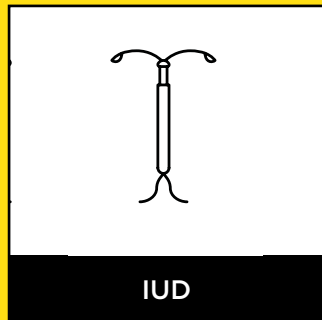
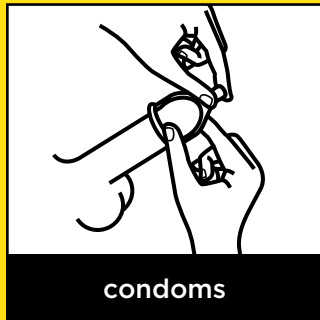
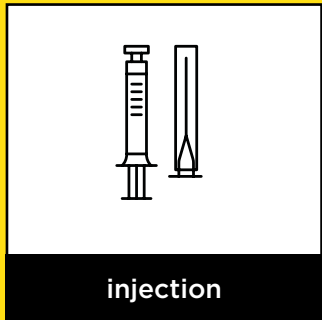
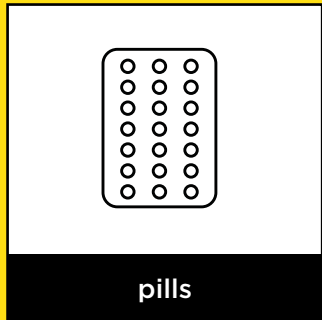
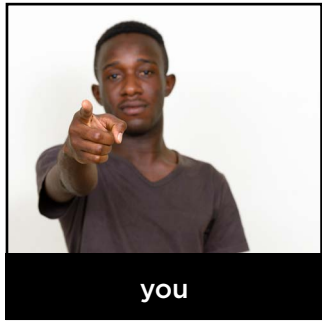
Go to the lab.



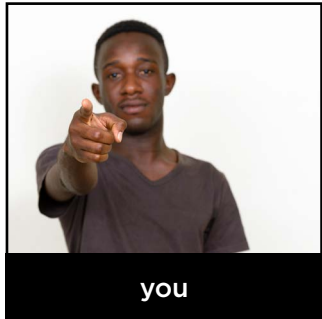
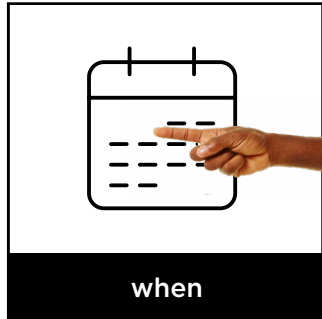
Provide some urine.



Were you using contraceptives?

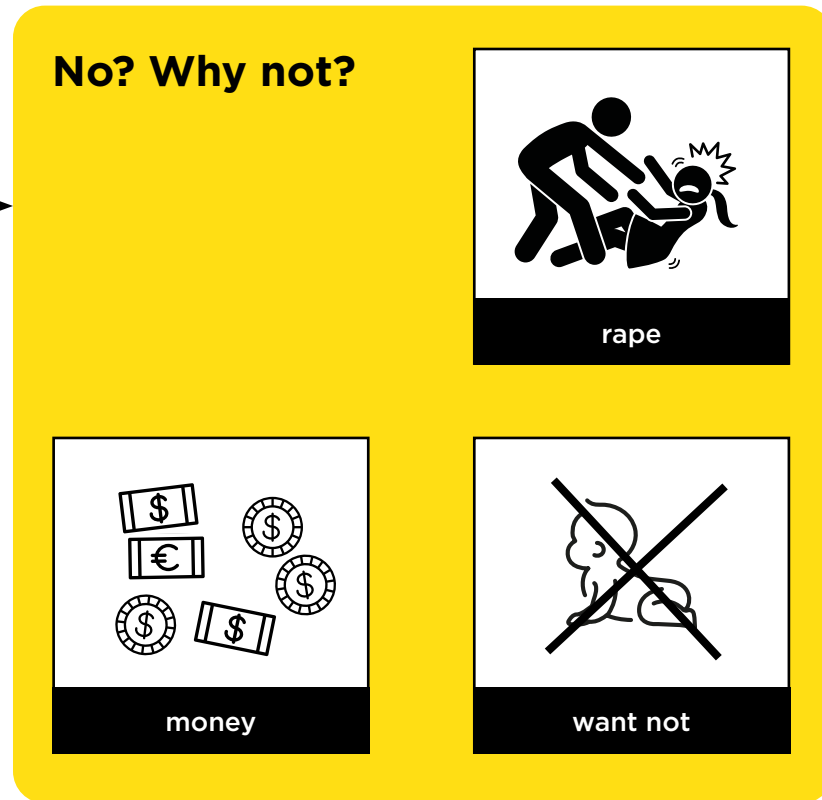
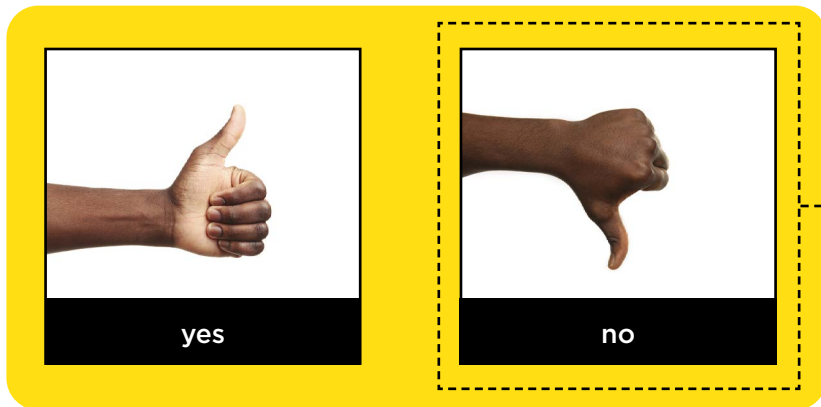
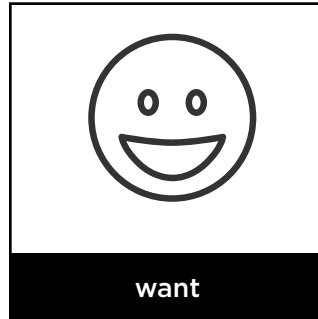
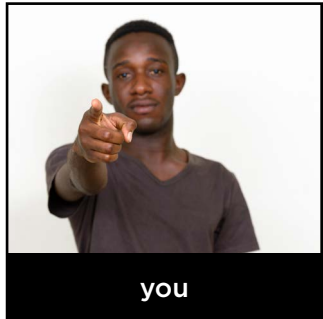


When did you stop?

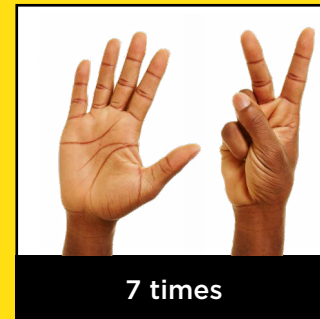
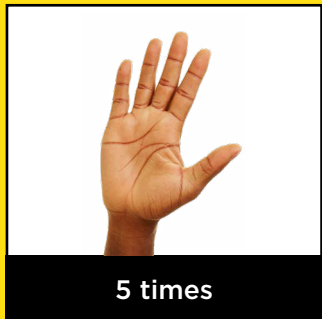
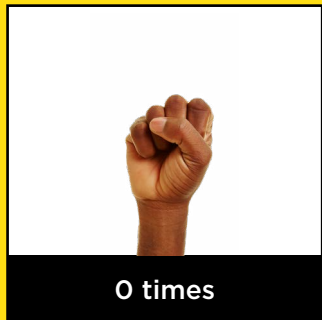
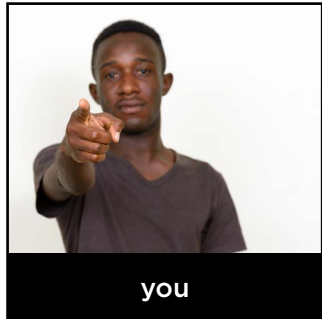


| | | | | | | | | | | | |
|---------|----------|-----------|---------|----------|----------|----|----|----|----|----|----|
| January | February | March | April | May | June | | | | | | |
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| 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 |
| 25 | 26 | 27 | 28 | 29 | 30 | 31 | | | | | |

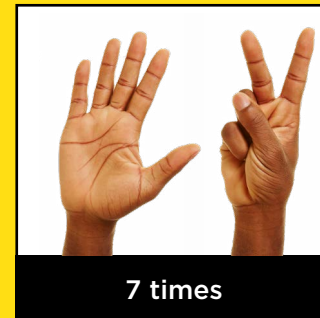
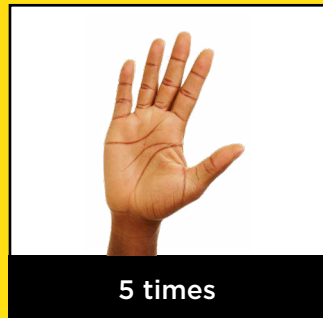
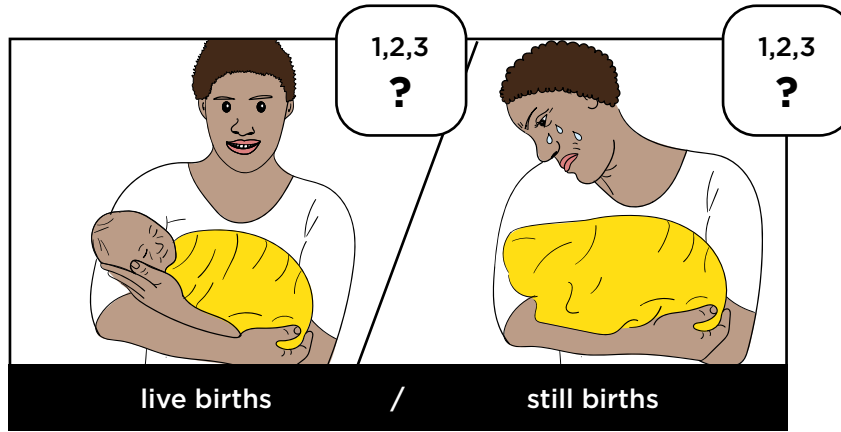
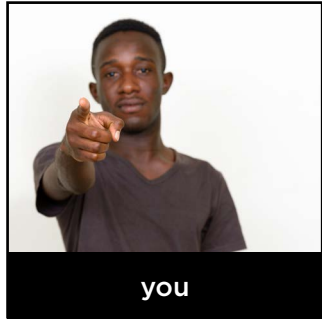
Do you want the pregnancy?



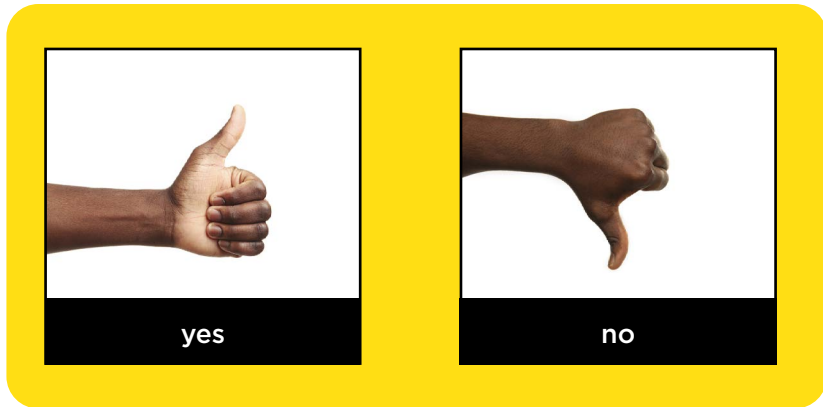
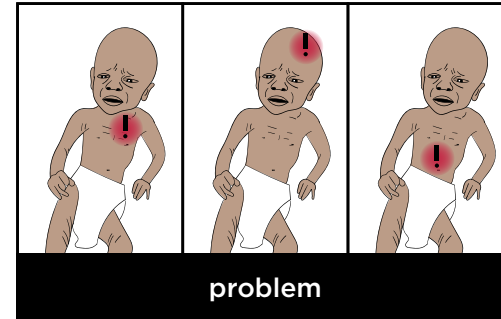
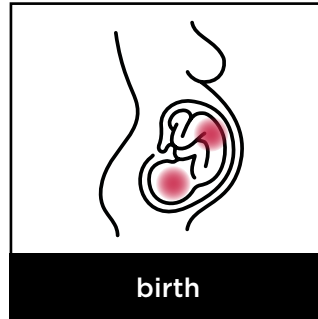
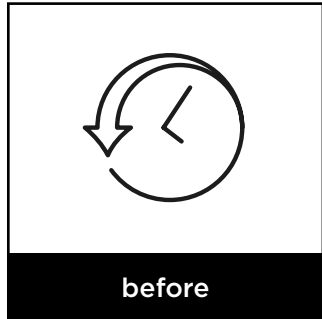
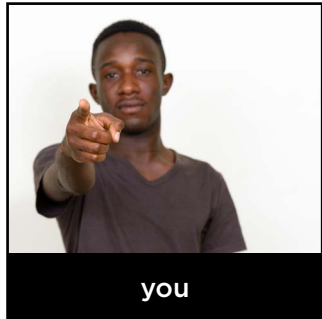
How many times have you been pregnant?



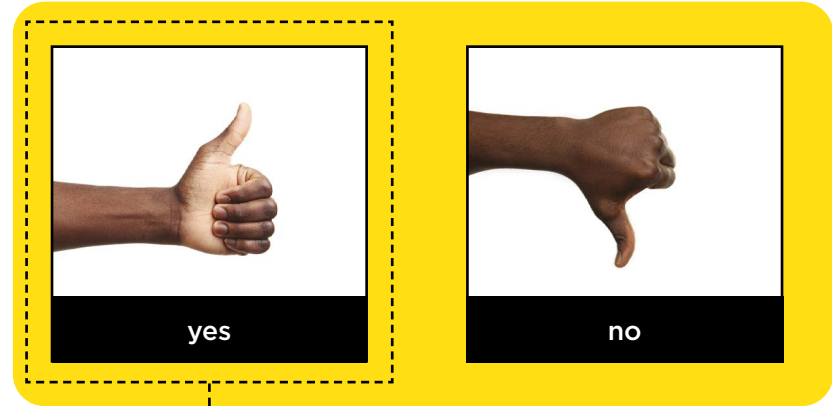
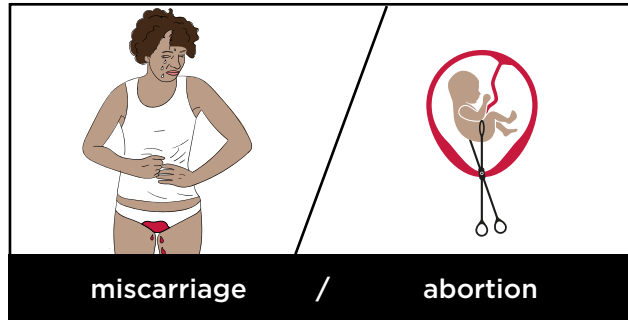
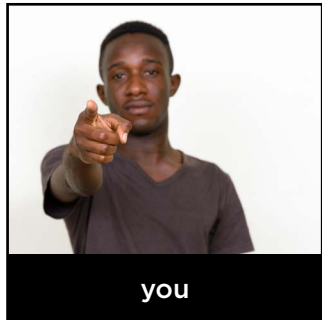
How many live births have you had?



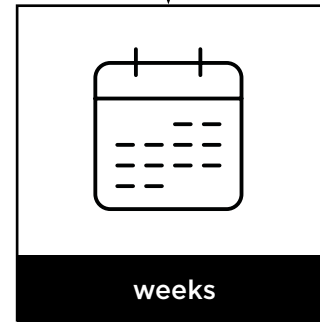
Did any of your previous babies have health or medical problems at birth?



Did you have a miscarriage or an abortion?

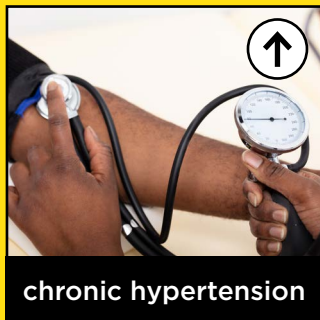
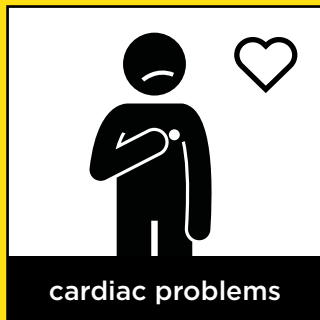
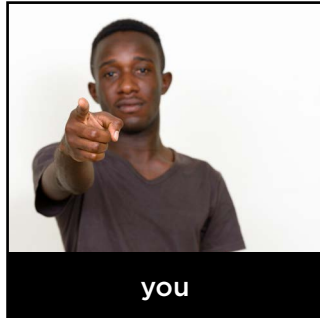


Yes? At how many weeks?

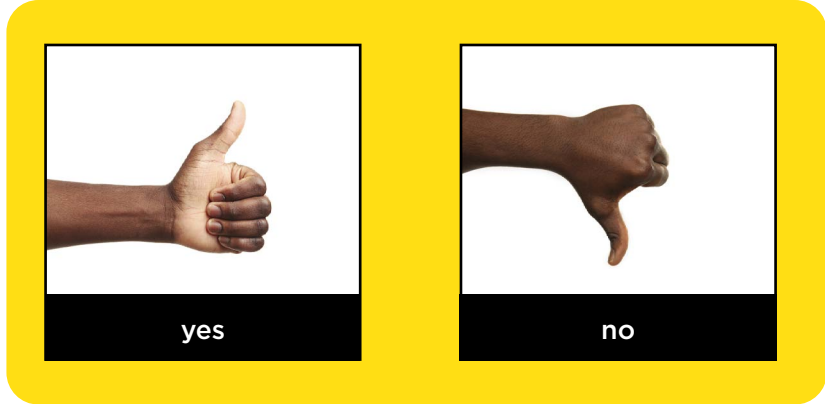
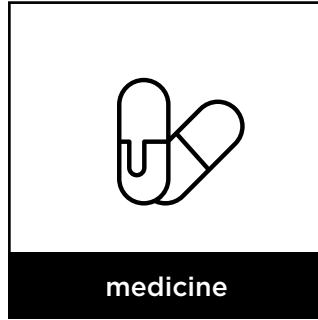
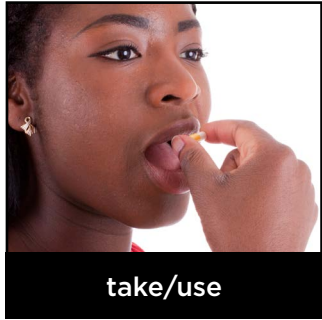
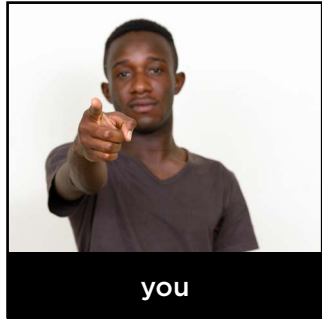


1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

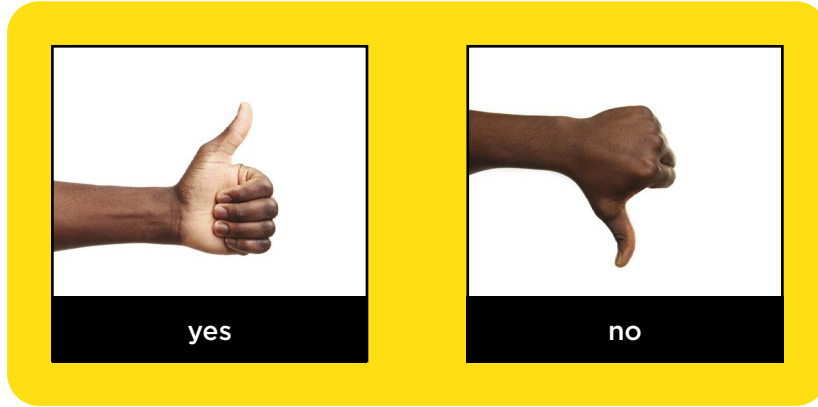
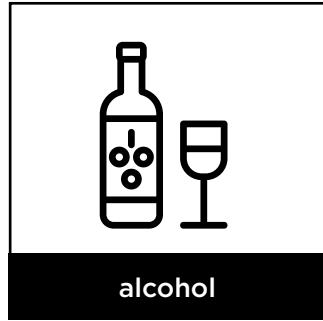
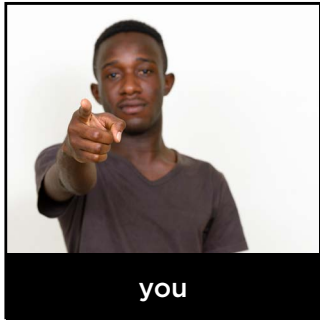
Do you have?



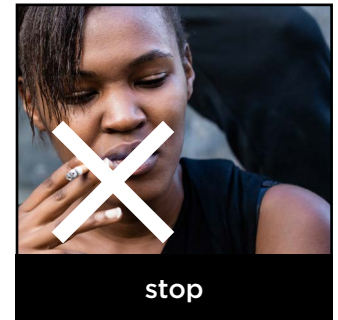
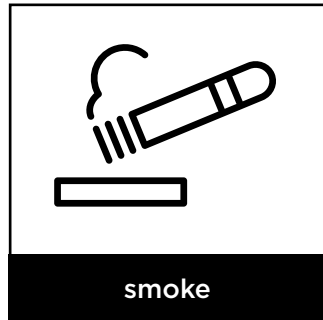
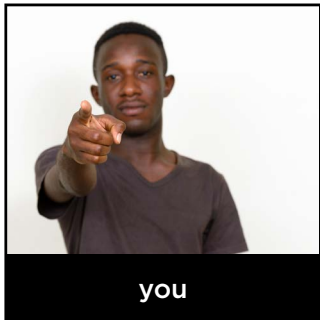
Are you taking any medication?



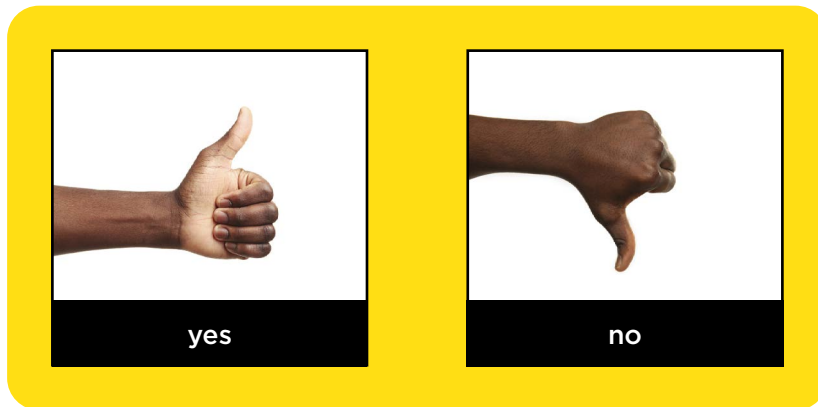
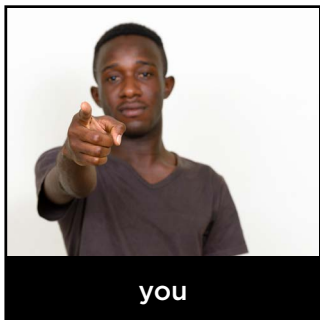
Are you drinking alcohol?



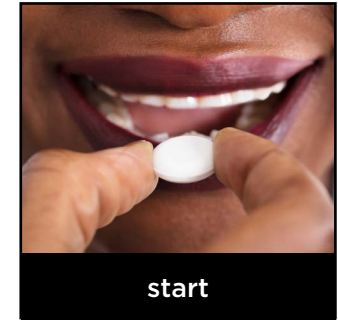
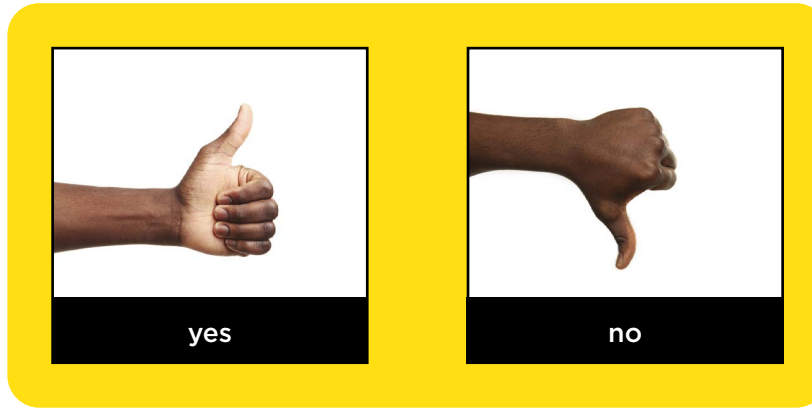
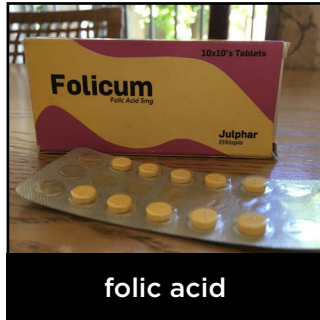
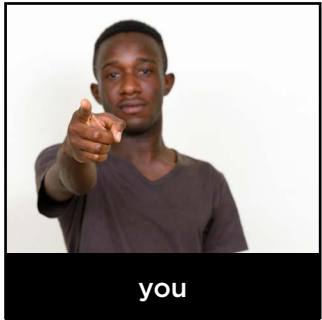
Are you smoking?



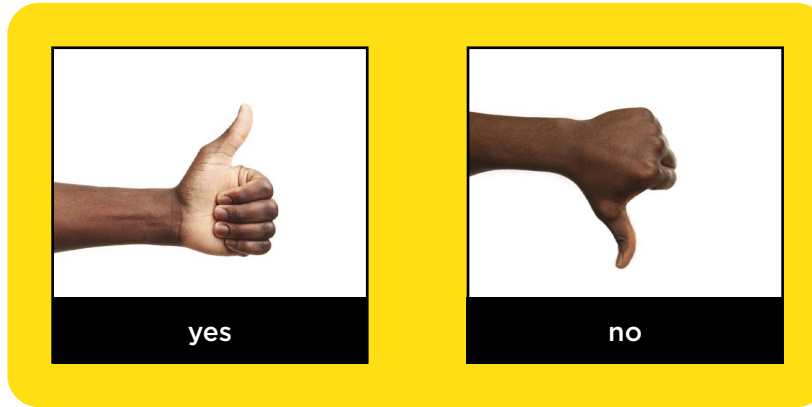
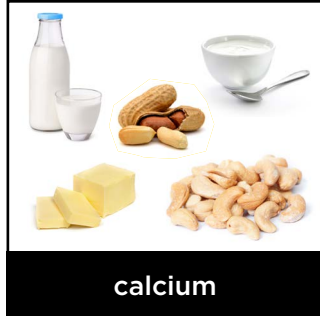
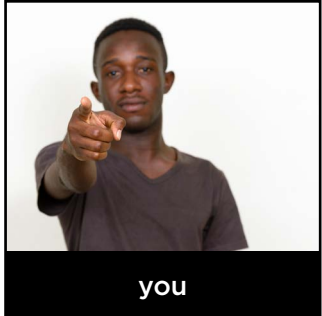
Are you using drugs?



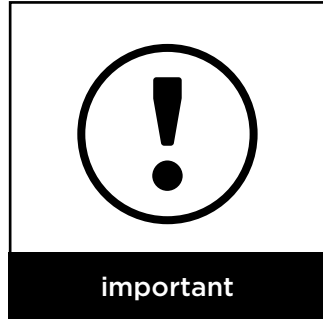
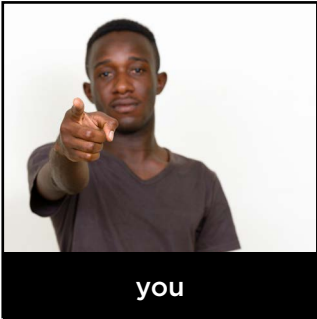
Are you taking folic acid?



Are you taking calcium?



Make sure to...



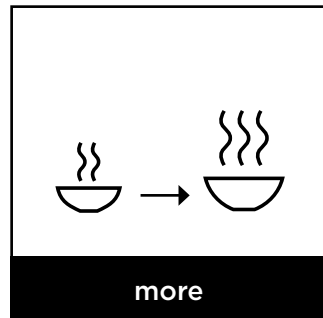
...take a balanced diet



...keep personal hygiene



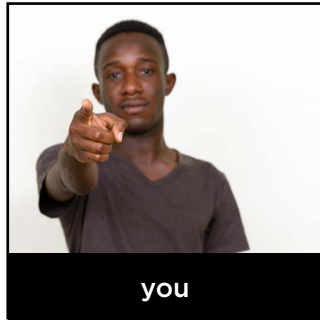
...eat more than usual



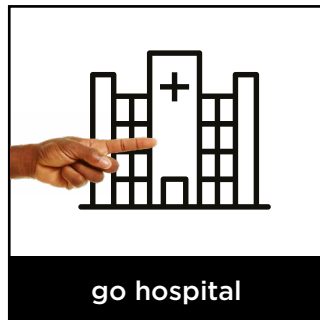
...take sufficient rest

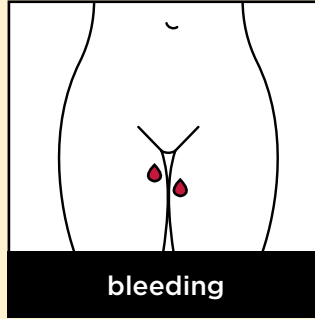

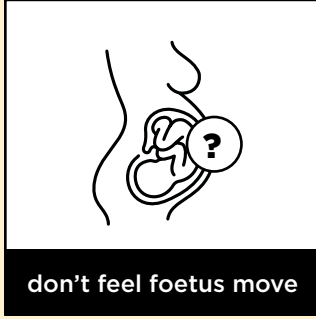

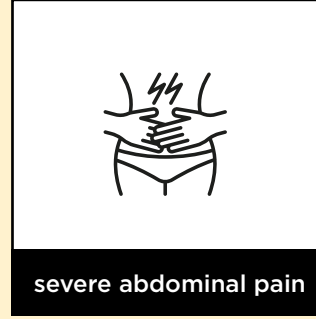

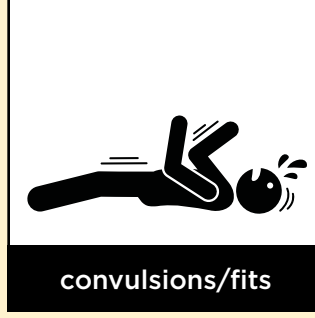
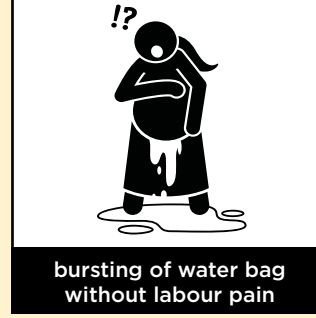



If you have any of these:

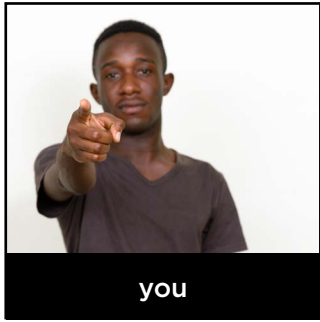


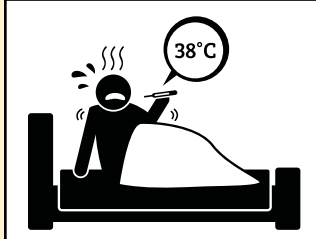
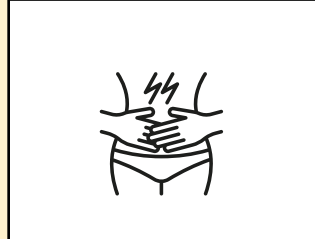



Go to hospital or health centre immediately!



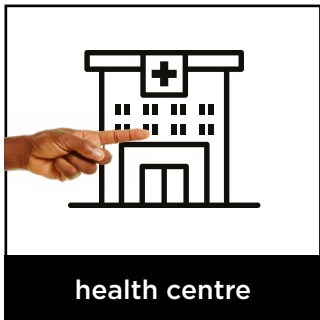
| | | |
|---|---|---|
|  <p>blurred vision</p> |  <p>bleeding</p> |  <p>severe headache</p> |
|  <p>don't feel foetus move</p> |  <p>leaking of fluid from the vagina</p> |  <p>severe abdominal pain</p> |
|  <p>fever and too weak to get out of bed</p> |  <p>convulsions/fits</p> |  <p>bursting of water bag without labour pain</p> |
|  <p>severe breathlessness</p> | | |

If you have any of these:

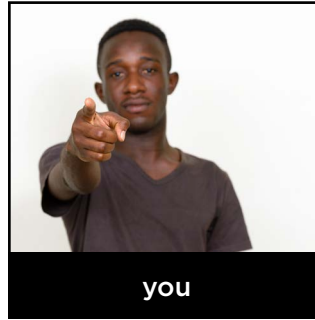
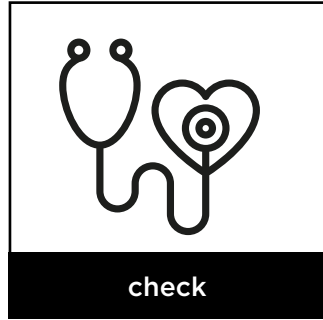
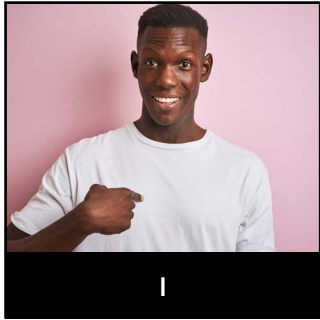


| | | |
|--|---|---|
|  <p>fever</p> |  <p>abdominal pain</p> |  <p>swelling of face, hands and legs</p> |
|  <p>feel ill</p> |  <p>nausea</p> | |

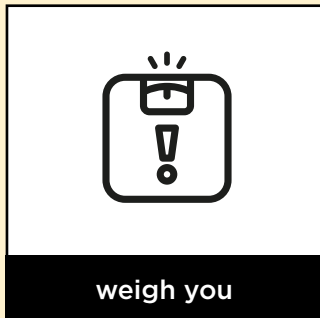
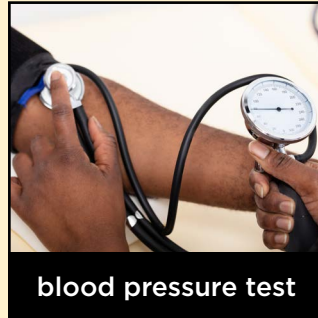
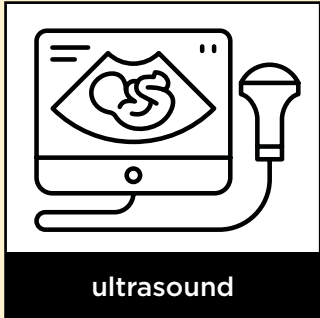
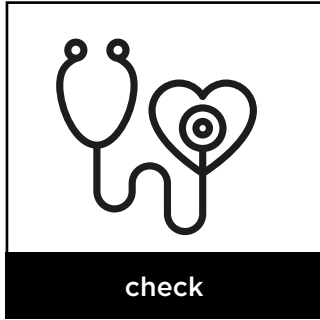
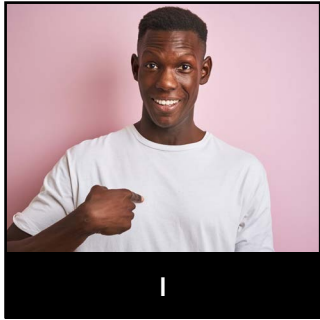
Go to health centre as soon as possible.



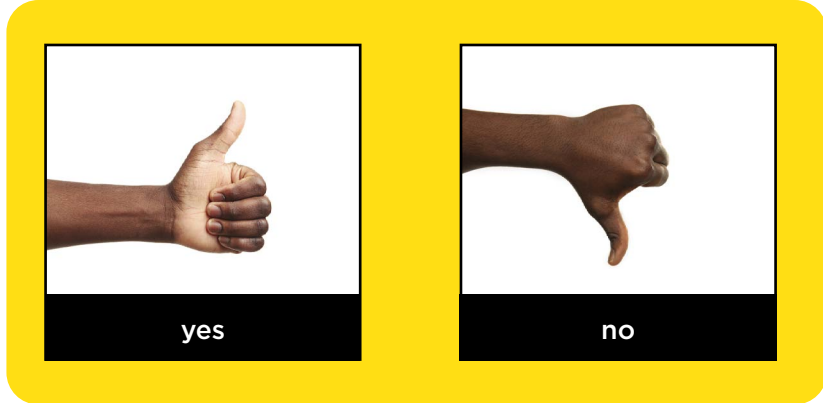
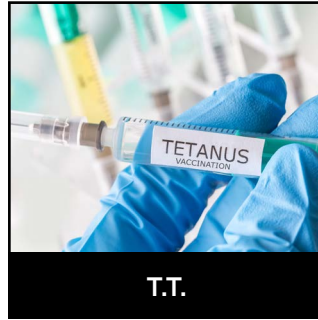
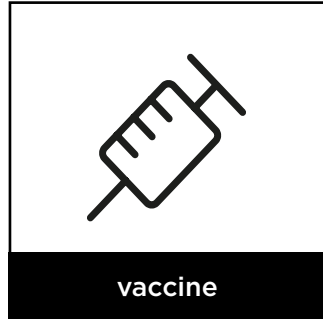
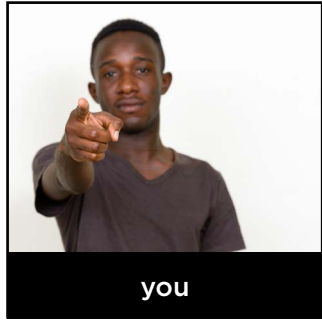
I will now check you for...



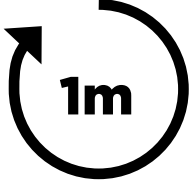
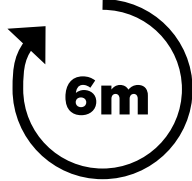
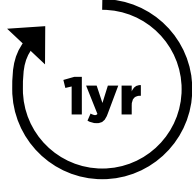
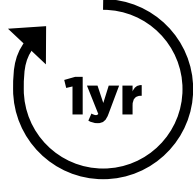

We will now do:



Have you had T.T. (Tetanus Toxoid) injections?



Injection schedule

| | | | | | |
|---|-------------|---|---|--|--|
| | #1 |  1m |  6m |  1yr |  1yr |
| | first visit | after one month | after 6 months | after one year | after one more year |
|  | | | | | |
| vaccine | | | | | |

