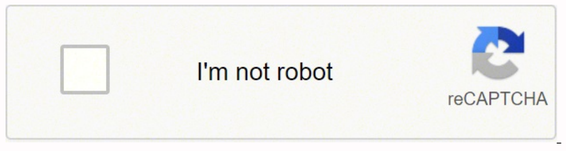

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Preconception care pdf template pdf files

lifestyle questionnaire

how healthy are you?

Maybe you need to lose weight, but you're pretty good about balancing the demands of your daily life. Or maybe you already eat healthfully but can't seem to find the motivation to exercise. Taking the Lifestyle Questionnaire will give you insight into how healthy your lifestyle is already—and what areas you can improve upon.

As you answer, be honest with yourself. Don't select the answer that you'd like to say is true; choose the one that best fits your lifestyle now. Regardless of whether you score on the low side—or do better than you thought—you'll have a snapshot of your current habits to compare your progress to in the future.

nutrition check

1. Do you agree with the following statement? "I'm usually aware of what and how much I'm eating."

a. Yes—I try to pay attention to my food because I enjoy it more.
b. It depends on how busy I am and whether I'm eating solo or with others.
c. No—in fact, I often eat at my desk, in the car, or while watching television.

2. How often do you feel "stuffed" or overly full after eating?

a. Rarely.
b. Occasionally.
c. Quite often.

3. How often do you skip meals? (And coffee doesn't count as breakfast.)

a. Rarely.
b. Sometimes—it depends on my schedule or if I'm not hungry.
c. Frequently—I don't eat breakfast, and lunch is often on the run.

4. How may 8-ounce glasses of water do you consume on an average day?

a. Five glasses or more.
b. Two to five glasses.
c. Less than two glasses.

5. How often do you snack on chips or other junk food? (Be honest.)

a. Rarely—and I pay attention to my portions.
b. A few times a week.
c. Frequently—I need my salt or sugar dose every day.

6. What type of protein do you usually consume?

a. Fish, beans, skinless chicken breast, extra-lean beef, or pork.
b. Chicken with the skin, or trimmed beef or pork.
c. Hamburgers, hot dogs, sausages, or marbled steaks.

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Preconception care guidelines. Preconception checklist pdf. Preconception care cdc.

National attention to preconception care interventions dates back to 1980 when the inaugural Healthy People initiative included a focus on the reduction of unintended pregnancies.1 The health objectives set forth in this initiative were designed to address the disparities in unintended pregnancy rates related to age and racial/ethnic group.2 These disparities were often associated with maternal risk factors3, 4 and subsequent adverse reproductive outcomes.5, 6 Preconception health care remains a strategic objective of Healthy People 2020.7 Despite reductions in the number of maternal deaths worldwide 8- maternal deaths in the United States have increased and birth outcomes in the United States are worse than many other high-income and even some low-income countries.8 In 2006, the CDC released Recommendations to Improve Preconception Health and Health Care - United States: A Report of the CDC/ATSDR Preconception Care Work Group and the Select Panel on Preconception Care.9 This report was published in an effort to improve reproductive health outcomes.9 However, in spite of these national and international efforts, there continue to be barriers to incorporating preconception counseling into routine primary care.10 To deliver on the promise to provide comprehensive care to patients, family physicians must possess the knowledge, ability, and skills to provide preconception care. A woman's personal childbearing goals (i.e., her reproductive plan) should be considered for discussion at each visit, regardless of her reason for the visit because her plans may change on the basis of changing life circumstances.24,25 Reproductive plan discussions with women who want to become pregnant or who may become pregnant should include assessment of risks due to age, maternal or paternal conditions, obstetric history, and family history.28 If a woman is sexually active and wants to prevent or delay pregnancy, comprehensive contraceptive services should be offered. Longer interpregnancy intervals (over 59 months) were also associated with poor outcomes. Due to the association of short interpregnancy levels with an increased risk of adverse perinatal outcomes, birth spacing should be discussed with patients.34 A meta-analysis on birth spacing and perinatal outcomes found that an interpregnancy interval of 18 to 24 months was associated with the lower risks of poor outcomes than intervals shorter than 6 months. Preconception care should also include counseling on immunizations. Transforming the way preconception care is delivered is critical to success. In order to successfully deliver preconception care, family physicians must understand the risk factors for- and the realities of-unintended pregnancy; recognize the value of reproductive planning in reducing these risks, and assess preconception health risks during chronic disease management visits and acute care visits that are not specifically focused on women's health or maternity issues. The postpartum visit provides one opportunity for interconception care; however, patient attendance is not guaranteed. Family physicians should provide counseling on lifestyle changes and appropriate medication adjustments for women who are diagnosed with hypertension.41 Women who have chronic hypertension should be counseled about preeclampsia and undergo a preconception assessment for ventricular hypertrophy, retinopathy, and renal disease to prevent end organ damage. STIs For all women of childbearing age and their partners, assess STI risk, provide counseling and immunizations as indicated to prevent acquisition of STIs, and provide indicated STI testing and treatment. Thirty-six percent of women aged 20 years and older are obese (body mass index [BM] greater than or equal to 30 kg/m2.40 It is essential to counsel women on obtaining a healthy weight prior to pregnancy because being obese increases the risk of pregnancy complications that include gestational diabetes, hypertension, macrosomia, birth trauma, and cesarean section,41 as well as increasing the risk of induced and spontaneous preterm birth.42 Compared with mothers who have a BMI in normal range, obese mothers have a higher likelihood of pregnancies affected by congenital anomalies, including NTDs, cardiovascular anomalies, and cleft palate.43 Women who have a BMI less than 18.5 kg/m2 are at increased risk for infertility,28 first trimester miscarriage,44 and preterm birth, and they are more likely to have an infant who has low birth weight.45 All women who have a BMI greater than 30 kg/m2 or less than 18.5 kg/m2 should be counseled about the risks their weight status poses to their own health and to future pregnancies; these patients should be offered specific strategies to improve the balance and quality of their diet and physical activity level.28 Chronic hypertension can increase maternal and fetal morbidity and mortality during pregnancy.46 All women of reproductive age should have their blood pressure checked during routine care. Your download should start automatically. The family physician should take into account the health risks and benefits of the timing of the subsequent pregnancy and should discuss effective contraceptive options. If diagnosed with hypertension, they should be counseled on lifestyle changes and medications that are safe in pregnancy. It was established on the 26th March 1993 as the Faculty of Family Planning and Reproductive Health Care. Alcohol use in pregnancy is the cause of fetal alcohol spectrum disorders (FASDs), a range of effects that include physical problems and behavioral and intellectual disabilities, and can have lifelong implications.39 All women of childbearing age should be screened for alcohol consumption and drug misuse. Barriers to Delivery of Preconception Care Traditionally, preconception care has focused on those patients planning a pregnancy and has primarily been delivered at the well-woman/preventive care visit. However, since 50% of U.S. pregnancies are currently reported as unintended at the time of conception, the timing of addressing preconception risks poses a challenge.2Additionally, until they are pregnant, many women of child bearing age do not seek care for themselves or may not have access to care.18 There are also barriers to achieving goals of interconception care; these goals include educating women about avoiding unintended rapid repeat pregnancy, following up on health risks identified during pregnancy, and transitioning into appropriate primary care. Women taking these medications who are planning a pregnancy or are not using an effective contraceptive method should strongly consider switching to a medication that is compatible with a healthy pregnancy. Medications should be prescribed/adjusted prior to conception, if appropriate. Preconception care should also address occupational hazards and exposures, sexually transmitted infections (STIs), and physical and emotional abuse. For example, mothers are present at over 98% of well-child visits for children from birth to 2 years of age.27 If a woman missed her postpartum care visit, her family physician would likely have an opportunity to address maternal risks during her child's routine health care visit.27 Key Concept Providing quality preconception care is the responsibility of all primary care providers, not just those who provide maternity care or handle a high volume of women's health. There are clinical practice guidelines based on good quality evidence for interventions that improve outcomes; this fact, strengthens the case for a more robust delivery of preconception services in routine primary care. Details and risk factors associated with previous pregnancies are integral to interconception care. Depression/Anxiety Disorders: Women of reproductive age should be screened for depression and anxiety disorders and counseled about potential risks of untreated illness. FSRH is a faculty of the Royal College of the Obstetricians and Gynaecologists. Current data shows that 3% of women of reproductive age are affected by diabetes.16 Poor glycemic control in the first trimester—before some women know they are pregnant—is associated with an increased risk of spontaneous abortion and congenital defects. 41,47 Other risks related to poor glycemic control include fetal macrosomia and associated birth trauma, stillbirth, and newborn hypoglycemia. If blood glucose remains uncontrolled during pregnancy, women with diabetes may have progression of any underlying retinopathy and/or nephropathy.48, 49 Women who have diabetes also have an increased risk of high blood pressure and/or preeclampsia during pregnancy.49 Optimal glycemic control can reduce, but not eliminate, risks. Preconception care is primary care and it should be a priority for primary care providers in all settings. Diabetes: Women who have diabetes should be counseled about the importance of glycemic control. Because preconception care and interconception care address the same risk factors, the term "preconception care" is used throughout this position paper to include issues related to interconception care, unless a distinction is required. In addition, clinical practice guidelines based on good-quality evidence have been developed for preconception interventions that improve maternal and fetal outcomes.24 Family physicians have a unique opportunity to make an impact by improving maternal and fetal outcomes in the United States. All women of reproductive of childbearing age who have diabetes should be counseled about the importance of glycemic control before pregnancy. All women of reproductive age should have their immunization status for tetanus-diphtheria-pertussis (Tdap); measles-mumps-rubella (MMR); and varicella reviewed annually and updated as indicated.52 In addition all women should be assessed annually to determine the need for vaccines that are recommended for those who have medical, occupational, or lifestyle risk factors for other infections. Yet, the delivery of preconception care has been less than satisfactory due to numerous barriers. The American Academy of Family Physicians (AAFP) outlines the following evidence-based recommendations for preconception care provided by family physicians. The U.S. infant mortality rate is higher than the majority of other high-income countries and has remained relatively unchanged in the past decade.11, 12 Prematurity and birth defects account for the majority of infant deaths in the United States, and interventions aimed at improving prenatal care have not been able to substantially improve these outcomes.13-15 To make matters worse, U.S. women ages 18 to 44 have numerous preconception risk factors that can negatively impact maternal and infant health; approximately 50% of these women are considered overweight or obese, 19% are current smokers, 10% have hypertension, and 3% have diabetes.16 The maternal mortality rate is also high in the United States. All women who wish to delay or prevent pregnancy should be offered the following: A full range of U.S. Food and Drug Administration (FDA)-approved contraceptive methods An assessment to identify safe methods using the U.S. medical eligibility criteria,29 Counseling to help choose a contraceptive method Prompt provision of the contraceptive method selected by the patient (preferably on site;- by referral-if necessary).30 Family physicians should use a tiered approach to present information on reversible contraceptive methods; information about the most effective methods should be presented first, followed by information on less effective methods.31, 32 Counseling should include an explanation that long-acting reversible contraception (LARC) is safe and effective for most women, including adolescents and women who have never given birth.29 Family physicians should use shared decision making and tailor information about contraceptive methods to focus on the patient's preferences; for some patients, efficacy may not be the highest priority.33 Routine counselling about emergency contraceptive methods and provision of emergency contraception when needed should also be components of comprehensive family planning services. The following are key interventions focused on addressing women's contraceptive needs and preconception risk factors. BMI = body mass index; NTDs = neural tube defects; STI = sexually transmitted infection For all women of childbearing age and their partners, family physicians should regularly assess STI risks, provide counseling and immunizations as indicated to prevent acquisition of STIs, and provide indicated STI testing and treatment.28, 58 Expedited Partner Therapy significantly reduces the risk of persistent infection.59 All women of reproductive age should be asked whether physical, sexual, or emotional violence from any source is happening currently or happened in the recent past, or during childhood.28 If a woman is being abused or has been abused in the recent past, the family physician should express concern and willingness to assist by giving support and referring the patient to appropriate organizations for help. For counseling, legal advice, and other services, women should be offered information about community agencies that specialize in cases of abuse. Some women may lose insurance coverage in the early postpartum period, which makes it difficult for them to get access to appropriate follow up care.16, 18 In 1990, Jack and Culpepper identified seven barriers to preconception care19: Women most in need of preconception care are the least likely to receive counseling Fragmented health care service delivery system Lack of treatment services for high-risk behaviors Inadequate physician reimbursement providing counseling services Lack of efficacy of counseling provided to unmotivated patients and their partner Limited number of conditions with evidence-based preconception interventions Lack of emphasis on risk assessment/health promotion in training programs.19 Unfortunately, most of these barriers still exist. If not download directly. Innovative strategies that incorporate preconception care into routine primary care visits are needed. All women of reproductive age should be advised to take a daily supplement (prenatal or multivitamin) of 400 to 800 mcg of folic acid daily and to consume a balanced, healthy diet of folate-rich foods.37 Folic acid supplementation starting prior to conception and continuing through 12 weeks of pregnancy reduces the risk of neural tube defects (NTDs) such as anencephaly, spina bifida, and encephalocoele.38 A higher dose of preconception folic acid (4 mg starting one month prior to attempting pregnancy and continuing through the first three months of pregnancy) is recommended for women at high risk for a pregnancy complicated by a NTD, and women who had a prior pregnancy complicated by a NTD, and women who have a personal or family history of NTD, insulin-dependent diabetes, or a seizure disorder (especially if it is treated with valproic acid or carbamazepine).39 Management of overall health and chronic conditions is crucial for proper preconception care. Chronic Disease Management Hypertension: Women of reproductive age should have blood pressure checks during routine care. She should also be informed about the risks and benefits of treatment options for depression and anxiety disorders during pregnancy. This position paper discusses the critical role family physicians play in preconception care and provides evidence-based recommendations addressing reproductive health care, which is essential to the promotion of healthy families. Preconception care offers family physicians and their patients an opportunity to discuss these risk factors so they can be minimized. Table 1 - General Recommendations for Preconception Interventions for Women Questions/Care Considerations: Reproductive Planning Discuss reproductive goals and issues at each visit When pregnancy is desired, discuss medications, health conditions, and activities that may affect fertility Folic Acid All women of reproductive age should be advised to take folic acid and to consume a balanced, healthy diet of folate-rich foods. Another important part of preconception counseling is addressing lifestyle risks—including alcohol, tobacco, and substance use—and providing resources and support for lifestyle modifications. Assess for use of teratogenic medications and optimize risk profile of medications Social and Behavioral History Assess social history, lifestyle, and behavioral issues that may affect pregnancy All women of childbearing age should be screened for alcohol consumption, tobacco use, and drug use. Family physicians should provide brief interventions that include describing the effects of drinking during pregnancy and warning that there are no safe levels of alcohol consumption during pregnancy.28,39 Tobacco smoking in pregnancy is associated with numerous pregnancy complications including spontaneous abortion, stillbirth, low birthweight, preterm birth, placenta previa, placental abruption, and cleft lip/palate as well as an increased risk of sudden infant death syndrome (SIDS).54-56 Family physicians should screen all women of childbearing age for tobacco use.28 Patients who use tobacco should be provided with brief interventions that focus on the importance of reducing smoking—and ideally, completely stopping smoking—prior to pregnancy; interventions should also include discussing tobacco cessation medications and referring patients for intensive services.28, 57 Similarly, family physicians should screen women of childbearing age for misuse of other drugs (recreational and prescription) and should provide brief interventions with referral to a treatment center or higher level care, as indicated. The majority of preconception health topics are important whether a woman desires a future pregnancy or not, so providing quality preconception care is essentially providing quality women's health care. Call to Action: Why Family Medicine Should Lead this Process Family physicians are ideally suited to lead healthcare system change related to preconception care. They are the most frequent provider of ambulatory primary care services to women aged 18-44.25, 26 They also play a major role in providing ambulatory primary care services to children and men.25 Family physicians have an outstanding opportunity to address health issues (e.g. preconception risk reduction and chronic disease management) with women in multiple settings. Immunizations Immunization status should be reviewed annually and updated as indicated. Women who have a chronic condition that poses a risk of serious morbidity to mother and infant, should be counseled to take the minimum number and the lowest dosages of medications that are essential to control the condition. For women who do not desire pregnancy, a plan for effective contraception should be discussed and initiated. Appropriate evaluation, counseling, and treatment for physical injuries, STIs, unintended pregnancy, and psychological trauma should be offered—including emergency contraception—if appropriate. A woman is 10 times more likely to die from childbirth related complications in the United States than in countries such as Austria or Poland and significant racial and ethnic disparities persist within the United States.17 Many of the potentially modifiable risk factors that affect future pregnancy outcomes occur prior to pregnancy. Preconception care is defined as individualized care for men and women that is focused on reducing maternal and fetal morbidity and mortality, increasing the chances of conception when pregnancy is desired, and providing contraceptive counseling to help prevent unintended pregnancies. Preconception Interventions for Women During routine care for women, family physicians should identify patients' childbearing goals, screen for risk factors that can impact future pregnancies, and provide indicated interventions to help women enter pregnancy in optimal health. Women who could become pregnant while taking angiotensin-converting enzyme (ACE) inhibitors or angiotensin II receptor blockers should be counseled about the adverse fetal effects of these medications and offered contraception. The term "interconception care" is used when referring specifically to care provided between pregnancies. If necessary, medications should be adjusted prior to conception. This timing decreases the exposure of the fetus to multiple medications and allows the medication dose to be tapered in order to minimize the risk of withdrawal symptoms.53 Treatment for depression and anxiety disorders during pregnancy should be individualized. This interval is consistent with the WHO's birth interval recommendation35 and the recommendation from the United Nations Children Fund (UNICEF) that breastfeeding for two years or more is optimal.36 The evidence on optimal birth spacing following spontaneous or induced abortion is currently insufficient. In a 2006 study, more than 95% of women surveyed recognized both the need to achieve optimal health prior to conception and the benefit of receiving information prior to conception.20However, a majority of women did not recall receiving any preconception counseling.20 In addition, while the majority of preconception counseling is important,21 most neither provide nor recommend counseling for their patients of childbearing age.22 Another study showed that in 2015, the number of women receiving preconception care services during ambulatory care visits (OB-GYN or FP) is only 14%.23 Changes in the current healthcare landscape are removing some of these barriers through expanded health insurance coverage, improved reimbursement for preventive services, and public health initiatives. a35e4ba6ad0bd02e1aaa2d2806e5bd84 Published on: 1 August 2016 Updated Document - Please note, this document was updated in September 2016. When possible, known teratogenic medications should be switched to safer medications before conception. Mental health assessment should be included in preconception care.53 Mood and anxiety disorders are highly prevalent among women of reproductive age, and there is a high prevalence of new psychiatric illness or relapse of a preexisting illness during pregnancy.53 Controlling depression and anxiety disorders prior to pregnancy may help prevent negative outcomes for a woman's pregnancy and her family; women of childbearing age should be screened for these disorders.53 If a woman who has depression or anxiety disorder could become pregnant or is planning a pregnancy, her family physician should inform her about the potential risk of untreated illness during pregnancy. Women at high risk for NTDs should take higher levels of folic acid Contraception When pregnancy is not desired, discuss safe sex and effective contraceptive methods Offer a full range of contraceptive methods and provide appropriate contraceptive counseling that is tailored to each patient's preference Counsel women on the importance of birth spacing Family and Genetic History Assess pregnancy risks on the basis of maternal age, maternal and paternal health, obstetric history, and family history Weight All women with a BMI greater than or equal to 30 kg/m2 or less than 18.5 kg/m2 should be counseled about infertility risk and risks during and after pregnancy. Benefits of Preconception Care Infant mortality is often used as a key indicator of the overall health of the nation. All women of childbearing age should be screened for the use of teratogenic medications and should be counseled about the potential impact of medications for chronic health conditions on pregnancy and fetal outcomes. Our specialist committees of SRH doctors and nurses work together to produce high quality training programmes, specialist conferences and events, clinical guidance and other SRH learning resources Faculty of Sexual and Reproductive Healthcare 10-18 Union StreetLondonSE1 1SZ Quick links As providers of preventive health and chronic disease care for men and women during their reproductive years, family physicians are well-positioned to proactively care for women, men, and families prior to, during, and after pregnancy. Women who have suboptimal diabetes control should be encouraged to use an effective contraceptive method.41 Assisting women who have diabetes and other chronic conditions with reproductive planning and optimal timing of pregnancy is an essential component of quality preconception care. Counseling on medication usage is an important part of preconception care.28 Approximately 10% to 15% of congenital anomalies in the United States are attributed to prescription medication use during pegnancy.41 Since the late 1970s, the use of prescription medications in the earliest weeks of pregnancy has increased by more than 60%.50 One study found that in 2006 to 2008, 82% of women reported taking at least one prescription or over-the-counter (OTC) medication in the first trimester.51 Many commonly prescribed medications are considered unsafe in pregnancy. Examples include ACE inhibitors, angiotensin receptor blockers (ARBs), warfarin, valproic acid, lithium, statins, and methotrexate. Physical/Sexual/Emotional abuse All women of reproductive age should be screened for current, recent past, or childhood physical, sexual, or emotional interpersonal violence and referred to appropriate resources when needed. Counseling on birth spacing should be individualized on the basis of a woman's reproductive plan.

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