



Frequently asked Questions for Pregnant Patients

What are my doctor's credentials?

We invite you to visit our website at www.completewomenscarecenter.com to learn about our physicians.

How many weeks/ months am I?

We measure pregnancy from the first day of your last period. There are 40 weeks in the average pregnancy, with the assumption that you conceived 2 weeks after your period started (you are only actually pregnant for the last 38 of the 40 weeks). When counting in months, start from the conception date, not the period date. So, if you are 10 weeks pregnant you got pregnant 8 weeks, or 2 months ago. If you did not get pregnant at the average time (you ovulated earlier or later than the 14th day), your due date will be based on the measurements from your first ultrasound.

We also commonly talk about “trimesters” (or thirds) of the pregnancy. The first trimester includes up to 13 weeks, the second trimester is 13-26 weeks, and the third trimester is 26 weeks until delivery.

When should I tell people that I am pregnant?

About 15% of diagnosed pregnancies end in miscarriage. The good news is that 85% don't. In most cases of miscarriage the embryo stops growing before the cardiac system is developed, and we never see a heartbeat on ultrasound. Once we see a heartbeat, the risk of miscarriage is much lower. If the baby has a heartbeat after 8 weeks from the last period, the risk of miscarriage is less than 5%. After 12 weeks, the risk is less than 1%. Many patients choose to wait to tell others about the pregnancy based on these statistics. This is a personal choice which depends on how you would feel about others knowing that you had a miscarriage, if this should occur.

What/how much should I eat during pregnancy?

We need an average of only 300 extra calories daily during pregnancy (one bagel or ½ a deli sandwich). “Eating for two” will result in excessive weight gain. Most women will lose only 15-20 pounds in the first few weeks postpartum, with the rest stored as fat, so weight gain of 20-30 pounds is ideal (0-5 pounds in the first 12 weeks, and ½ pound-1 pound a week after that). Eat small frequent meals to avoid heartburn and hypoglycemia. Eat what you enjoy, but make healthy choices and go easy on sugars and starches to prevent excessive weight gain and gestational diabetes.

Certain fish accumulate high levels of mercury from swimming in polluted waters. The FDA recommends avoiding those fish that are highest in mercury, including shark, tilefish, swordfish and king mackerel. Shellfish, shrimp and smaller fish such as snapper, catfish and salmon are lower in mercury, and up to 12 ounces a week is recommended. Canned tuna is low in mercury and can be included in the total of 12 ounces a week. Tuna steak is higher in mercury than canned tuna, and should be limited to 6 ounces a week. (If you would like more information on fish in pregnancy, go to www.epa.gov/waterscience/fishadvice/advice.html).

Unpasteurized cheeses and deli meats can carry Listeria, a bacterium that can cause miscarriage and fetal infection. While this is extremely uncommon in the USA, it is wise to avoid

regular intake of unpasteurized dairy products or deli meats for this reason. Listeria is killed by high temperatures so deli meats heated in the microwave until steaming are certainly safe. Highly processed meats such as hotdogs contain chemicals that are not healthy for any humans, pregnant or not. While there is no evidence of direct fetal harm caused by eating hotdogs or other highly processed meats, we recommend making healthier choices except on rare occasions.

Raw fish and meat can carry parasites and other microbes that could cause potential harm to the mother and fetus. While these infections are extremely rare, it is wise to avoid raw meat and fish for this reason.

There is no safe limit of alcohol in pregnancy. Complete avoidance is the best policy. Caffeine is safe in small quantities (1-2 caffeinated beverages daily).

There is no scientific evidence that nutrasweet (aspartame) or other sugar substitutes are harmful in pregnancy.

Can I exercise?

Staying active is great for you and the baby. If you have an uncomplicated pregnancy you can continue your current exercise regimen with a few modifications. When doing cardiovascular exercise (walking, running, biking, elliptical trainer) a good guideline is to keep your heart rate at a maximum of about 140 beats per minute. This will allow blood flow to go to the uterus as well as your large muscles. If you are working out with weights, modify exercises that require you to be flat on your back or flat on your stomach after 12 weeks. Cut out abdominal exercises, they won't be effective.

If you are not a regular exerciser, walk for 20-30 minutes 3-5 times a week, and consider a prenatal yoga or pilates class (we can recommend one).

Occasionally complications such as bleeding, preterm labor or high blood pressure will prevent you from being able to exercise, but for most women regular exercise is a great way to prevent excessive weight gain, reduce stress, and keep the physical strength necessary to deliver and take care of a new baby.

What about sex?

Sex is safe in pregnancy unless you have complications such as bleeding, preterm contractions or a low-lying placenta. While sex may make you have mild contractions, it will not make an otherwise healthy pregnant woman go into premature labor. Unless we tell you otherwise, continue your normal sexual practices if you want to.

Can I get my hair colored?

Hair color including highlights are safe during pregnancy. The portion of hair that is outside of the scalp is dead tissue and does not absorb anything into the bloodstream.

Can I paint my baby's room?

Inhaling volatile paint fumes is not good for any human, pregnant or not. While normal casual exposure to paint does not cause birth defects, use good judgment if you are painting and make sure the room is well ventilated.

Can I take a bath?

Exposure to very high temperatures (more than 103 degrees F) for long periods of time in baths, hot tubs or saunas can increase the risk of spina bifida during the first 2 months of pregnancy.

Normal temperature baths (98-101 degrees) are safe and can be very relaxing. If you are concerned, put a thermometer in your bathtub.

Can I travel?

If you have an uncomplicated pregnancy it is safe to travel until you are likely to go into labor. We generally recommend staying close to home after 36 weeks, and not leaving the country in the third trimester (after 26-28 weeks) unless absolutely necessary. Flying is safe in pregnancy but may increase your risk for blood clots, so wear support hose on long flights and move about the cabin once an hour. With long road trips make frequent rest stops to stretch your legs and maintain circulation.

What if I have a cat?

Outdoor cats can be exposed to Toxoplasmosis and can pass this parasite to humans through the feces. One could acquire it by changing the litter box of an infected cat. If your cat goes outside, have someone else change the litter box when you are pregnant, or wear gloves and wash your hands well. If your cat lives inside and only eats processed cat food she cannot get the disease. Cuddling your cat is safe and will not expose you to the disease. Dogs are not affected. Toxoplasmosis can be harmful to a developing fetus but is very rarely seen in the USA.

Which vitamins/supplements should I take?

Folic acid is a B vitamin that has been shown to reduce the risk of spina bifida. 1 mg (1000 micrograms) is recommended during the month prior to pregnancy and for the first 2 months after conception to reduce this risk. More folic acid may be recommended if you have a personal or family history of spina bifida including a prior affected child.

A prenatal vitamin is a general multivitamin with 800-1000 micrograms of folic acid, as well as calcium and iron. Most women continue their vitamins after the second month to help reduce anemia and make up for any imperfections in diet. If you are not anemic and eat a well balanced diet, stopping prenatal vitamins at 2 months of pregnancy is acceptable.

After 12 weeks the baby begins to make bone and will draw the necessary calcium from your bones. To prevent bone loss 1000-1500 mg of calcium is recommended. This equates to 4-5 servings of milk, yogurt or dairy. Since this is difficult to consume, take a calcium supplement (usually 500-600 mg) to make up the difference. Don't take calcium and iron (in the multivitamin) at the same time as they can offset each other's absorption. While calcium citrate ("Citracal") is the best absorbed, other types of calcium such as fruit flavored "Tums" and "Viactiv" (chocolate flavored) may be more appealing.

If you eat fish 3 times weekly you are getting plenty of Omega-3 fatty acids, or Essential Fatty Acids (EFAs). If not, take a supplement containing 200mg of DHA (from fish oil or flax seed oil). There is a growing body of evidence that EFA deficiency may contribute to a number of pregnancy complications including preterm labor and pre-eclampsia. EFAs may help fetal eye and brain development, may improve mom's skin, hair and nails and are also passed into the breast milk.

What medications can I take?

Please refer to our medication list to see safe choices for medications in pregnancy. If you need a medication that is not on the list please call us during business hours for advice.

Do I have to lie/sleep on my left side?

When we lay on our back the large blood vessels that run close to our spine can be compressed by the pregnant uterus. In the third trimester this can decrease blood flow to the baby. At the same time, blood flow to your head will be decreased and you may feel dizzy and lightheaded. While there is no evidence that lying on your back sometimes is harmful, blood flow to the baby will be maximized if you tilt your abdomen even slightly to the left or the right. Assuming you have a normal healthy heart, either the right side or the left is fine. Before the third trimester most women can lie comfortably on their back as blood flow is not significantly affected.

Should I have the baby tested for Down's syndrome and other diseases?

Testing your baby for disease prior to birth is a personal choice. Depending on your age, family history and race you may be at higher risk of having a baby with a certain disease. Caucasians are more likely than people of other races to carry the gene for cystic fibrosis, for example. African Americans are more likely to carry the gene for sickle cell disease, and people of European Jewish ancestry are more likely to carry the gene for Tay Sach's disease. Blood tests can be done to see if you carry the genes for any of these diseases, to help establish whether the baby may be affected.

Down's syndrome (an extra chromosome 21) is a form of mental retardation. While it can happen to anyone's baby, the chance increases as the mother gets older. At 35, the risk of having a baby with Down's syndrome or other chromosomal disorders is about 1/200, and at 40 is about 1/50. Women who are 35 or older may opt to have an amniocentesis (fluid is withdrawn from the amniotic sac and is tested for the number of chromosomes) to have a definite diagnosis. Other non-invasive tests are also available but are not 100 % accurate. These include 1st trimester ultrasound along with a blood test for multiple markers which can detect more than 85% of Down's syndrome ("Ultrascreen"), and a blood test alone at 16-20 weeks that detects about 75% of Down's syndrome ("Quadscreen"). Women of any age may choose to do these non-invasive tests. Some patients opt not to test at all, because the results would not change their feelings about the pregnancy. While there is no right or wrong answer your doctor will help you to navigate these decisions at the appropriate time.

Is ultrasound safe?

Obstetric ultrasound has been extensively studied and found to be safe for the baby. While no fetal harm has been found, current recommendations are to limit the use of ultrasound to that which is medically useful or necessary. In our office this includes an average of 4 ultrasounds. These include an ultrasound performed at the first visit to confirm viability, an optional ultrasound for Down's Syndrome screening at about 12 weeks, an optional ultrasound at about 16 weeks to establish gender, a detailed ultrasound at 20-22 weeks to assess the baby's anatomy, and an ultrasound for growth and fetal well being at about 35 weeks. Only any medically necessary ultrasounds are ordered later in pregnancy. A "4D" ultrasound is not medically necessary but may be chosen at 28-32 weeks to get a picture of the baby and preserve your memories. Since there is no evidence of harm, we are happy to recommend a 4-D ultrasound for you

Can I go to the dentist?

Routine dental work is safe during pregnancy and we encourage you to keep up with your normal dental health routine. Most dentists will require a note from us saying that the visit is safe,

and we can give you a standardized letter to take to your visit. If you need extensive dental work we can discuss the best options for medications with your dentist.

Where will I deliver?

As of October 1, 2011, we deliver only at The Woman’s Hospital of Texas (TWH), just south of the the Texas Medical Center. TWH has a state-of-the-art labor and delivery facility and is adjacent to our new offices. Anesthesia and neonatology services are in house 24 hours a day, and all rooms are large and private with private bathrooms. TWH is unique in that is offers 1:1 nursing for labor patients, assuring the highest level of care. The hospital also has a high level nursery including a neonatal intensive care unit, and encourages “rooming in” so that you are not separated from your baby, as well as providing a lactation consultant to assist you after delivery.

How do I register at the hospital and take a tour?

You can register online by visiting www.womanhospital.com and clicking on “on-line registration” (in the “account management” section). If you would like to schedule a tour or a class, the schedule can be found on the website in the “education” section.

When will I deliver?

Most people deliver close to their due date (40 weeks from the last period). About 10% of women deliver before 37 weeks. It is more likely that you will go over your due date in the first pregnancy than in subsequent pregnancies. While it is sometimes safe to go as long as 2 weeks over the due date, we generally recommend induction at 41 weeks. If you have had a preterm (less than 37 weeks) delivery before, you are more likely to have another preterm delivery.

If you are planning a C-section, we generally will schedule it at about 39 weeks or 37 weeks if you have twins.

Who will deliver me?

You may be delivered by any of the doctors in our group. Our doctors share a call schedule for nights and weekends, and each doctor is responsible for deliveries and surgeries at the hospital on one day of the week. If you would like to be sure that your own doctor delivers you, she may offer induction at full term (usually around 39 weeks) on a day that she is on call.

How long will I stay in the hospital?

After an uncomplicated vaginal delivery you can stay 24-48 hours. After an uncomplicated C-section you may be ready to leave as soon as 48 hours, or as long as 96 hours. We see most of our patients 2 weeks after a C-section and 6 weeks after a vaginal delivery.

Who will my baby’s doctor be?

You will need a pediatrician with privileges at The Woman’s Hospital of Texas to see your baby before discharge. If you do not have one already we will recommend some excellent doctors for you to consider (look at the online form called “referral list”). Some patients like to meet and interview the doctor before delivery, or you may be comfortable meeting the doctor when he/she comes to see your baby in the hospital. After discharge, the first visits with the pediatrician are usually at 2 weeks of life, and you can make this appointment as soon as the baby is born.

Should I take a childbirth class?

If this is your first baby you may want to take a childbirth class. While this is not required it may help you to be more comfortable about what to expect. Most people take a class in the last 2-3 months of pregnancy. The hospital has a very good childbirth class as well as many other educational opportunities that you can schedule by visiting the website at www.womanshospital.com and looking at the “education” section. The childbirth class costs \$85.00 and includes a book, and is offered at various times of the week to suit your schedule.

Should I get an epidural?

This is a personal choice, but in our practice the great majority of patients do opt for an epidural. Epidurals are a very safe and effective means of controlling the pain associated with childbirth. Complications from an epidural are extremely rare and often easily corrected (such as a severe headache). You do not have to make any arrangements for an epidural prior to your delivery day. Anesthesiologists are available 24 hours a day to help you whenever you request their services.

Do I need a birth plan?

Some patients like to write a “wish list” of events that they hope to happen at the birth of their baby. While forming a written birth plan is optional, we generally do not recommend it. Instead we feel that it is important to discuss your wishes with your physician so that she can make the other doctors in the practice aware if you have special requests, and to convey your wishes to the nursing staff at the hospital. We do our best to adhere to your plan within the boundaries of safety, knowing that the labor process is very dynamic and unpredictable, and unplanned events happen frequently. An important part of forming a birth plan is accepting that it may change, and allowing your doctor to make the best decisions for you and your baby at all times during the labor process.

What is my doctor’s C-section rate?

We pride ourselves on having a lower C-section rate than the national average of 30%, and think it is largely because we believe that patience is of the utmost importance when managing labor, and that each woman labors at her own speed. We do not place rigorous time limits on your labor and make all safe, reasonable efforts to avoid unnecessary C-sections. Our overall C-section rate is about 25%, with the majority of these deliveries representing repeat C-sections. If this is your first baby, your chance of C-section is only about 10%. In our practice, if your first pregnancy results in a C-section, there was no safe alternative. **If we recommend a C-section we expect your full cooperation even though we know a C-section was not your desire.**

Can I deliver vaginally after a C-section?

Vaginal birth after C-section (VBAC) is not offered in our practice. There is a 1% risk that when a mother is in labor with a C-section scar on the uterus, the scar could open up and expel the baby and the placenta into the mother’s abdomen. This is called a uterine rupture and is a catastrophic emergency which can result in the death or permanent disability of the baby, as well as serious complications for the mother including severe blood loss and hysterectomy. As mothers ourselves we believe that a 1% risk is too high when it comes to a baby’s safety. After all, we go to enormous lengths to prevent much rarer events such as injury in a car accident (using car seats) or exposure to life threatening illnesses (getting vaccinations), for example.

Will I get induced?

We cannot predict when a patient will have a medical need to be induced, such as high blood pressure, poor fetal growth, low amniotic fluid, or being more than a week past your due date. Your doctor will explain in detail why induction of labor is necessary if this should occur. The decision to induce labor is the result of a complex set of decisions, the end-point of which is that the mother's and/or baby's health will be better with the baby on the outside than the inside. **If we recommend a medically necessary induction we expect your full cooperation even if induction was not your desire.**

Some patients may choose an "elective" induction which is not medically necessary but is timed to provide convenience for family members, work schedules, or to coincide with your doctor's schedule. Elective inductions are scheduled at around 39 weeks.

Will I have an episiotomy?

There is no evidence that routine episiotomies are beneficial, and we try to avoid them. At times your doctor may decide that it is safer to make a small episiotomy than to risk a large tear, but this decision is not made until the baby's head is partially delivered. There are variable factors that we cannot control including the size of the baby and your body's ability to stretch, which ultimately affect your ability to deliver without an episiotomy. It is less likely that you will have an episiotomy with each successive pregnancy.

Should I have my baby boy circumcised?

The American Academy of Pediatrics does not recommend circumcision for any medical reason. Still, many couples opt to have their baby boy circumcised for religious, cultural or cosmetic reasons. If you decide to have your baby circumcised we will call a urologist to perform the procedure with local anesthesia, usually on the day after birth.

Should I collect my baby's cord blood?

Blood from your baby's umbilical cord contains stem cells, which may be collected and stored after the baby's birth. Stem cells have numerous current and possible future medical uses that warrant consideration. At present there is no public banking system but you can pay a private company to store it for you. If you are interested in cord blood collection, visit the websites of Cord Blood Registry (www.cordblood.com) and Viacord (www.viacord.com) to learn more. We can give you the necessary collection kits in our office if you decide to proceed.

How do I prepare for breastfeeding?

In our experience the best breastfeeding class comes when you have your baby in your arms. While physically preparing the breasts is unnecessary, you may want to mentally prepare by taking a breastfeeding class, which can be scheduled through www.womanshospital.com (in the "education" section). Most of our patients have found that the lactation consultant in the hospital can get you off to a good start without any other preparation. If you need help after the baby is born we can recommend a lactation consultant which can be arranged at home or at a location such as The Motherhood Center or a woman's work. Information can be found at their websites at www.motherhoodcenter.com or www.awomanswork.com. Also, our doctors have a "standing prescription" at a woman's work which will allow you to purchase some breastfeeding supplies tax-free.

When should I call the doctor? How do I contact my doctor in an emergency?

If you have a true emergency that cannot wait until the office reopens (if you are in labor, for example) our office number will prompt you to connect to an operator who will page the doctor on call. While we are always available in emergencies, we ask you to use your judgment and not disturb the doctors after hours with matters that can be dealt with the next business day.

Examples of reasons to call the emergency line (24 hours) in the first and second trimester include vaginal bleeding that is more than spotting, persistent cramping, any severe pain, fever higher than 101.0 F, or vomiting that is preventing fluid intake for more than 24 hours.

Examples of reasons to call the emergency line (24 hours) in the third trimester include leaking amniotic fluid (a persistent trickle or gush of watery fluid), vaginal bleeding that is more than spotting, decreased or absent fetal movement (at rest, you should feel at least 4 small movements in an hour), or regular, painful contractions. If you are 36 weeks or more, you have not had a C-section before, and your doctor is planning a vaginal delivery, call us when your contractions have been 5 minutes apart or less for at least an hour. If you are worried or not sure if you are in labor, it is always best to call. If you feel that you need to go to the hospital at any time, please call us first so that the doctor on call can advise you and let the hospital know that you are coming.

How does my insurance work?

Since every insurance plan is different, it is important that you understand the way your policy works. Before your first visit our staff will check on your benefits and will be able to explain this to you when you arrive. Most insurance companies pay us for the prenatal care (about 13 visits) as well as the delivery in one lump sum after you deliver. Usually you will have one co-pay for the whole package (the “global fee”). If you have visits that are not related to normal prenatal care, these will be additional charges to your insurance and will have additional co-pays. Tests such as ultrasounds are billed separately and have separate co-pays. Most policies have a deductible or patient portion that you will be asked to pay before you deliver. The hospital will bill your insurance separately, as will other doctors at the hospital including the anesthesiologist and pediatrician. We have a lab in our office but this is an independent business entity that will bill your insurance separately. Our Obstetrics Co-ordinator Samantha Cervantes will meet with you in the first trimester to go over your insurance benefits and answer any questions that you may have. She may be reached at (713) 791-9100 extension 303 during normal business hours.

Remember that your doctors are medical experts, not insurance experts. Please direct your insurance and billing questions to the Obstetrics Co-ordinator, not to your doctor.

What can I expect at my appointments?

If you have a normal pregnancy your scheduled visits will be monthly until 30 weeks, then every 2 weeks until 36 weeks, then weekly until delivery. At each visit we will record your weight and blood pressure, check your urine, listen to the baby’s heartbeat and assess the baby’s growth.

Drs. Hardwick-Smith, Journey and Beard have Nurse Practitioners who are advanced level nurses with Masters Degrees in Women’s Health and many years of experience in obstetrics. The Nurse Practitioner will see you at your first visit to perform a thorough health assessment, gather information and perform an initial ultrasound. She will also see you at several visits during the pregnancy and at times when your doctor is unavailable or is running late. Some appointments will include specific events as follows:

1st visit- 6-12 weeks from last period: A pelvic exam and pap smear will be done as well as tests for vaginal infection. A standard panel of blood tests will be done to check your blood type, blood count, immunity to Rubella, as well as tests for exposure to HIV, hepatitis and syphilis. An ultrasound will be done to confirm your due date and check for viability. First trimester screening for Down's syndrome and other chromosomal abnormalities ("Ultrascreen") will be offered. Other necessary tests based on your individual health assessment will be done.

2nd visit- Another ultrasound may be performed to confirm viability.

16-20 weeks from last period. An optional ultrasound may be performed to see the sex of your baby, if you want to find out early. This ultrasound is not considered medically necessary and will not be covered by insurance. An alpha-fetoprotein (AFP) test for spina bifida will also be offered. If you are having an amniocentesis it will be scheduled at about 16 weeks. A detailed ultrasound of the baby's anatomy will be scheduled as a separate appointment between 20-22 weeks, at which time we can usually see the sex of the baby (this ultrasound is covered by most insurance).

24-28 weeks- testing for gestational diabetes will be done. You will be given a sweet drink and your blood will be drawn an hour later to screen for diabetes. If your first test is high you will be asked to do a second test that takes 3 hours. If your blood type is RH negative you will receive a shot of Rhogam at about 28 weeks. At this time we will begin reminding you to register at the hospital, sign up for a childbirth class if desired, choose a pediatrician, and consider issues such as cord blood banking and circumcision.

36-40 weeks- testing for GBS (group B strep) will be done with a vaginal/anal swab. GBS is a harmless bacterium that many people carry without symptoms, but can rarely lead to a serious neonatal infection. If you are a carrier we will give you antibiotics when you are in labor to prevent neonatal infection. Your cervix will be checked weekly for dilation and effacement, and to make sure the baby's head is down. If you haven't met all the doctors in the practice, you will be given an opportunity to do this before you deliver if you wish to.

We do our best to be on time but occasionally the doctors are delayed at the hospital with deliveries or surgery. Bring a book to your appointments, as we cannot predict when this may happen. We will do our best to inform you of the delay, if there is one. If you have no problems sometimes it may suffice to see the nurse, nurse practitioner or PA, who can relay any questions to your doctor when she returns.

Where do the beautiful baby pictures in our waiting room and hallways come from?

These photographs are by Kristi Zontini with [Bellababies Photography](http://www.bellababiesphotography.com) at www.bellababiesphotography.com. [Bellababies](http://www.bellababiesphotography.com) specializes in photographing pregnant mothers, babies, children, and families and has become the personal family photographer of many of our patients as well as our doctors.

What if I have other questions?

Since you are seen frequently, write your questions down and bring them to your next appointment. If you have more urgent questions, leave a message with your doctor's nurse and you will get a reply by the end of the business day.

USE OF MEDICATIONS DURING PREGNANCY

There is no medication considered to be 100% safe for long-term use in pregnancy. Each medication carries risks and benefits. Therefore, it is recommended that you:

1. Limit the use of medication unless you are severely impaired or the medication is recommended by your doctor.
2. Minimize the number of days or doses taken.

THESE MEDICATIONS ARE GENERALLY SAFE CHOICES FOR:

ALLERGIES	Claritin or Claritin-D, Allegra or Allegra-D, Zyrtec or Zyrtec-D, Flonase, Benadryl.
COLD/FEVER	Tylenol or Extra Strength Tylenol, Sudafed, Tylenol Sinus. Increase your fluids and rest. Report a fever over 101.0.
COUGH	Robitussin DM, and/or cough drops.
CONSTIPATION	Metamucil, Surfak, Colace, Fibercon. Increase fiber and fluids in your diet.
DIARRHEA	Kaopectate, Imodium AD.
HEADACHE	Tylenol, Extra Strength Tylenol, Acetaminophen. Report any headache not relieved by Tylenol.
HEARTBURN / INDIGESTION	Maalox, Mylanta, Tums, Pepcid.
HEMORRHOIDS	Anusol cream or suppositories, Preparation H, Tucks, Witch Hazel
HERPES	Dom Burrows soaks, Zovirax cream, Valtrex after the first trimester.
GAS	Mylicon, Mylanta.
NAUSEA	Vitamin B6 (200 mg) 3 times a day, ginger in any form, Unisom (will make you sleepy).
SORE THROAT	Cepacol lozenges, warm salt water for gargling, chloroseptic throat spray, Tylenol for pain.
SKIN IRRITATION/ACNE	Calamine lotion, any topical steroid including hydrocortisone, Neosporin Ointment, any benzoyl peroxide product.

DO NOT TAKE UNLESS PRESCRIBED BY YOUR DOCTOR

- Aspirin
- Ibuprofen Products (i.e, Motrin, Advil, Aleve)

Modified 11/10