PERSONAL HEALTH MANAGEMENT RECORD

A. GENERAL INFORMATION

Household Code:……..

Full name: Relationship to head of household:
Gender: Male ☐ Female ☐ Blood type: ABO:……..Rh:……
DOB:……..Place of birth (Province/District): ……..
Ethnic:……...Nation:……Religion:……Occupation:……
ID No. :…….. Issue Date:……Place of issue:…….
Health Insurance ID /Health Insurance Card No. :……..
Registered permanent residence: (No. , street):……...
Ward:…….District/Commune:……..Province/City:……..
Present residence: (No. , street):……..
Ward:…….District/Commune:……..Province/City:……..
Phone No. : Telephone:…….Mobile phone:……Email:…….
Mother (Full name):……Father (Full name):……..
Primary caregiver (Full name):……..……Relationship:……..…….
Phone No. (mother/father/primary caregiver):…….
Telephone:……Mobile phone:…….

B. MEDICAL HISTORY

1. Previous pregnancies

Vaginal ☐ C-section ☐ Premature birth ☐ infant breathing problem ☐
Birth weight:……gr Birth height:……..cm
Birth defects (if have please write in details):……
Other problems (if have please write in details): ……..

2. Personal health risk factors

Tobacco use	No ☐	Yes ☐	Often	Stopped	☐
Alcoholic beverages (often)	No ☐	Yes ☐	Cup/day:……	Stopped	☐
Drug use	No ☐	Yes ☐	Often ☐	Stopped	☐
Physical activity	No ☐	Yes ☐	Often (physical exercises) ☐		
Occupational exposure factors / Living environment (chemicals, dust, virus,…), please write in details:……... Duration of exposure: …….. Toilet type in family (flush toilet / two-compartment latrine / no toilet): ……...					
Other risk factors: …….....					

3. Illness / allergies history

Allergies:

Type	**Description**
Medicine	
Chemical/Cosmetic	
Food	
Other	

Diseases:

Heart problems	☐	High blood pressure	☐	Diabetes	☐	Gastropathy	☐
Chronic lung disease	☐	Asthma	☐	Goiter	☐	Hepatitis	☐
Congenital heart disease	☐	Mental disease	☐	Autism	☐	Epileptic	☐
Cancer (write in details): ……							
Tuberculosis (write in details): ……							
Other (write in details): ……							

4. Disabilities

Body parts / organs	**Description**
Hearing	
Eyesight	
Arms	
Legs	
Scoliosis	
Cleft Lip and Palate	
Other	

5. Surgical history (specify the body part and year of surgery):

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……

6. Family history

Allergies:

Type	**Description**	**Infected person** (grandfather, grandmother, father, mother, brother, sister, …)
Medicine		
Chemical/Cosmetic		
Food		
Other		

Diseases:

Disease		**Infected person** (grandfather, grandmother, father, mother, brother, sister, …)	**Disease**		**Infected person** (grandfather, grandmother, father, mother, brother, sister, …)
Heart problems	☐	……	Asthma	☐	……
High blood pressure	☐	……	Diabetes	☐	……
Mental disease	☐	……	Epileptic	☐	……
Cancer (type, infected person, relationship)			……		
Tuberculosis (type, infected person, relationship)			……		
Other (type, infected person, relationship)			……		

7. Reproductive health and family planning

Contraceptives in use:……
Last pregnancy: ……
Number of pregnancies:……Number of miscarriages:……..……
Number of abortions:……Number of deliveries:……...Vaginal:……..C-section:……....
Difficult delivery:……..Full-term birth:…….Premature birth:……Live birth:……..
Gynecological diseases: ……

8. Other problems (if have): ……..
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C. VACCINATION

1. Basic vaccination for children

Type of vaccines	**Not yet vaccinated**	**Already vaccinated (clearly state the date)**	**Reaction after injection**	**Appointment date for vaccination**
BCG	☐	…/…/…		…/…/…
Newborn VGB	☐	…/…/…		…/…/…
DPT -VGB-Hib 1	☐	…/…/…		…/…/…
DPT -VGB-Hib 2	☐	…/…/…		…/…/…
DPT -VGB-Hib 3	☐	…/…/…		…/…/…
Polio 1	☐	…/…/…		…/…/…
Polio 2	☐	…/…/…		…/…/…
Polio 3	☐	…/…/…		…/…/…
Measles 1	☐	…/…/…		…/…/…
Measles 2	☐	…/…/…		…/…/…
DPT4	☐	…/…/…		…/…/…
VNNB B1	☐	…/…/…		…/…/…
VNNB B2	☐	…/…/…		…/…/…
VNNB B3	☐	…/…/…		…/…/…
Number of tetanus vaccine injections that mother has taken: ……..				

2. Vaccination outside the Expanded Program on Immunization

Type of vaccines	Not yet vaccinated	Already vaccinated (clearly state the date)	Reaction after injection	Appointment date for vaccination
Cholera 1	☐	…/…/…		…/…/…
Cholera 2	☐	…/…/…		…/…/…
Mumps	☐	…/…/…		…/…/…
Mumps 2	☐	…/…/…		…/…/…
Mumps 3	☐	…/…/…		…/…/…
Flu 1	☐	…/…/…		…/…/…
Flu 2	☐	…/…/…		…/…/…
Flu 3	☐	…/…/…		…/…/…
Typhoid	☐	…/…/…		…/…/…
HPV 1	☐	…/…/…		…/…/…
HPV 2	☐	…/…/…		…/…/…
HPV 3	☐	…/…/…		…/…/…
Pneumococcal vaccine	☐	…/…/…		…/…/…
…	☐	…/…/…		…/…/…
…	☐	…/…/…		…/…/…
…	☐	…/…/…		…/…/…

3. VX tetanus vaccination for pregnant women

Content	UV1	UV2	UV3	UV4	UV5
Not yet vaccinated	☐	☐	☐	☐	☐
Already vaccinated (clearly state the date)	…/…/…	…/…/…	…/…/…	…/…/…	…/…/…
Month of pregnancy					
Reaction after injection					
Appointment date for vaccination	…/…/…	…/…/…	…/…/…	…/…/…	…/…/…

D. CLINICAL AND SUBCLINICAL EXAMINATIONS

Examination date:…/…/…

1. Medical history

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2. Physical examination

2.1. Vital signs, anthropometric indices

Pulse rate	Temperature	HA	Respiratory rate	Weight	Height	BMI	Waist circumference

2.2. Eyesight

Without glasses: Right eye:……Left eye:…….

With glasses: Right eye:……Left eye:…….

2.3. Physical examination

2.3.1. Body

- Skin, mucosa: ……
- Other: ……

2.3.2. Organs

- Heart and pulses: ……
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- Chest and lungs: ……..
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- Abdomen and digestion: ……
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- Urinary system: ……..
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- Musculoskeletal: ……
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- Endocrine system: ……...
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- Nervous system: ……
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- Mental health: ……
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- Surgery: ……...
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- Obstetrics and Gynecology: ……
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- Ears, nose, throat: ……
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- Mouth and teeth: ……
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- Eyes: ……
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- Skin: ……
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- Nutrition: ……
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- Movement: ……..
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- Other: ……..
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- Evaluation of physical and mental development: ……...
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3. Subclinical results

No.	Test	Result
1	Hematology	
2	Serum biochemistry	
3	Urinalysis	
4	Abdominal ultrasound	

4. Diagnosis / Conclusion (disease name, disease code according to ICD 10): ……....
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5. Consultation:..……...
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6. Doctor: ……
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HEAD OF COMMUNE HEALTH STATION…….
(Signature, stamp)