Clinique de Sante Communautaire de l'Eglise Chretienne des Cities

Haiti Outreach Ministries/Mission Communautaire de l'Eglise Chretienne des Cites

PATIENT HEALTH RECORD

Nom De Famille: _____ **Prenom**:_____ **Date De Naissance: (J/M/A)** _____

Sexe: H/F **Paran (pou timoun) oswa yon kontak ijans** _____ **Telefòn** _____
Parent (for children) or emergency contact

Adres _____

HX *(Circle)* HTN DM Seizures Asthma Anemia GERD Other:_____

Vaccinations: TDap Hep A/B Polio MMR BHG **OB/GYN**: P G A Kantite moun ki vivan
(Number of living children)

DATE: _____ **BP:**_____ **HR:** _____ **Resp:**_____ **Temp:** _____ **Weight:**_____kg _____lb

CC: Fever Weakness Dizziness HA Pain_____ Rash_____ Cough SOB Vaginal D/C/Odor N&V Diarrhea GERD Other: _____

MUAC:_____ **BS**:_____mg/dl **U/A:** Protein Glucose Blood Leuk. _____Sp/Gr_____ **Pregnancy**: +/- **MVI** **Worm Med**

☐ **Retounen nan klinik** (Return to Clinic) **Date:** **Doktè** (Doctor)

DATE: _____ **BP:**_____ **HR:** _____ **Resp:**_____ **Temp:** _____ **Weight:**_____ kg _____lb

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