



Personal History

Facility Name _____ Visit Date _____ / _____ /20____

Surname _____

Other Names _____

ID - -

State Facility No. Serial No.

Hospital No. _____ Sex F M

Date of Birth _____ / _____ / _____ Age yrs, if <5 yrs mths

dd/mm/yyyy

GENERAL (FILLED FOR ADULTS AND PAEDIATRIC PATIENT)

Patient's address _____

City/Town _____ State _____

Phone No. _____

Contact person: Spouse Parent Family member Friend

Name _____

Address _____

City/Town _____ State _____

Phone No. _____

Marital status* Educational level** Occupation status***

Preferred language _____

Time from home to hospital _____ Hour(s) _____ Minutes

No. of dependents at home _____ No. of dependents under 18 yrs _____

Service entry into program****

VCT client code (if service entry is VCT)

Date of positive HIV test confirmed _____ / _____ / _____

FILLED FOR PAEDIATRIC PATIENT ONLY (No. 17 – 22)

The child lives with: _____ Name _____ Relationship _____

The mother of the child is alive If alive, Name _____

Address _____

The father of the child is alive If alive, Name _____

Address _____

Child's parents/caregivers are: Married Living together

Occupation status of child's parents/caregivers

Educational level of child's parents/caregivers

Number of child's siblings

CODES

*Marital Status: 1 N/A 2 Single 3 Married 4 Widowed 5 Separated 6 Divorced	**Educational Level: 1 N/A 2 None 3 Qur'anic 4 Started Primary 5 Completed Primary 6 Secondary 7 Post Secondary 8 Other (specify): _____	***Occupation Status: 1 N/A 2 Unemployed 3 Employed 4 Retired 5 Student 6 Other (specify) _____	****Service Entry into Program: 1 N/A 2 In-patient 3 TB 4 PMTCT 5 VCT 6 Outside clinic/program 7 Other (specify) _____
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