

Home Visit Record for Pediatric Malnutrition Patients

I. Patient identification

Patient's name: _____
Age: ____

Father's name: _____

Mother's name: _____

Location: _____

Date of visit: ____ / ____ / _____ planned unplanned

Family composition: Two-parent family
 Single-parent family
 Orphaned child living with _____

Followed at health center site: _____

II. Living conditions

House type: _____ Number of rooms: ____
Number of inhabitants: ____

Latrine? Yes No

Water source: _____

Parents' principal occupation:

Typical number of meals eaten per day: _____

Food source: _____

Food reserves: _____

Cooking fuel: _____

III. General evaluation of patient

HIV status:	Patient	<input type="checkbox"/> positive	<input type="checkbox"/> negative	<input type="checkbox"/> unknown
	Patient's mother	<input type="checkbox"/> positive	<input type="checkbox"/> negative	<input type="checkbox"/> unknown
	Patient's father	<input type="checkbox"/> positive	<input type="checkbox"/> negative	<input type="checkbox"/> unknown

Family members:

Name and age	Relationship	Work/School	Nutritional status

Patient card available: Yes No

Child's vaccination card available: Yes No

Family planning appointment for mother?: Yes No

IV. Clinical evaluation

Primary problem:

Physical exam findings:

Proposed treatment:

Brought to clinic: Yes No

Date for next home visit: ___ / ___ / _____

V. Additional comments

Signatures of all visitors:
