Federal Ministry of Health

"Federal Ministry of Health Woman's Card"

Name of health facility _____

Name of woman _____ Woreda _____

Medical Record Number (MRN):_____ Kebele _____

DOB ___/___/_____ Marital status _____ House number _____

Educational status _____ Date of registration ____/____/_____

General Medical Information

Past medical hisotory (√)		Laboratory		Prescription	
Diabetes	☐	Date	Results	Date	Drug
Renal	☐				
Cardiac	☐				
Hypertension	☐				
Use of known substance	☐				
Tuberculosis	☐				
HIV	☐				
Other _____					

Vaccination

TT vaccination	TT1	TT2	TT3	TT4	TT5
Date of vaccination					

Obstetric History

Year of pregnancy	Outcome of pregnancy	Mode of delivery	Complications	Place of delivery	Status of the offspring
yyyy	delivery/abortion	SVD C/S Inst	Yes/No	Institution/ Home	Alive/dead

Counseling and Testing

Date of the visit	Counseling			Testing Results	
	STI	HIV	FP	HIV	RPR/VDRL

Federal Ministry of Health

Family Planning

Date of visit	BP	Weight	Method provided	Reason for method switch	Date of next visit	**Abbreviate Method Provided as follows:**
						MaC - Male Condom; FeC - Female Condom;
						Inj - Injectable; EC - Emergency Contraception
						OC- Oral Contraceptive
						TL- tubal ligation , V -vasectomy; Imp -Implanon; Nr -Norplant; JD -Jedale
						Abbreviate Reason for Method Switch :
						MethUn - Unavailability of the method;
						S/E - Unwanted side effects
						Preg - Desire being pregnant;
						Ill - Developed illness and disease
						Int - Potential interaction with newly
						initiated treatment ingredient
						STI - Risk of STI exposure; Oth - Other

Abortion Care

Date:___/___/_____	Gravidity ☐	Parity ☐	Gestational age (Wks) ☐	
Type of abortion		**Type of evacuation**	**Condition on discharge**	**Remarks**
Spontaneous ☐	Inevitable ☐	MVA ☐		
Unsafe ☐	Incomplete ☐	E&C ☐	Improved ☐	
Safe abortion ☐	Complete ☐	MA ☐	Referred ☐	
		D&C ☐	Died ☐	
Analgesia	**Place Procedure Performed**	Other ☐		**Signature**
Yes ☐ No ☐		**Post abortion contraception**		
Type:_____ _____	☐ Outpatient procedure	Counseling ☐ Yes ☐ No		
Notes:_____ _____	☐ Inpatient procedure	Method provided _____		

Abortion Care

Date:___/___/_____	Gravidity	Parity	Gestational age (Wks)	
Type of abortion		**Type of evacuation**	**Condition on discharge**	**Remarks**
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Safe abortion ☐	Complete ☐	MA ☐	Referred ☐	
		D&C ☐	Died ☐	
Analgesia	**Place Procedure Performed**	Other ☐		**Signature**
Yes ☐ No ☐		**Post abortion contraception**		
Type:_____ _____	☐ Outpatient procedure	Counseling ☐ Yes ☐ No		
Notes:_____ _____	☐ Inpatient procedure	Method provided _____		