Republic of the Philippines
ILOCOS SUR POLYTECHNIC STATE COLLEGE
Sta. Maria Campus, Sta. Maria, Ilocos Sur
Health Services Unit

1x1 Picture

STUDENT'S HEALTH RECORD FORM

Name ***(Last Name, First Name, Middle Name)*** **Age** **Course/Year** **Birth Sex: Male:** ☐ **Female** ☐

Permanent Address: **Phone Number:** **Civil Status:** **Religion:**

Contact Person (*In case of Emergency*): **Address:** **Contact No.:**

Blood Type: **ALERT AND ALLERGY:** **Disability (if any):**

HEALTH INFORMATION

(Instructions: For items that are not Applicable, LEAVE IT BLANK. Mark with (√) if YES, and Leave it Blank for NO)

Past Medical History

Chicken Pox ☐
Mumps ☐
Measles ☐
Tuberculosis ☐
*Specify Type*_____
Hepatitis ☐
*Specify Type*_____

☐ Hypertension
☐ Diabetes
☐ Bronchial Asthma
☐ Peptic Ulcer Disease
☐ Epilepsy

☐ Thyroid Disease
☐ Heart Disease
☐ Previous Blood Transfusion
☐ Cancer
*Specify Form*_____
☐ Use of Anti-coagulants
☐ Bone Fracture

Hospitalizations: Date: Diagnosis: Hospital:

Surgery (if any): Accident/s:

Family Medical History

Hypertension ☐
Diabetes ☐
Bronchial Asthma ☐

☐ Thyroid Disease
☐ Cancer
Specify Form _____

☐ Autoimmune Disease
Specify Form _____
☐ Heart Disease Others: _____

Immunization History

☐ MMR - Date Completed: _____ ☐ Hepatitis Vaccine – Date Completed: _____ ☐ FLU Vaccine – Date Completed: _____
☐ Anti-Rabies – Date Completed: _____ ☐ Anti-Tetanus – Date Completed: _____ ☐ PPV23 (Pneumothorax) _____
Anti-COVID19 Vaccine: 1st Dose: _____ Date: _____ 2nd Dose: _____ Date: _____
1ST Booster: _____ Date: _____ 2nd Booster: _____ Date: _____

Personal/Social History

Smoker ☐ Alcohol Drinker ☐ Illicit Drug User ☐
No. of Sticks Per Day: _____ Type of Alcohol: _____ Type of Illicit Drug: _____
No. of Years: _____ No. of Bottles/mL per Bottle: _____
Pack Years: _____ Frequency: _____

Maternal and Menstrual History (For Female/s Only)

No. of Pregnancy: _____ LMP: _____ Duration: _____
No. of Alive: _____ Menarche: _____ Amount: _____
No. of Stillbirth/Abortion: _____ Interval: _____ Symptom/s: _____
Gyne Pathology: _____

Dental History: Last Dental Visit: _____ Procedure Done: _____

PHYSICAL EXAMINATION (*to be filled up by Health Provider*)

General Survey
☐ Conscious ☐ Afebrile ☐ Not in CPD
☐ Coherent ☐ Febrile
Remarks: _____

Vital Signs:
BP: _____ RR: _____ Temp.: _____ PR: _____
Weight: _____ Height: _____
BMI: _____ Interpretation: _____

Integumentary
☐ Pallor ☐ Jaundice ☐ Cyanosis ☐ Warm to touch
Remarks: _____

HEENT
☐ Symmetric ☐ Alar Flaring ☐ Pink Oral Mucosa
☐ Asymmetric ☐ Anicteric Sclera ☐ Pale Oral Mucosa
☐ CLAD

CHEST
☐ Retractions
☐ Symmetrical Chest Expansion
☐ Asymmetrical Chest Expansions
☐ Rales
☐ Wheezes

HEART
☐ Adynamic Precordium
PMI at ___th ICS MCL
☐ Tachycardic
☐ Irregular Rhythm
☐ Regular Rhythm
☐ Murmur

ABDOMEN
☐ Scar ☐ Flat ☐ Flabby
☐ Globular ☐ Scaphoid
☐ Dull
☐ Tympanitic
☐ Non-Tender
☐ Tender
☐ Organomegaly
☐ NABS

Extremities
☐ Gross Deformities Remarks: _____
☐ Edema
CRT at ____ Seconds

Visual Acuity:
OD: _____ **OS:** _____ **OU:** _____

REMARKS:

Assessment

Management

DECLARATION AND DATA PRIVACY CONSENT

I hereby declare that the information above is accurate and complete. I understand that withholding any relevant medical information, any misrepresentation of facts or misleading information given by me may be used as a ground for the filling of cases against me in accordance with the law. I voluntarily and freely consent to undergo physical assessment and the collection and processing of the information above to enable the Ilocos Sur Polytechnic State College – Health Services Unit to render necessary Health services to all its clients. I also declare that I was excellently informed on the process of data collection, purpose of this medical information, and the Provisions of Republic Act 10173, Data Privacy Act of 2012.

Signature over Printed Name: _____ *Date Signed:* _____

_____
Name and Signature of Healthcare Provider