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|  | | Republic of the Philippines  **SORSOGON STATE UNIVERSITY**  **Office of Student Development and Services**  **Health Services Unit – Bulan Campus**  *Zone 8, Bulan, Sorsogon* | | |  | |
| Tel. No. 056-311-9800, E-mail Address: hsubulan@sorsu.edu.ph | | |
| **MEDICAL CONSULTATION FORM** | | | | | | |
| Course/Designation: | | | | Date: | | |
| Name: |  | |  |  | |  |
|  | Surname | | First Name | Middle Name | | Ext. |
| Birthdate: |  | |  | Sex: | |  |
| Age: |  | |  | Nationality: | |  |
| Address: |  | |  | Religion: | |  |
|  |  | |  | Cellphone No.: | |  |
|  |  | |  | E-mail Address: | |  |
| **Name of Parents** | | | | | | |
| Father: |  | |  | Date of Birth: | |  |
|  |  | |  | Occupation: | |  |
| Mother: |  | |  | Date of Birth: | |  |
|  |  | |  | Occupation: | |  |
| **IN CASE OF EMERGENCY** | | | | | | |
| Person to be notified: | | |  | **(If parents cannot be reached)** | | |
| Cellphone No.: | | |  | Name: | |  |
|  |  | |  | Cellphone No.: | |  |
|  |  | |  | Relation to the patient: | |  |
| **MEDICAL HISTORY** | | | | | | |
| Blood Type: | A | | B | AB | | O |
| Height: |  | |  | Weight: | |  |
| **History of Allergy:** | | | | **History of Asthma for 3 years:** | | |
|  |  | |  |  | |  |
| Food |  | |  | Yes | | No |
| Medicine |  | |  |  | |  |
| Others |  | |  |  | |  |
| **For PWD ( Person With Disabilities )** | | | |  | |  |
| Blind or Visually Impaired | | | Autism |  | |  |
| Deaf/Mute |  | | Chronic Illness (stroke, diabetes) |  | |  |
| Orthopedically Challenged | | |  |  | |  |
| Congenital Defects | | |  |  | |  |
| Communication Disorder, Speech & Language Impairment (cleft lip/palate) | | | |  | |  |
| A. Are you suffering from an illness at the moment? Which do you think we need to be aware of? Please state | | | | | | |
|  |  | |  |  | |  |
|  |  | |  |  | |  |
| B. Did you undergo Surgical operation? Please state | | | | | | |
|  | Yes | | Date of operation: |  | |  |
|  |  | | Type of operation |  | |  |
|  |  | | Hospital |  | |  |
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