



Republic of the Philippines
Laguna State Polytechnic University
Province of Laguna

MEDICAL RECORDS

Surname			Given name		Middle Name
Age	Sex	Status	Date of Birth (MM-DD-YYYY)	Course	School year entered (if applicable)
Current Address					Tell/Cell No.
Mother's name		Father's name		Guardian's name (if applicable)	
Name of Contract Person in CASE OF EMERGENCY (REQUIRED)				Relationship	Contact No. (Required)

I, _____ hereby ascertain that I have willingly shared/ disclosed all information contained within this Medical Report and that this information is TRUE and CORRECT to the best of my knowledge.

Printed Full name and signature

Date

INSTRUCTIONS: Pls. check all that apply and provide details.

I. PAST MEDICAL AND DENTAL HISTORY

- | | |
|--|--|
| <input type="checkbox"/> Previous/ present KNOWN illness | <input type="checkbox"/> Present immunization (ex. Flu, Hepa B. etc) |
| <input type="checkbox"/> Past hospitalizations/ confinement | <input type="checkbox"/> currently taking medicine/ vitamins |
| <input type="checkbox"/> Known allergies to food or medicine | <input type="checkbox"/> Dental problems (ex. Gingivitis, etc) |
| <input type="checkbox"/> Childhood immunization | <input type="checkbox"/> Primary care Physician (name, specialty, clinic location and date of last check-up/follow-up :) |

II. FAMILY MEDICAL HISTORY

- | | |
|--|--|
| <input type="checkbox"/> Allergy _____ | <input type="checkbox"/> Cancer _____ |
| <input type="checkbox"/> Asthma/"hika" _____ | <input type="checkbox"/> Liver disease _____ |
| <input type="checkbox"/> Tuberculosis/TB _____ | <input type="checkbox"/> Kidney or bladder disease _____ |
| <input type="checkbox"/> Hypertension/"high blood" _____ | <input type="checkbox"/> Blood disorder _____ |
| <input type="checkbox"/> Heart disease/"sakit sa puso" _____ | <input type="checkbox"/> Epilepsy _____ |
| <input type="checkbox"/> Stroke _____ | <input type="checkbox"/> Mental Disorder _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Others _____ |

III. PERSONAL AND SOCIAL HISTORY

- | | |
|---|-----------------------------|
| 1. Alcohol intake: <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Tobacco use: <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Illicit drug use: <input type="checkbox"/> Yes | <input type="checkbox"/> No |

4. For FEMALES:

a. Menstrual Period

Date of first day of Last menstrual period (MM-DD-YYYY): _____

☐ Regular ☐ Irregular

Duration: _____ days/weeks

No. of pads/day: _____

b. History of dysmenorrhea: ☐ Yes ☐ No

c. If YES, how severe is your dysmenorrhea? ☐ Mild ☐ Moderate ☐ Severe

d. Date of last check-up with an OB-gynecologist (MM-DD-YYYY): _____

e. Date of excessive/ abnormal bleeding? ☐ Yes (pls. give details) _____
☐ No

f. Previous pregnancy? ☐ Yes (number, normal/ C-section, home/hospital, etc.) _____
☐ No

g. Children? ☐ Yes (how many?) _____
☐ No

-----STUDENT FILL UP FORM UNTIL HERE ONLY-----

IV. PHYSICAL EXAMINATION

Height (m)	Weight (w)	BMI (kg/m ²)	BP (bpm)	HR (bpm)	RR (cpm)	Temp (C)
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	Normal	
Gen. Appearance and Skin		
Head and Neck		
Chest and Back		
Abdomen		
Extremities		
Others		

V. DIAGNOSTIC RESULTS: (Pls. include date of examination)

☐ Chest X-ray: _____

VI. IMPRESSION:

VII. PLAN:

☐ Diagnostics: _____

☐ Home Medication: _____

☐ Home Instructions: _____

☐ Advice: _____

☐ F-f(Date): _____

☐ Medical Certificate issued

☐ Referred: _____

Recommendation: ☐ Fit to Enroll ☐ Fit to Enroll but requires further evaluation
☐ Fit to Work ☐ Fit to Work but requires further evaluation
☐ Fit to Participate in Sports ☐ Fit to Participate in Sports but requires further evaluation

Physician's Name and Signature

Lic. No. _____

Date _____

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