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

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

### II.FAMILY MEDICAL HISTORY

- ☐ Allergy_____
- ☐ Asthma/"hika"_____
- ☐ Tuberculosis/TB_____
- ☐ Hypertension/"high blood"_____
- ☐ Heart disease/"sakit sa puso"_____
- ☐ Stroke_____
- ☐ Diabetes_____
- ☐ Cancer_____
- ☐ Liver disease_____
- ☐ Kidney or bladder disease_____
- ☐ Blood disorder_____
- ☐ Epilepsy_____
- ☐ Mental Disorder_____
- ☐ Others_____

### III.PERSONAL AND SOCIAL HISTORY

1. Alcohol intake: ☐ Yes_____ ☐ No
2. Tobacco use: ☐ Yes_____ ☐ No
3. Illicit drug use: ☐ Yes_____ ☐ 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 dysmenorrheal? ☐ 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**

| Heigh (m) | Weight (w) | BMI (kg/m2) | BP (bpm) | HR (bpm) | RR (cpm) | Temp (C) |
|---|---|---|---|---|---|---|
| | | | | | | |

| | **Normal** | |
|---|---|---|
| Gen. Appearance and Skin | | |
| Head and Neck | | |
| Chest and Back | | |
| Abdomen | | |
| Extremities | | |
| Others | | |

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

☐ Ches 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 Work

☐ Fit to Participate in Sports

☐ Fit to Enroll but requires further evaluation

☐ Fit to Work but requires further evaluation

☐ Fit to Participate in Sports but requires further evaluation

_____

**Physician's Name and Signature**

Lic. No. _____

Date_____

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