



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 dysmenorrhea? ☐ Mild ☐ Moderate ☐ Severe

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

e. History 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)
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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)

☐ 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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