



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-YY)	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

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 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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