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  Tg | | | 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.**

1. **PAST MEDICAL AND DENTAL HISTORY**

 Previous/ present KNOWN illness

Tg

 Past hospitalizations/ confinement

Tg

Known allergies to food or medicine

Tg

 Childhood immunization

Tg

Present immunization (ex. Flu, Hepa B. etc)

Tg

currently taking medicine/ vitamins

Tg

Dental problems (ex. Gingivitis, etc)

Tg

Primary care Physician (name, specialty, clinic location and date of last check-up/follow-up :) Tg

1. **FAMILY MEDICAL HISTORY**

 Allergy\_Tg

 Asthma/”hika”\_Tg

 Tuberculosis/TB\_T g  Hypertension/”high blood”\_T g  Heart disease/”sakit sa puso”\_T g  Stroke\_Tg  Diabetes\_T g

Cancer

Liver disease

Kidney or bladder disease Blood disorder Epilepsy Mental Disorder Others

1. **PERSONAL AND SOCIAL HISTORY**

4. For

* 1. Alcohol intake:  Yes  No
  2. Tobacco use:  Yes  No
  3. IIIicit drug use:  Yes  No
  4. For **FEMALES:**
     1. Menstrual Period

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

 Regular  Irregular Duration: days/weeks No. of pads/day:

* + 1. History of dysmenorrhea:  Yes No
    2. If YES, how severe is your dysmenorrheal?  Mild  Moderate  Severe
    3. Date of last check-up with an OB-gynecologist (MM-DD-YYYY):
    4. Date of excessive/ abnormal bleeding?  Yes (pls. give details)

 No

* + 1. Previous pregnancy?  Yes (number, normal/ C-section, home/hospital, etc.)  No
    2. Children?  Yes (how many?)  No

STUDENT FILL UP FORM UNTIL HERE ONLY

1. **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 |  |  |

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

Ches X-ray:

1. **IMPRESSION:**
2. **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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