NAME: {{name}}

*Last name, First name, Middle initial Month/ day/ year*

## DATA SUBJECT CONSENT

In accordance with the provisions of the Data Privacy Act of 2012 and its corresponding regulations, we implement appropriate security measures to safeguard the personal data we collect. We assure you that your personal data will be collected, processed, and stored with the utmost care for the purpose of health assessment, treatment, and/or research, adhering to ethical research guidelines to enhance healthcare services. The Bohol Island State University Health Service maintains strict security and confidentiality protocols when handling personal data.

* By providing my authorization and consent, I acknowledge and agree to the aforementioned purposes. I understand that this consent will remain valid until I choose to revoke it in writing.

## CONSENT FOR ASSESSMENT

* I hereby provide my voluntary consent for the healthcare professionals at Bohol Island State University Health Service to perform a comprehensive physical examination and mental health screening, review my laboratory tests, and administer any necessary treatment before admission to the University.

*Signature over Printed Name / Date signed*

In order to finalize your admission to Bohol Island State University (BISU), it is mandatory to undergo a comprehensive medical history and physical examination. The completion of this rests solely, and is the responsibility of the STUDENT and not of the physician. Kindly fill out this form legibly using BLACK ink. Your submitted form will be kept confidential and will be included in your enrollment medical records. Please ensure that your medical history and physical examination are completed and on file prior to your registration.

You are REQUIRED to fill out this form if you are a/an:

2x2 picture

1. Newly admitted undergraduate or post-graduate student of BISU
2. Transfer student from another school or university
3. Cross-enrolling student from another campus in BISU
4. Returning student from Leave of Absence (LOA) or Absence Without Leave (AWOL) for whatever reason

Name:

*Last Name, First Name, Middle name*

Civil Status: ☐ Single ☐ Married ☐ Widowed ☐ Legally separated

Date of Birth: Birthplace: Campus: Course & Year:

* Freshman ☐ Post-graduate ☐ Transferee
* Cross-enrollee ☐ Returning from LOA/AWOL

EMAIL: {{email}}

*Street, Barangay/ City/Municipality/ Province*

Address while in school:

Name of Parent/Guardian:

EMAIL: {{email}}

Address:

### PERSONAL HISTORY

* Food Allergies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ Drug Allergies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_☐ No known allergies

Are you taking medications regularly? ☐ Yes ☐ No If yes, please specify:

Have you ever had any of the following diseases or problems? Check the corresponding box.

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Remarks |
| Headaches (frequent) | ☐ | ☐ |  |
| Dizziness (frequent) | ☐ | ☐ |  |
| Fainting/Loss of consciousness | ☐ | ☐ |  |
| Insomnia | ☐ | ☐ |  |
| Depressed mood (>2 weeks) | ☐ | ☐ |  |
| Eye/Visual problems | ☐ | ☐ |  |
| Hearing problems | ☐ | ☐ |  |
| Cough (>2 weeks) | ☐ | ☐ |  |
| Colds/ Nasal congestion | ☐ | ☐ |  |
| Fever (frequent/recurrent) | ☐ | ☐ |  |
| Frequent early morning sneezing | ☐ | ☐ |  |
| Nosebleed (frequent) | ☐ | ☐ |  |
| Sore throat (frequent) | ☐ | ☐ |  |
| Chest pain | ☐ | ☐ |  |
| Back pain | ☐ | ☐ |  |
| Easily gets tired | ☐ | ☐ |  |
| Difficulty breathing | ☐ | ☐ |  |
| Palpitations | ☐ | ☐ |  |
| Swelling of feet | ☐ | ☐ |  |
| Nausea (frequent) | ☐ | ☐ |  |
| Vomiting | ☐ | ☐ |  |
| Abdominal pain/discomfort | ☐ | ☐ |  |
| Loss of appetite | ☐ | ☐ |  |
| Weight loss/gain | ☐ | ☐ | *Specify:* |
| Diarrhea/constipation | ☐ | ☐ | *Specify:* |
| Joint pains | ☐ | ☐ |  |
| Muscle pain (frequent) | ☐ | ☐ |  |
| Frequent urination | ☐ | ☐ |  |
| Eczema/Skin problems | ☐ | ☐ |  |
| Fracture | ☐ | ☐ |  |
| Accident/Injuries | ☐ | ☐ |  |
| Hospitalization | ☐ | ☐ | *Reason:* |
| Operation | ☐ | ☐ | *Specify:* |
| Others | ☐ | ☐ | *Specify:* |

Give the appropriate AGE to which you had the following:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Anemia/Blood Disorder | Age | N/A  ☐ | Measles | Age | N/A  ☐ |
| Asthma  Cancer |  | ☐  ☐ | Mental problem/disorder  Mumps |  | ☐  ☐ |
| Chickenpox |  | ☐ | Neurologic problem/disorder |  | ☐ |
| Convulsions Dengue |  | ☐  ☐ | Pertussis (whooping cough) Pleurisy |  | ☐  ☐ |
| Diabetes |  | ☐ | Pneumonia |  | ☐ |
| Diphtheria |  | ☐ | Poliomyelitis |  | ☐ |
| Ear disease/defect |  | ☐ | Rheumatic fever |  | ☐ |
| Eye disease/defect Gonorrhea |  | ☐  ☐ | Skin disease Syphilis |  | ☐  ☐ |
| Heart disease  Hepatitis (indicate type) |  | ☐  ☐ | Thyroid disease  Tonsillitis |  | ☐  ☐ |
| Hernia  High blood pressure |  | ☐  ☐ | Tuberculosis/Primary complex  Typhoid |  | ☐  ☐ |
| Influenza (indicate date)  Joint pains |  | ☐  ☐ | Ulcer (peptic)  Ulcer (skin) |  | ☐  ☐ |
| Kidney disease |  | ☐ | COVID-19 |  | ☐ |
| Malaria |  | ☐ | Other conditions: *please list* |  | ☐ |

Are you a person with a disability? ☐ Yes ☐ No If yes, check the corresponding boxes.

|  |  |  |  |
| --- | --- | --- | --- |
| **Type of disability:** |  | **Cause of disability:** | ☐ |
| Deaf or Hard of Hearing | ☐ | Acquired | ☐ |
| Intellectual Disability | ☐ | Cancer | ☐ |
| Learning Disability | ☐ | Chronic Illness | ☐ |
| Mental Disability | ☐ | Congenital/ Inborn | ☐ |
| Orthopedic Disability | ☐ | Injury | ☐ |
| Physical Disability | ☐ | Rare Disease | ☐ |
| Psychosocial Disability | ☐ | Autism | ☐ |
| Speech and Language Impairment | ☐ |  |  |
| Visual Disability | ☐ |  |  |

### IMMUNIZATION RECORD

|  |  |  |  |
| --- | --- | --- | --- |
|  | Date/ Year given |  | Date/ Year given |
| BCG |  | Hepa A Dose 1 |  |
| Hepa B Dose 1 |  | Dose 2 |  |
| Dose 2 |  | COVID 19 vaccine brand: |  |
| Dose 3 |  | Dose 1 |  |
| Tetanus Toxoid |  | Dose 2 |  |
| Rabies Vaccine |  | Booster 1 |  |
| Flu |  | Booster 2 |  |
| Pneumococcal |  |  |  |
| *\*Write N/A if vaccine not given* | |  |  |

***FOR FEMALE STUDENTS****:*

Menstruation: Age of onset: Regularity: ☐ Regular ☐ Irregular Duration: days Flow: ☐ Light ☐ Moderate ☐ Heavy Dysmenorrhea: ☐ Yes ☐ No Last menstrual period (month and year): Have you had any trouble with your breasts, such as lumps, tumor, surgery? ☐ Yes ☐ No

If so, give details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### FAMILY HISTORY

Mother: Living (indicate age)

Diseases: Maintenance medications: If deceased, (age of death) Cause of death:

Father: Living (indicate age)

Diseases: Maintenance medications: If deceased: (age of death) Cause of death:

**If married:**

Spouse: Living: (indicate age) General health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor Diseases: Maintenance medications: If deceased: (age of death) Cause of death:

Children: (number of children)

Health problems:

Among your blood relatives, is there a history of any of the following?

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Yes | No | Relation |  | Yes | No | Relation |
| Cancer | ☐ | ☐ |  | Diabetes | ☐ | ☐ |  |
| Heart disease | ☐ | ☐ |  | Mental disorder | ☐ | ☐ |  |
| High blood pressure | ☐ | ☐ |  | Asthma | ☐ | ☐ |  |
| Stroke | ☐ | ☐ |  | Neurologic problems/convulsions | ☐ | ☐ |  |
| Tuberculosis | ☐ | ☐ |  | Bleeding disorders | ☐ | ☐ |  |
| Kidney Disease | ☐ | ☐ |  | Digestive problems | ☐ | ☐ |  |
| Arthritis/Rheumatism | ☐ | ☐ |  | Skin disease | ☐ | ☐ |  |
|  |  |  |  |  |  |  |  |

I confirm that I have provided a truthful account of my history to the best of my knowledge. Furthermore, I have made a complete disclosure of all medical conditions that could potentially impact my performance as a student at the University.

*Signature above printed name / Date signed*

**PLEASE DO NOT WRITE BELOW THIS LINE.**

**Results of required tests according to course:**

CBC \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Urinalysis \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chest X-ray \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stool Exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_

HbSAg - test for Hepatitis B \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Neuropsychiatric Exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug test \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ishihara test for color blindness \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Certificate:**

Remarks \_\_\_\_\_\_\_\_\_\_\_\_\_\_