 4th floor SKK Bldg. 63-65 Sen. Gil Puyat Ave., Pasay City  
**Tel. No. 834-7046 / 0920-9537443**  
Email address: [sjladi.adm@gmail.com](mailto:sjladi.adm@gmail.com)  
DOH Accreditation No.: 13-083-17-MF-2  
ISO Certified 9001:2015

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| --- | --- | --- |
| Patient ID: | Date: | Form No: |
| Name: | Package: | |
| Age: | Company: | |
| Gender: | Account: | |
| Civil Status: |  | |

**Medical Certificate**

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| --- | --- | --- | --- |
| **I. History** |  |  |  |
| **Childhood Illness:** |  |  |  |
| **Past Illness:** |  |  |  |
| **Present Illness:** |  | **Supplements:** |  |
| **Surgeries:** |  |  |  |
| **Hospitalization:** |  |  |  |

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| **II. Personal & Social History** | | **Y/N** |  | | | | **Y/N** |  |
| **Smoking History:** |  | | | **Pack per:** | **Drug Use:** |  | | |
| **Alcohol Intake:** |  | | | **Bottle per:** | **Allergy:** |  | | |
| **For Women:** |  | | |  |  |  | | |
| **Pregnant:** |  | | |  |  |  | | |
| **Last Menstrual Period:** |  | | | **Lasting:** | **Days** |  | | |
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| **III. Family History** | | **Y/N** |  | | | | **Y/N** |  |
| **Hypertension:** |  | | |  | **Kidney Disease:** |  | | |
| **Heart Disease:** |  | | |  | **Diabetes Mellitus:** |  | | |
| **Others:** |  | | |  |  |  | | |

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| **IV. Review of Systems: (With Objective findings? *Y - Yes N – No*)** | | | | | |
| **System** | **Y/N** | **Remarks** | **System** | **Y/N** | **Remarks** |
| Eyes |  |  | Musculoskeletal |  |  |
| ENT/Mouth |  |  | Skin/Breast |  |  |
| Cardiovascular |  |  | Neurological |  |  |
| Respiratory |  |  | Endocrine |  |  |
| Gastrointestinal |  |  | Hematological |  |  |
| Genitourinary |  |  | Others |  |  |

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| **IV. Physical Examination** | | | | | | | | |
| Height (cm) |  | Weight (kg) | |  | | Body Mass Index: | |  |
| Blood Pressure |  | PR | |  | | RR: | |  |
| Visual Activity | **Left** | |  | | **Right** | |  | |
| **(With Objective findings? *Y - Yes N - No*)** | | | | | | | | |
| **System** | **Y/N** | **Remarks** | | **System** | | **Y/N** | | **Remarks** |
| General Appearance |  |  | | Back | |  | |  |
| Skin |  |  | | Heart | |  | |  |
| Head & Neck |  |  | | Abdomen | |  | |  |
| Ears, Eyes, Nose |  |  | | Extremities | |  | |  |
| Mouth/ Throat |  |  | | Neurological | |  | |  |
| Chest Lungs |  |  | | Rectal | |  | |  |
| Breast |  |  | | Genitalia | |  | |  |

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| **V. Impression** |
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| **VI. Recommendation** |
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| Examining Physician License No.: | This is to certify that I have been informed of the content of this medical certificate and of the right to review. |