Republic of the Philippines
BUREAU OF FIRE PROTECTION
HEALTH SERVICE
Region 3
PHYSICAL PROFILE EVALUATION SHEET

FORM 1

TO BE FILLED OUT BY THE APPLICANT

1 RANK	LAST NAME	FIRST NAME	MIDDLE NAME	Recent Passport size <6 months	Right thumb mark
2. HOME ADDRESS			3. RELIGION		
4. SEX	CIVIL STATUS	5. AGE (<30 y.o >30 y.o)	6. MOBILE NO.		
7. DATE AND PLACE OF BIRTH (mm/dd/yyyy)			8. DATE AND TIME OF EXAMINATION:		
9. PURPOSE OF EXAMINATION:			10. Email		

Applicant's Signature

TO BE FILLED OUT BY HEALTH EXAMINER

STEP 1: GENERAL INITIAL EVALUATION

CRITERIA		FINDINGS	P1	P2	P3	P4
WEIGHT				P / R	P / R	
HEIGHT	M- 1.62m F- 1.57m	☐ with waiver ☐ without waiver		P / R	P / R	
WAISTLINE	M- <37" F- <31.5"			P / R	P / R	
BMI		☐normal ☐ underweight ☐ obese 1 ☐ obese 2 ☐ obese 3		P / R	P / R	
Visual Acuity	R	with correction		P / R	P / R	
	L	with correction		P / R	P / R	
Ishihara Test Screening	R			P / R	P / R	
	L			P / R	P / R	
(Optional) Farnsworth Lantern Test	R			P / R	P / R	
	L			P / R	P / R	
Blood Pressure DATE	1	AM PM		P / R	P / R	
	2	AM PM		P / R	P / R	
	3	AM PM		P / R	P / R	
Cardiac Rate 60-100/min				P / R	P / R	
Respiratory Rate 12-20/min				P / R	P / R	
Temperature 36.5-37.5°c				P / R	P / R	
SPO2 94-100%				P / R	P / R	

ASSESSMENT:

Profile Score

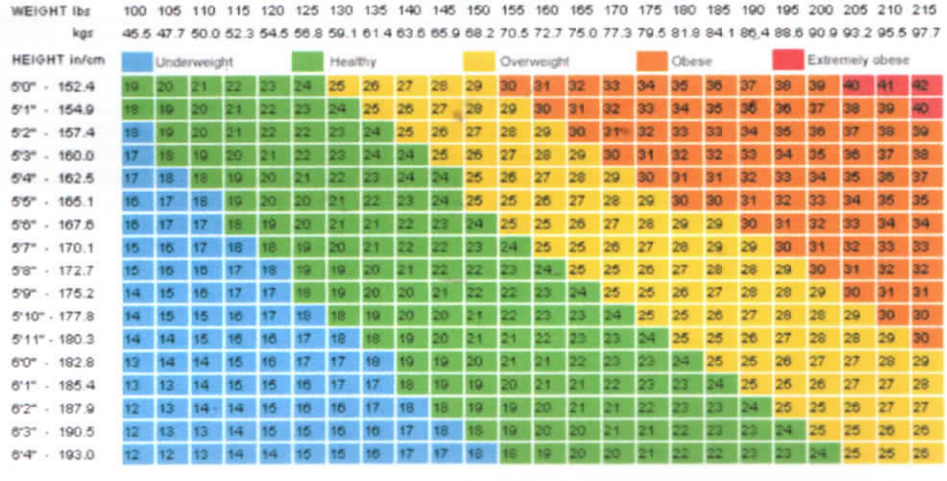
☐ P1 ☐ R
☐ P2 ☐ P
☐ P3
☐ P4

F

☐ GO
☐ NO GO _____

Signature: _____
NAME: (Print) **F/CINSP MARK JOHN N DULIN, MD**
OFFICIAL DESIGNATION: MEDICAL OFFICER
REG CERTIFICATE NO:

BMI Chart



Legend:
P1-
P2
P3
P4
R -remediable
P -permanent

MDG 2018-01

Republic of the Philippines
Department of the Interior and Local Government
BUREAU OF FIRE PROTECTION
NATIONAL HEADQUARTERS
Agham Road, Barangay Bagong Pag-asa, Quezon City
Telefax Number: (02) 426 - 0219
Email: hemd_nhq@yahoo.com

Rank /Name: _____ Region: _____ Date: _____

Age: _____ Sex: _____ Civil Status: _____ Course: _____

Signature of Examiner / Date

1. Height and Weight _____
2. Visual Acuity _____
3. Laboratory
   - 3.1 Chest X-ray (PA view) _____
   - 3.2 ECG _____
   - 3.3 CBC with blood typing _____
   - 3.4 Urinalysis _____
   - 3.5 Drug Test _____
   - 3.6 Fasting blood sugar (FBS) _____
   - 3.7 Cholesterol _____
   - 3.8 HBsAg (Hepa B Screening) _____
   - 3.9 Pregnancy Test (Female) _____
4. Neuro-Psychiatry Exam _____
5. Dental Examination _____
6. Physical Examination _____

_____ _____

Medical Secretariat Signature Over Printed Name of Applicant

BUREAU OF FIRE PROTECTION
HEALTH SERVICE
REPORT OF PHYSICAL EXAMINATION

1. RANK	LAST NAME	FIRST NAME	MIDDLE NAME
2. HOME ADDRESS			
3. SEX / CIVIL STATUS		4. AGE	5. MOBILE NO.
6. DATE AND PLACE OF BIRTH (mm/dd/yyyy)			7. DATE OF EXAMINATION:
8. DESIGNATION / UNIT ASSIGNMENT:			

Past Passport - sizedpicture

9. PURPOSE OF EXAMINATION:

THIS PART IS TO BE FILLED-UP BY BFP DOCTORS OR MEDICAL PERSONNEL ONLY

10. HEIGHT (Bare Foot)	36. BLOOD PRESSURE
11. WEIGHT (Stripped) in kilos	
12. BUILD: Small ☐ Medium ☐ Big ☐	37. CARDIAC RATE
13. SKIN:	
14. COLOR OF EYES:	38. DRUG TEST
15. COLOR OF HAIR:	
16. HEAD & FACE:	39. URINALYSIS
17. NECK:	
18. NOSE & SINUSES:	40. FBS
19. MOUTH & THROAT:	
20. EARS & EARDRUMS R L	41. Hepa-B Screening
21. WHISPER VOICE TEST R L	
22. EYES / PUPILS: R L	42. CBC
23. VISION: **R** **L** w/ correction: R L	
24.COLOR VISION:	43. Blood Type
25. HEART:	
26. VASCULAR SYSTEM:	44. Pregnancy Test
27. LUNGS AND CHEST:	
28. ABDOMEN VISCERA:	45. Cholesterol
29. ANUS AND RECTUM:	TC LDL
30. GENITAL:	HDL VLDL
31. UPPER EXTREMITIES:	46. ECG
32. LOWER EXTREMITIES:	
33. SPINE & MSK SYSTEM:	
34. PELVIC:	47. Chest x-ray
35. PSYCHIATRIC: **NR:** ☐ **Recommended:**	

48. SIGNIFICANT MEDICAL HISTORY:	Signature: _____
49. OVER ALL PHYSICAL EVALUATION:	NAME: (Print)
	OFFICIAL DESIGNATION: Medical Officer
50. RECOMMENDATION:	REG CERTIFICATE NO:

Revised March 2018

REPORT OF MEDICAL HISTORY

1. LAST NAME	FIRST NAME	MIDDLE NAME

2. DATE OF BIRTH	3. AGE (last birthday)	4. PLACE OF BIRTH

FAMILY HISTORY:

NAME	AGE	State of Health	If deceased, cause of death		YES	NO
Father:				TB		
Mother:				Syphillis		
Brother/s:				Cancer		
				Epilepsy		
				Kidney		
				Kidney Trouble		
Sister/s:				Asthma		
				Allergy/Hives		
				Psychiatric		
				Committed suicide		
Spouse:				Hypertension		
Children:				Diabetes		

PERSONAL HISTORY:

OB History: Have you been pregnant? _____ How many times? _____

How many children do you have? _____ Hove you had abortion _____If Yes, quantify _____

Have you ever: (Pls check)

	YES	NO		YES	NO
Worn eye glasses			Worn brace or back support		
Worn hearing aid			Worn artificial eyes		
Had syphillis			Had paralysis / infantile		
Had fracture			Had serum reaction		
Attempted suicide			Lived with person with tuberculosis		
Had foot trouble			Had stuttered or stammered speech		
Diphtheria			Gall bladder disease		
Rheumatic fever			Frequent / severe headache		
Measles			Dizziness / fainting spell		
Mumps			Chronic / frequent colds		
Chicken pox			Palpitation / pounding heart		
Whooping cough			Tumor, cyst or cancer		
Tuberculosis			Frequent / painful urination		
Pneumonia			Sugar / albumin in urine		
Asthma			Recent weight gain / weight loss		
Jaundice			Bone / joint deformity		
Ear discharge			Loss of arm, finger, toe		
Goiter			Pain in shoulder		
Epilepsy			Motion sickness		
Venereal disease			Shortness of breath		
Knocked-knee			Stomach, liver or intestinal disorder		
Depression			Terrifying nightmare		
Pyorrhea / bleeding gums			Sleeping trouble		
Arthritis			Drug, narcotic-habit or alcoholism		
Loss of memory			Pain or pressure in the chest		
Nervousness			Frequent or severe indigestion		
Sinusitis			Piles or rectal disease		
Bedwetting			Diarrhea		

_____

Signature over printed name of applicant

Do you have or have you been advised to undergo any surgical operation? Yes _____ No _____

If yes describe what type and at what age it was done: _____

Have you had accidents or injuries other than those listed? Yes _____ No _____

If Yes, give details and data: _____

Have you ever been hospitalized? Yes _____ No _____ If yes, when: _____

Where? _____ Why: _____

Have you ever been immunized of the ff:

	YES	NO	YEAR
Cholera	_____	_____	_____
Influenza	_____	_____	_____
Tetanus	_____	_____	_____
Typhoid	_____	_____	_____
Hepatitis B	_____	_____	_____
Mumps	_____	_____	_____

OCCUPATIONAL HISTORY

Are you _____right handed? _____left handed?

Have you ever worked with radioactive materials? Yes _____ No _____

Have you ever refused employment with BFP because of your health/ other reasons? Yes _____ No _____

Give details: _____

Are you unable to hold a job because of the following: If Yes, give details

Sensitivity to chemicals, dust, sunlight, etc Yes _____ No _____
Inability to assume certain positions Yes _____ No _____
Other medical reasons Yes _____ No _____

Have you ever been disqualified from work due to physical or mental reasons? Yes _____ No _____

If Yes, give reasons: _____

How many jobs did you have in the past three years? _____ Longest period in a job? _____

What is your usual occupation? _____

Have you ever consulted / been treated by physician or other practitioners within the last 5 yrs? Yes No____

If Yes, give details and data: _____

Have you tried self-medication? Yes _____ No _____ If Yes, give details: _____

Have you had any physical or mental complaints at present? Yes _____ No _____

If Yes, give details and duration: _____

Have you ever applied at BFP? Yes_____No _____ If Yes, Have you been examined by a Medical Officer of the BFP? Yes _____ No _____ Date of last examination done: _____

When was the last time you took the BFP nueropsychiatric exam (NPE)? _____
What was the result of the Nueropsychiatric exam? ☐ Passed ☐ Failed

I HEREBY CERTIFY THAT ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. ANY MISREPRESENTATION/ CONCEALMENT OF MEDICAL HISTORY SHALL BE A GROUND FOR DISQUALIFICATION/ DISAPPROVAL OF APPLICATION WITHOUT PREJUDICE TO ANY ADMINISTRATIVE OR CRIMINAL LIABILITY THAT MAY BE INITIATED AGAINST THE APPLICANT.

_____ Date Accomplished

_____ Signature over printed name of applicant