**ROSARIO INSTITUTE**

**Rosario, Cavite**

**HEALTH HISTORY FORM**

NAME:\_**valimento, israel** \_\_\_ GENDER: \_\_**male**\_\_ DATE:\_**2025-06-08**\_\_\_

HOME ADDRESS: \_**Navarro General Trias**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH: \_\_**2025-06-04**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BIRTHPLACE: \_**Trece martires**\_\_\_\_

RELIGION: \_\_**Catholic**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITIZENSHIP: \_\_**Filipino**\_\_\_\_\_\_\_

PERSON TO CONTACT IN CASE OF EMERGENCY: \_\_**Nanay nya**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RELATIONSHIP:\_\_**mother**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CONTACTNUMBER:\_\_**09279364188**\_\_\_\_\_

Do you have or have you ever had..

|  |  |  |  |
| --- | --- | --- | --- |
|  | **✔/✘** |  | **✔/✘** |
| ADHD (Attention Deficit Hyperactivity Disorder) | **✔** | Heart Condition | **✘** |
| Asthma | **✔** | Lung Problem | **✔** |
| Anemia | **✔** | Mental or psychological problems | **✘** |
| Bleeding problem | **✔** | Migraine/Headache | **✔** |
| Cancer | **✘** | Seizure/Convulsion | **✘** |
| Chest pain | **✔** | Tuberculosis | **✔** |
| Diabetes | **✘** | Hernia | **✘** |
| Fainting | **✔** | Urinary/Kidney Problem | **✔** |
| Fracture | **✘** | Vision: Glasses/Contact Lens | **✘** |
| Hearing/Speech Problem | **✔** | Other Issues: | **✔** |

If YES, please specify \_\_**asdgasd**\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| Are you under medical treatment now? |  |

If so, what is the condition being treated\_\_**yes, gonorrhea**\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICATIONS that are already taken from the past:

\_\_**co-amoxiclav**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CURRENT MEDICATIONS

\_\_**none**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have ALLERGY? (insects, foods, medications etc) \_**yes**\_

If yes, please specify and give the medication you are taking.

\_\_**bee's sting**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CHILDHOOD ILLNESSES:\_\_\_**mumps**\_\_\_\_\_

Ex. (Mumps/Chickenpox/Measles/German Measles)

IMMUNIZATION (BCG\_**✔**\_\_\_ ,DPT$\_**✘**\_\_\_ , OPV\_**✔**\_\_\_ ,HEP.B\_**✔**\_\_\_ ,

MEASLES VACCINE \_**✘**\_\_\_ . FLU VACCINE **✔**\_\_\_ , Varicella \_✘\_\_\_ ,

MMR \_**✘**\_\_\_ etc.\_**✔**\_\_\_)

Complete /Incomplete\_**complete**\_ Tetanus toxoid:\_**yes**\_\_Date-last-given: \_**2025-06-01**\_\_

Have you been hospitalized? YES /NO\_**✔**\_

(accident, illness, surgery, fracture, etc.)

|  |  |
| --- | --- |
| YEAR | REASON |
| **2025-06-01** | **car accident** |
|  |  |

FAMILY MEDICAL HISTORY:

Write below all the conditions or illnesses that your family has. (example: Asthma, Diabetes, TB, Migraine, Hypertension)

\_\_\_**none**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FOR FEMALE : MENARCHE \_\_\_\_\_ht.(cm.) \_\_\_wt.(kg.) \_\_\_(first menstrual period)

Covid-19 Vaccine

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Date of 1st dose | Date of 2nd dose | Vaccine manufacturer | Booster | (+) Covid ( When) |
| **2025-06-19** | **2025-06-03** | **pfizer** | **none** | **2025-06-01** |