**ROSARIO INSTITUTE**

**Rosario, Cavite**

**HEALTH HISTORY FORM**

NAME:\_**${lastname}, ${firstname}** \_\_\_ GENDER: \_\_**${gender}**\_\_ DATE:\_**${\_date}**\_\_\_

HOME ADDRESS: \_**${\_address}**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH: \_\_**${birthdate}**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BIRTHPLACE: \_**${birthplace}**\_\_\_\_

RELIGION: \_\_**${religion}**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITIZENSHIP: \_\_**${citizenship}**\_\_\_\_\_\_\_

PERSON TO CONTACT IN CASE OF EMERGENCY: \_\_**${guardian}**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RELATIONSHIP:\_\_**${relationship}**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CONTACTNUMBER:\_\_**${contact}**\_\_\_\_\_

Do you have or have you ever had..

|  |  |  |  |
| --- | --- | --- | --- |
|  | **✔/✘** |  | **✔/✘** |
| ADHD (Attention Deficit Hyperactivity Disorder) | **${adhd}** | Heart Condition | **${heart\_condition}** |
| Asthma | **${asthma}** | Lung Problem | **${lung\_prob}** |
| Anemia | **${anemia}** | Mental or psychological problems | **${mental\_prob}** |
| Bleeding problem | **${bleeding}** | Migraine/Headache | **${migraine}** |
| Cancer | **${cancer}** | Seizure/Convulsion | **${seizure}** |
| Chest pain | **${chestpain}** | Tuberculosis | **${tubercolosis}** |
| Diabetes | **${diabetes}** | Hernia | **${hernia}** |
| Fainting | **${fainting}** | Urinary/Kidney Problem | **${kidney\_prob}** |
| Fracture | **${fracture}** | Vision: Glasses/Contact Lens | **${vision}** |
| Hearing/Speech Problem | **${hearing\_speech}** | Other Issues: | **${other}** |

If YES, please specify \_\_**${specify}**\_\_\_\_\_\_\_

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

If so, what is the condition being treated\_\_**${medication\_treatment}**\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICATIONS that are already taken from the past:

\_\_**${medication\_past}**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CURRENT MEDICATIONS

\_\_**${current\_medication}**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have ALLERGY? (insects, foods, medications etc) \_**${allergy}**\_

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

\_\_**${if\_yes}**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CHILDHOOD ILLNESSES:\_\_\_**${childhood\_illness}**\_\_\_\_\_

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

IMMUNIZATION (BCG\_**${\_bcg}**\_\_\_ ,DPT$\_**${\_dpt}**\_\_\_ , OPV\_**${\_opv}**\_\_\_ ,HEP.B\_**${\_hepb}**\_\_\_ ,

MEASLES VACCINE \_**${\_measleVac}**\_\_\_ . FLU VACCINE **${\_fluVaccine}**\_\_\_ , Varicella \_$**{\_varicella}**\_\_\_ ,

MMR \_**${\_mmr}**\_\_\_ etc.\_**${\_etc}**\_\_\_)

Complete /Incomplete\_**${tetanus}**\_ Tetanus toxoid:\_**${\_vaccineName}**\_\_Date-last-given: \_**${date\_last\_given**}\_\_

Have you been hospitalized? YES /NO\_**${hospitalize\_before}**\_

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

|  |  |
| --- | --- |
| YEAR | REASON |
| **${\_year}** | **${reason}** |
|  |  |

FAMILY MEDICAL HISTORY:

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

\_\_\_**${family\_med\_history}**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FOR FEMALE : MENARCHE \_\_\_**${fem\_height}**\_\_ht.(cm.) \_\_**${fem\_weight}**\_wt.(kg.) \_\_**${first\_menstrual}**\_(first menstrual period)

Covid-19 Vaccine

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Date of 1st dose | Date of 2nd dose | Vaccine manufacturer | Booster | (+) Covid ( When) |
| **${first\_dose\_date}** | **${second\_dose\_date}** | **${vaccine\_manufacturer}** | **${booster}** | **${plus\_covid\_date}** |