**ROSARIO INSTITUTE**

**Rosario, Cavite**

**HEALTH HISTORY FORM**

NAME:\_**israel valimesnt0sdfsdfsdf,** \_\_\_ GENDER: \_\_**male**\_\_ DATE:\_**2025-06-03**\_\_\_

HOME ADDRESS: \_**Anahaw St. Block- 57 Lot-08**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH: \_\_**2025-06-11**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BIRTHPLACE: \_**asdfsdf**\_\_\_\_

RELIGION: \_\_**asdf**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITIZENSHIP: \_\_**asdf**\_\_\_\_\_\_\_

PERSON TO CONTACT IN CASE OF EMERGENCY: \_\_**asfd**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RELATIONSHIP:\_\_**asdf**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CONTACTNUMBER:\_\_**09519037664**\_\_\_\_\_

Do you have or have you ever had..

|  |  |  |  |
| --- | --- | --- | --- |
|  | YES |  | YES |
| 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 \_\_**no**\_\_\_\_\_\_\_

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

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

MEDICATIONS that are already taken from the past:

\_\_**asdf**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CURRENT MEDICATIONS

\_\_**adsf**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have ALLERGY? (insects, foods, medications etc) \_**no**\_

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CHILDHOOD ILLNESSES:\_\_\_\_\_\_\_\_

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

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

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

MMR \_**✘**\_\_\_ etc.\_**✘**\_\_\_)

Complete /Incomplete\_\_ Tetanus toxoid:\_**no**\_\_Date-last-given: \_**2025-07-04**\_\_

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

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

|  |  |
| --- | --- |
| YEAR | REASON |
| **2025-06-05** | **asfd** |
|  |  |

FAMILY MEDICAL HISTORY:

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

\_\_\_**asdfasdf**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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) |
| **2025-07-10** | **${secode\_dose\_date}** | **asfd** | **asdf** | **2025-07-03** |