**ROSARIO INSTITUTE**

**Rosario, Cavite**

**HEALTH HISTORY FORM**

NAME:\_**caraig, kurt russel** \_\_\_ GENDER: \_\_**male**\_\_ DATE:\_**2025-15-17**\_\_\_

HOME ADDRESS: \_**phase 2 tanza**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH: \_\_**3/18/2011**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BIRTHPLACE: \_**cavite city**\_\_\_\_

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

PERSON TO CONTACT IN CASE OF EMERGENCY: \_\_**Pedro Santos**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RELATIONSHIP:\_\_**father**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CONTACTNUMBER:\_\_**09981234567**\_\_\_\_\_

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 \_\_**glasses**\_\_\_\_\_\_\_

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

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

MEDICATIONS that are already taken from the past:

\_\_**salbutamol**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CURRENT MEDICATIONS

\_\_**ventolin**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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

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: \_**2025-15-17**\_\_

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

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

|  |  |
| --- | --- |
| YEAR | REASON |
| **2025-15-12** | **heart attack** |
|  |  |

FAMILY MEDICAL HISTORY:

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

\_\_\_**asthma**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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) |
| **2025-15-12** | **2025-15-12** | **moderna** |  | **2025-15-12** |