UNIVERSITY OF THE PHILIPPINES VISAYAS
HEALTH SERVICE UNIT
Miagao, Iloilo

PERIODIC HEALTH EXAMINATION

Year of Examination _____

Date (MM/DD/YYYY): _____

PLEASE PRINT LEGIBLY. USE BLACK OR BLUE INK. MARK APPROPRIATE BOXES WITH CHECK (✓). PRINT ON A4 PAPER BACK TO BACK.

Last Name			First Name			Middle Initial	
Age	Sex	Birthdate (MM/DD/YYYY)	Civil Status	Student/Employee No.	College/Division/Unit	☐	Student
						☐	Employee

ADDITIONAL DATA INFORMATION SHEET

Present Mobile Number:	Network:
Present Address in Miagao:	
Name of Landlord/Landlady/Dorm Head:	
Contact Number of Boarding House/Dormitory:	
Guardian/Person to be contacted in CASE OF EMERGENCY, especially if PARENTS are not available (Preferably within Panay Island):	
Name:	Relationship:
Address:	Landline Number:
	Mobile Number:
	Network:

PAST OR CURRENT MEDICAL PROBLEMS (Do not leave blanks. Write either: **NA or Not Applicable**; **Unrecalled**; or **None**)

Medical Condition	When Identified	Maintenance Medications If Any

Allergies: FOOD _____ DRUG _____ ENVIRONMENTAL AGENTS/FACTORS _____

Hospitalization: _____ Operations: _____

FAMILY HISTORY (Check and indicate closest family member affected. Do not leave blanks. Write either: **NA or Not Applicable**; **Unrecalled**; or **None**)

	Yes	No	Relationship		Yes	No	Relationship
Cancer				Bronchial Asthma			
Heart Disease				Allergies/Allergic Rhinitis			
High Blood Pressure				Mental Disorder/Problem			
Stroke				Digestive Disturbances			
Tuberculosis				Convulsions/Neurologic Problems			
Kidney Disease				Bleeding Problems/Blood Disorders			
Diabetes				Others: _____			

LIFESTYLE EVALUATION (Do not leave blanks. Write either: **NA or Not Applicable**; **Unrecalled**; or **None**)

Lifestyle	What to describe?	Description of behavior
Diet	High or Low or Just Right Carbohydrate/Fat/Fiber/Salty/Sweet	
Tobacco/Smoking	If active: duration and quantity	
Alcohol	Quantity and Frequency	
Physical Activity/Sports Activity	Type and number of hours per week	
Sexual Activity		
Personal Hygiene		

RECURRING SYMPTOMS IF ANY (Write the symptoms that is causing concern. Do not leave blanks. Write either: **NA or Not Applicable**; **Unrecalled**; or **None**)

General		Heart		Muscles/Joints	
Head/Neck		Abdomen		Blood related	
Chest/Lungs		Back		Others	
Sense Organs (Eyes, Ears, Nose)		Skin			
For **FEMALES**:	Previous Menstrual Period	Last Menstrual Period	Flow	Duration (Days)	☐ Regular ☐ Irregular
OBGyne History (TO BE FILLED UP WITH THE CLINIC NURSE ON DUTY DURING INTERVIEW): G _____ P _____ (F _____ P _____ A _____ L _____)					

IMMUNIZATIONS (Please indicate booster doses. Do not leave blanks. Write either: **NA or Not Applicable**; **Unrecalled**; or **None**)

Vaccine	Given When (MM/YYYY)	Vaccine	Given When (MM/YYYY)
Influenza		HPV	
Pneumonia		Varicella/Chicken Pox	
Hepatitis A		Typhoid	
Hepatitis B		Rabies	
MMR		DTaP/Tetanus	
Others:		Others:	

PHYSICAL EXAMINATIONS

Height (cm)		Weight (kg)		BP (mmHG)		PR (bpm)		BMI	
VISION TEST		Right Eye	Far			Left Eye	Far		
			Near				Near		

*(**DO NOT WRITE** beyond this line, to be **FILLED** out by the **PHYSICIAN**.)*

ORGAN SYSTEM	Essentially Normal	Findings if Abnormal
Skin		
HEENT		
Neck		
Chest and Lungs		
Heart		
Abdomen		
Genitalia		
Back		
Skin		
Extremities		

LABORATORY/DIAGNOSTIC PROCEDURES

Laboratory/Diagnostic	Pertinent Results	Findings/Diagnosis
CBC		
Urinalysis		
Fecalysis		
CXR PA		
Drug Test		
Others:		

OVERALL HEALTH ASSESSMENT/DIAGNOSIS:

	EMPLOYEE CLASSIFICATION		STUDENT CLASSIFICATION
	Fit for employment: Class A		Fit to enrollment with no PE restrictions
	Fit for employment: Class B		Fit for enrollment but with PE restrictions
	Fit for employment: Class C		Fit for enrollment but hold chart temporarily
	Not fit for employment		Not fit for enrollment

RECOMMENDATIONS/REMARKS:

Examining Physician: _____

PRC License Number: _____

[BMI: Underweight (<18.5), Good/Normal (18.5-23), Overweight (23-27.4), Obese (27.5-37.4), Extremely Obese (>37.5)]
{Class A – Physically fit for any work; Class B – Physically under-developed or w/ corrective defects (EOR, dental carries, defective hearing) but otherwise fit to work; Class C – Employable but owing to certain impairments or conditions (heart disease, HPN, DM2) requires special placement or limited duty in a specified or selected assignment requiring follow-up treatment/periodic evaluation; Class D – unfit or unsafe for any type of employment (active TB, advanced heart disease w/ threatened heart failure, malignant HPN}