



**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 (✓)*

Last Name			First Name			Middle Initial	
Age	Sex	Birthdate (MM/DD/YYYY)	Civil Status	Student/Employee No.	College/Division/Unit	<input type="checkbox"/> Student	<input type="checkbox"/> Employee

**ADDITIONAL DATA INFORMATION SHEET**

Present Mobile Number:	Network:
Permanent Address:	
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 Iloilo):	
Name:	Relationship:
Address:	Landline Number:
	Mobile Number:
	Network:

**CURRENT MEDICAL PROBLEMS within the PAST YEAR** (Do not leave blank. Write either: **NA or Not Applicable; Unrecalled; or None**)

Medical Condition	When Identified	Maintenance Medications If Any

**RECURRING SYMPTOMS IF ANY** (Write the symptoms that is causing concern. Do not leave blank. 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				
<b>For FEMALES:</b>	1 <sup>st</sup> Day of Last Menstrual Period (LMP) mm/dd/yyyy	Duration (No. of Days)	Flow <input type="checkbox"/> Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy	Frequency {Monthly, etc.}	Regularity <input type="checkbox"/> Regular <input type="checkbox"/> Irregular

**IMMUNIZATIONS** (Received for the past year. Please indicate boosters. Do not leave blank. Write either: **NA or Not Applicable; Unrecalled; or None**)

Vaccine	Given When (MM/YYYY)	Vaccine	Given When (MM/YYYY)

**PHYSICAL EXAMINATION**

Height (cm)		Weight (kg)		BP (mmHG)		PR (bpm)		BMI	
<i>(DO NOT WRITE beyond this line, to be FILLED out by the PHYSICIAN.)</i>									
VISION TEST	Right Eye	Far		Left Eye	Far				
		Near			Near				
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		
Fecalalysis		
CXR PA		
Drug Test		
Others:		

**OVERALL HEALTH ASSESSMENT/DIAGNOSIS:**

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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:**

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<b>Name of Examining Physician</b>	<b>Signature</b>	<b>License Number</b>	<b>Date Signed</b>

[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)}