UNIVERSITY OF THE PHILIPPINES VISAYAS
HEALTH SERVICE UNIT
Miagao, Iloilo

ENTRANCE HEALTH EXAMINATION

A complete Medical History and Physical Examination is compulsory to complete your admission to the University of the Philippines Visayas and must be on file before your registration. This is your responsibility as applicant and not that of your physician. Please type or complete in ink. This record will be treated with utmost confidentiality.

Important: Please bring accomplished form with you to the UPV Health Service Unit when you come for a physical examination.

PLEASE KEEP THIS FORM NEAT AND CLEAN

A. Complete this form if you are enrolling during a regular semester and if you are:
   1. A beginning undergraduate or a beginning graduate student.
   2. A transfer student from a regional campus or another school or university.
   3. A re-entry student (undergraduate or graduate) who has been out of the University of the Philippines for at least one semester.

B. Completion of this form is not required if:
   1. You are a foreign student sponsored by a government agency whose files provide a complete health record signed by a physician. A copy of the health record should be submitted in lieu of this form.
   2. Enrolling for a Midyear Session only.

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 Name

Age: _____ Sex: ☐ Male ☐ Female Citizenship: _____ Civil Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Date of Birth (MM/DD/YYYY): _____ Place of Birth: _____

College/School: _____ Degree: _____ Student No.: _____

☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior ☐ Graduate ☐ Special

Home Address: _____ Tel. No.: (_____) _____

_____ Mobile No.: _____ Network: _____

Father's Name: _____ Mobile No.: _____ Network: _____

Mother's Name: _____ Mobile No.: _____ Network: _____

Address in School: _____ Tel. No.: (____) _____

Name of Landlord/Landlady/Dorm Head: _____

Contact No. of Boarding House/Dormitory Tel. No.: (_____) _____ Mobile No.: _____ Network: _____

PERSON TO CONTACT IN CASE OF EMERGENCY, IF PARENTS ARE NOT AVAILABLE:

Name of Guardian/Spouse: _____

Address: _____ Tel. No.: (____) _____

_____ Mobile No.: _____ Network: _____

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

Medical Condition	When Identified	Maintenance Medications If Any

Allergies: Food _____ Drugs _____ Environmental Agents/Factors _____

Hospitalizations _____ Operations _____

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

Vaccine	Given When (MM/YY)	Vaccine	Given When (MM/YY)	Vaccine	Given When (MM/YY)
Influenza		MMR		HPV	
Pneumonia		Varicella/Chicken Pox		Typhoid	
Hepatitis A		DTaP/Tetanus		Rabies	
Hepatitis B		COVID-19 (2nd Dose)		COVID-19 (Booster)	

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

Father Living _____ (Age) If Deceased, _____ (Age of Death) Cause of Death _____

Mother Living _____ (Age) If Deceased, _____ (Age of Death) Cause of Death _____

Among your blood relatives, is there a history of any of the following:

	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		
Others		

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

Give the appropriate age to which you have the following:

	AGE		AGE		AGE
Anemia/Blood Disorder		Hernia		Poliomyelitis	
Asthma		High Blood Pressure		Rheumatic Fever	
Cancer		Influenza A (H1N1) (indicate date)		Skin Disease	
Chickenpox		Joint Pains/Arthritis		Smallpox	
Convulsions		Kidney Disease		Syphillis	
Dengue		Malaria		Thyroid Disease	
Diabetes		Measles		Tonsilitis	
Diptheria		Mental Problems/Disorders		Tuberculosis/Primary Complex	
Ear disease/defect		Mumps		Typhoid	
Eye disease/defect		Neurologic Problems/Disorders		Ulcer (Peptic)	
Gonorrhea		Pertussis (Whooping Cough)		Ulcer (Skin)	
Heart Disease		Pleurisy		Other Conditions:	
Hepatitis (indicate type)		Pneumonia			

Have you ever had or do you have any of the following? Check each item, Yes or No.

	Yes	No		Yes	No		Yes	No
Headaches (frequent)			Sore throat (frequent)			Diarrhea/Constipation (specify)		
Dizziness (frequent)			Chest pain			Joint pains		
Fainting/Loss of Consciousness			Back pain			Muscle pain (frequent)		
Insomnia			Easily gets tired			Frequent urination		
Depressed mood (>2 weeks)			Difficulty of breathing			Eczema/Skin problems		
Eye/Visual Problems			Palpitations			Fracture		
Hearing Problems			Swelling of feet			Accident/Injuries		
Cough (>2 weeks)			Nausea (frequent)			Hospitalization (reason)		
Colds/Nasal Congestion			Vomiting			Operation (specify)		
Fever (frequent/recurrent)			Abdominal pain/discomfort			Others (specify)		
Frequent early morning sneezing			Loss of appetite					
Nosebleed (frequent)			Weight loss/gain (specify)					

If answer is YES, please give details: _____

_____

_____

_____.

Do you worry too much? ☐YES ☐NO. Does your self-consciousness interfere with your getting along with others easily? ☐YES ☐NO
Are you bothered by a feeling that people are watching you or talking about you? ☐ YES ☐NO. Are you concerned about alternating period of gloom and cheerfulness? ☐ YES ☐NO. Is it difficult for you to pull out of a depressed mood? ☐YES ☐NO. Are you inclined to be secretive or seclusive? ☐YES ☐ NO. Do you have any thoughts of self-harm or suicidal thoughts? ☐ YES ☐ NO.

Date of last dental check-up: _____ Date of last eye refraction: _____

Do you consider yourself in good health? ☐ YES ☐ NO. If not, give details _____
_____
_____.

Are you taking any medicines regularly? ☐YES ☐NO. If so, what are these medicines? _____
_____
_____.

Do you have any physical condition or handicap which requires special treatment, diet or other special consideration? ☐ YES ☐NO. Please specify _____
_____.

FOR FEMALE STUDENTS ONLY

Menstruation: Age of Onset/Start _____ Duration: _____ days Interval: ☐ Regular (monthly) ☐ Irregular (skips in months)
1st day of Previous Menstrual Period (MM/DD/YY): _____ 1st day of Last Menstrual Period (MM/DD/YY): _____
Flow: ☐Moderate ☐ Excessive ☐ Scanty Pain: ☐ YES ☐ NO, Incapacitating: ☐ YES ☐NO Bleeding between periods? ☐YES ☐ NO
OBGyne History (TO BE FILLED UP WITH THE CLINIC NURSE ON DUTY DURING INTERVIEW): G _____ P _____ (F _____ P _____ A _____ L _____)

Have you had any trouble with your breasts, such as lumps, tumor, surgery? ☐ YES ☐ NO If so, give details _____
_____
_____.

I certify that the above answers and statements are true and complete, and to the best of my knowledge.

_____	_____	_____
Patient's Signature	Parent/Guardian's Signature Above Printed Name	Date

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CONSENT FOR PHYSICAL EXAMINATION

Date (MM/DD/YYYY): _____

PLEASE CHECK ONE (1):

☐ For Minors (18 years of age and below)

I hereby grant consent to any of the staff physicians of the UPVHSU, Miagao, Iloilo to conduct a thorough physical/medical examination of my son/daughter/charge _____ as a pre-requisite for admission to UP Visayas.

☐ For those of legal age (19 years of age and above)

I grant my consent to any of the staff physicians of the UPVHSU, Miagao, Iloilo to conduct a thorough physical/medical examination on myself as a pre-requisite for admission to UP Visayas.

I, therefore, hereunder set my hand on the _____ of _____, 20 _____.

_____	_____
Signature above Printed Name	Relationship (in the case of minors)

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

Name _____ Age _____ Sex _____ Civil Status _____

(DO NOT WRITE ON THIS SIDE. TO BE FILLED OUT BY YOUR PHYSICIAN AND NURSE)

VITAL SIGNS AND ANTHROPOMETRIC MEASUREMENTS:

Pulse rate _____ beats/min Blood pressure _____ mmHg Respiratory rate _____ breaths/min

Temperature _____ ◦C Height _____ cm Weight _____ kg Body Mass Index _____

_____ Under (<18.5)
_____ Good (18.5-23)
_____ Overweight (23-27.4)
_____ Obese (27.5-37.4)
_____ Extremely Obese (>37.5)

GENERAL HEALTH APPEARANCE: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

VISUAL ACUITY:

	Without Glasses		With Glasses/Contact Lenses	
	FAR (Snellen)	NEAR (Jaeger)	FAR (Snellen)	NEAR (Jaeger)
Right	_____	_____	_____	_____
Left	_____	_____	_____	_____

Color Vison _____

Please check appropriate box whether findings are normal or abnormal to each organ systems; if with abnormal findings, please describe below.

ORGANS/SYSTEMS	Normal	Abnormal	If abnormal, please describe findings
Skin			
Head/Scalp			
Eyes			
Ears			
Nose			
Mouth/Oropharynx			
Neck			
Heart			
Lungs			
Back/Spine			
Abdomen			
Extremities			
Genito-urinary/Ano-rectal			
Neurologic			

LABORATORY/DIAGNOSTIC PROCEDURES:

Procedures	Results	Findings/Diagnosis
CBC		
Urinalysis		
Fecalysis		
Chest X-ray		

OVERALL HEALTH ASSESSMENT/DIAGNOSIS:

Classification:

☐ Fit for enrollment with no PE restrictions
☐ Fit for enrollment with PE restrictions
☐ Fit for enrollment but hold chart temporarily, reason: _____
☐ Not fit for enrollment

RECOMMENDATIONS/REMARKS:

Examined by: _____

PRC License No. _____

Date Examined _____