UNIVERSITY OF THE PHILIPINES VISAYAS
HEALTH SERVICE UNIT
Miagao, Iloilo
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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
Home Address							

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 (s) to be contacted in CASE OF EMERGENCY, esp. if PARENTS are not available (Preferably within Iloilo City/Province):	
Name:	Relationship:
Address:	Landline Number:
	Mobile Number:
	Network:

PAST AND 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. Please check your appropriate answer.)

Lifestyle	Check all that applies.
Diet	□ High Carbohydrate/Sugar □ High Fat □ High Fiber □ High Salty □ Low Water Intake
Tobacco/Smoking	□ Never □ Used to but stopped □ Currently using, specify # of sticks/day: _____
Alcohol	□ Never □ Occasional □ Periodic, specify # and type of drinks/session: _____
Physical Activity/Sports Activity	□ Sedentary ☑ Regularly exercise/sports activity, specify average # of hours/week: _____
Sexuality and Gender	Having difficulty with sexuality or gender orientation? □ Yes □ No
Personal Hygiene	Daily bath? □ Yes □ No Oral Hygiene? □ Yes □ No
Sleep	Average # hours/day: Do you feel refreshed? □ Yes □ No
Others	

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**:	Last Menstrual Period (1st day of latest menstrual cycle)	Menstrual Symptoms	Duration	Pads/Day	□ Regular □ Irregular
OB-Gyne 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	
COVID-19 1° Series (Name/Date)		Covid-19 BOOSTER (Name/Date)	

PHYSICAL EXAMINATIONS

Weight (kg)		BMI: _____ [BMI: UNDERWEIGHT (<18.5), GOOD/NORMAL (18.5-23), OVERWEIGHT (23-27.4), OBESE (27.5-37.4), EXTREMELY OBESE (>37.5)] *TAKEN FROM WHO-WPR, 2000, ASIA-PACIFIC PERSPECTIVE: REDEFINING OBESITY AND ITS TREATMENT*		BP (mmHg) 1st Reading		BP (mmHg) 2nd Reading		RR (cpm)	
Height (m)				PR (bpm)		Sp02 (%)		TEMP (°C)	
VISION ACUITY		Right Eye	Far (Snellen)			Left Eye	Far (Snellen)		
			Near (Jaeger)				Near (Jaeger)		
			Color (Ishihara)	☐ POSITIVE ☐ NEGATIVE			Color (Ishihara)	☐ POSITIVE ☐ NEGATIVE	

*(**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/IMPRESSION:

EMPLOYEE CLASSIFICATION		STUDENT CLASSIFICATION	
	Fit for employment: Class A		Fit for enrollment without activity restrictions
	Fit for employment: Class B		Fit for enrollment but with activity restrictions
	Fit for employment: Class C		Fit for enrollment but to comply w/ medical advice. (Referrals, laboratory requests, etc.)
	Not fit for employment: Class D		Not fit for enrollment

RECOMMENDATIONS/REMARKS:

Examining Physician: _____

PRC License Number: _____

{BMI: Underweight (<18.5), Good/Normal (18.5-22.9), Overweight (23-24.9), Obese (25-29.9), Extremely Obese (>30) [*taken from WHO-WPR, 2000, Asia-Pacific Perspective: Redefining Obesity and its Treatment*]}

{OSHC Rule 1960, Section 1967.01: 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, and other similar illnesses)}

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MENTAL HEALTH SCREENING TOOL

Name: _____

Student No.: _____ Date Accomplished (*mm/dd/yyyy*): _____

Part A (GAD-7): Please mark (**X**) the box to your corresponding answer.

Over the **last 2 weeks**, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly everyday
1. Feeling nervous anxiety, or on the edge				
2. Not being able to stop or control worrying.				
3. Worrying too much about different things.				
4. Trouble relaxing.				
5. Being so restless that it is hard to sit still.				
6. Becoming easily annoyed or irritable.				
7. Feeling afraid as if something awful might happen.				
SCORE =				

Part B (PSQ-9): Please mark (**X**) the box to your corresponding answer.

Over the **last 2 weeks**, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly everyday
1. Little interest or pleasure in doing things.				
2. Feeling down, depressed, or hopeless.				
3. Trouble falling asleep, staying asleep or sleeping too much.				
4. Feeling tired or having little energy.				
5. Poor appetite or overeating.				
6. Feeling bad about yourself – or that you're a failure or have let yourself or your family down.				
7. Trouble concentrating on things, such as reading the newspaper or watching television.				
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.				
9. Thoughts that you would be better off dead or of hurting yourself in some way.				
SCORE =				
If you checked off any of the problems on this questionnaire, **how difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?				

	YES	NO
In the past year, have you felt depressed or sad most days, even if you felt okay sometimes?		
If you checked off any of the problems on this questionnaire, **how difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?		
Has there been a time in the past month when you have serious thought about ending your life?		
Have you ever in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?		