



UNIVERSITY OF THE PHILIPPINES 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-Course-Yr.Level/ Office		Student
Home Address							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 (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	<input type="checkbox"/> High Carbohydrate/Sugar <input type="checkbox"/> High Fat <input type="checkbox"/> High Fiber <input type="checkbox"/> High Salty <input type="checkbox"/> Low Water Intake
Tobacco/Smoking	<input type="checkbox"/> Never <input type="checkbox"/> Used to but stopped <input type="checkbox"/> Currently using, specify # of sticks/day: _____
Alcohol	<input type="checkbox"/> Never <input type="checkbox"/> Occasional <input type="checkbox"/> Periodic, specify # and type of drinks/session: _____
Physical Activity/Sports Activity	<input type="checkbox"/> Sedentary <input type="checkbox"/> Regularly exercise/sports activity, specify average # of hours/week: _____
Sexuality and Gender	Having difficulty with sexuality or gender orientation? <input type="checkbox"/> Yes <input type="checkbox"/> No
Personal Hygiene	Daily bath? <input type="checkbox"/> Yes <input type="checkbox"/> No Oral Hygiene? <input type="checkbox"/> Yes <input type="checkbox"/> No
Sleep	Average # hours/day: _____ Do you feel refreshed? <input type="checkbox"/> Yes <input type="checkbox"/> 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 (1 st day of latest menstrual cycle)	Menstrual Symptoms	Duration	Pads/Day	<input type="checkbox"/> Regular <input type="checkbox"/> Irregular

OB-Gyne History (TO BE FILLED UP WITH THE CLINIC NURSE ON DUTY DURING INTERVIEW): G _____ P _____ (F _____ P _____ A _____ L _____)

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:

This is to acknowledge that I have been advised to comply with above recommendations by the undersigned medical examiner.

Signature over Printed Name

Examined by: _____

PRC License No: _____

Hospital Address: _____

Date Examined: _____

{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?		