UNIVERSITY OF THE PHILIPINES VISAYAS
HEALTH SERVICE UNIT
Miagao, Iloilo

PRE-ENROLLMENT EXAMINATION

Year of Exam________

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 record will be treated with utmost confidentiality.

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 (✓).

Please attach 2x2 recent photo here

____
Last Name First Name Middle Name

Age: ________ Sex: __________ Civil Status: ___________ Date of Birth (MM/DD/YYYY): __________________

Cell No./Network: ____

College: ______________________________ Course: ____________________________ Student No.: ________________________

Home Address: ____ Tel. No.: _______________________

Father's Name: ____ Mobile No.: ____________________ Network: ____________

Mother's Name: ____ Mobile No.: ____________________ Network: ____________

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 (PREFERABLY WITHIN ILOILO):

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		Hepatitis B		Others:	

FAMILY HISTORY (Do not leave blank. 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 blank. 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	
Others		

PERSONAL HISTORY (Do not leave blank. 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		Syphilis	
Dengue		Malaria		Thyroid Disease	
Diabetes		Measles		Tonsillitis	
Diphtheria		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 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:

____

____

____

Please answer the following questions TRUTHFULLY. Thank you.

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. *Pls. specify*? ____
____

Do you have any physical condition or handicap which requires special treatment, diet or other special consideration? ☐ YES ☐ NO. *If yes, pls. specify*: ____

FOR FEMALE STUDENTS ONLY

Menstruation: Age at first menstruation: __________ Interval: ☐Regular (monthly) ☐ Irregular (skips in months)
1st day of Last Menstrual Period (MM/DD/YY): ________________
Flow: ☐Moderate ☐ Excessive ☐ Scanty
Dysmenorrhea: ☐YES ☐ NO Incapacitating: ☐ YES ☐NO Bleeding between periods? ☐YES ☐NO
Age at first pregnancy (*if applicable):* __________
Have you had any trouble with your breasts, such as lumps, tumor? ☐YES ☐NO *if yes, pls. specify* __________________
____

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

______________________________	______________________________	______________
Patient's Signature	Parent's/Guardian's Signature Above Printed Name	Date

Name ____ Age _________ Sex _________ Civil Status _________

(DO NOT WRITE ON THIS SIDE. TO BE FILLED OUT BY EXAMINING PHYSICIAN)

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	_______	_______	_______	_______

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 but hold chart temporarily, reason: ________________________
☐ Fit for enrollment with PE restrictions ☐ Not fit for enrollment

RECOMMENDATIONS/REMARKS:

Name of Examining Physician	Signature	License Number	Date Signed