**MEDICAL EXAMINATION FORM**

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Attach 2x2 I.D/passport size ID

 **Surname First Name Middle Name**

**CIVIL STATUS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GENDER: \_\_\_\_\_\_\_\_\_\_ AGE: \_\_\_\_\_\_**

**COURSE AND YEAR LEVEL: \_\_\_\_\_\_\_\_\_\_\_\_ SCHOOL YEAR AND SEMESTER: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**HOME ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRESENT ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CONTACT NO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**GUARDIAN (PERSON TO CONTACT IN CASE OF EMERGENCY) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CONTACT NO. OF GUARDIAN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I. PAST MEDICAL HISTORY**

**Childhood Illnesses: \_\_\_ Measles \_\_\_Mumps \_\_\_Rubella \_\_\_Chicken Pox \_\_\_ Rheumatic Fever\_\_\_\_ Polio**

**Present Illnesses: \_\_\_ Hypertension \_\_\_Diabetes M; \_\_\_ Asthma \_\_\_PTB \_\_\_ Goiter**

 **\_\_\_ Cancer \_\_\_ Allergies \_\_\_Thyroid diseases \_\_\_Others: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical Illnesses taking maintenance medications:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Surgeries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Hospitalizations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**II. FAMILY HISTORY (***Put a check mark on the columns of your answer; if yes kindly put your relationship on the remarks)*

|  |  |  |  |
| --- | --- | --- | --- |
|  | **YES** | **NO** | **REMARKS** |
| **Allergy**  |  |  |  |
| **Arthritis**  |  |  |  |
| **Bronchial Asthma**  |  |  |  |
| **Pulmonary tuberculosis** |  |  |  |
| **Hypertension**  |  |  |  |
| **Thyroid disease** |  |  |  |
| **Neurological disorders** |  |  |  |
| **Diabetes mellitus** |  |  |  |
| **Heart disease** |  |  |  |
| **Kidney Disease** |  |  |  |
| **Psychiatric Illness** |  |  |  |
| **Others:**  |  |  |  |

**III. PERSONAL AND SOCIAL HISTORY**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Yes** | **No** | **Remarks** |
| **Smoking history**  |  |  |  |
| **Alcohol Intake** |  |  |  |
| **Allergies**  |  |  |  |
| **Illegal Drug use** |  |  |  |
| **Disabilities** |  |

**For women:**

 **Have you ever been pregnant: Yes \_\_\_\_\_ No \_\_\_\_\_**

I certify that the following answers are true and correct to the best of my knowledge and belief and I agree that my miss statement or incorrect information as to material facts will not constitute ground for the medical staff liable on their professional practice.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature over Printed Name of Client**

1. **PHYSICAL EXAMINATION**

|  |  |
| --- | --- |
| **GENERAL APPEARANCE** |  |
| **HEIGHT (m)** |  |
| **WEIGHT (kg)** |  |
| **BODY MASS INDEX (kg/m2)** |  |
| **BLOOD PRESSURE** |  |
| **CARDIAC RATE**  |  |
| **RESPIRATORY RATE** |  |
|  |  |  |
| **VISUAL ACUITY** | **W/O Glasses R:**  | **W/O Glasses L:**  |
| **W/ Glasses R:** | **W/ Glasses L:**  |
|  |  |  |
| **FINDINGS** | **NORMAL** | **IF ABNORMAL: (PLS SPECIFY)** |
| **HEAD** |  |  |
| **EYES AND EARS** |  |  |
| **NOSE** |  |  |
| **MOUTH** |  |  |
| **NECK** |  |  |
| **CHEST AND BREAST** |  |  |
| **HEART AND LUNGS** |  |  |
| **ABDOMEN** |  |  |
| **GENITOURINARY** |  |  |
| **SKIN** |  |  |
| **EXTREMITIES** |  |  |
| **NEUROLOGICAL EXAM** |  |  |

1. **LABORATORY TESTS: (ATTACH RESULTS)**

**CHEST X-RAY**

**URINALYSIS**

**CBC**

**FECALYSIS**

**HEPA B SCREENING**

**BLOOD TYPE**

1. **DENTAL EXAMINATION: (ATTACH DENTAL CERTIFICATE)**
2. **IMPRESSION:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **RECOMMENDATION:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Nurse on duty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical Examiner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**License No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date Examined: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**