Form No. 07-OPD-008, *Revised, April 2014*

UNIVERSITY HEALTH SERVICE
University of the Philippines Los Baños
Tel. Nos.: (049) 536-3247; 536-2470; 536-6238
Philhealth Accredited Health Care Provider

PRE–ENROLMENT MEDICAL EXAMINATION REPORT

(Use blue or black permanent ink. DO NOT USE sign pens. Print on size A4 paper.)

PERSONAL INFORMATION

Name:_____ UHS ID No.: _____
(Last) (First) (Middle) *(c/o UPLB-UHS)*

Date of Birth:_____ Age:_____ Sex:_____Civil Status:_____ Nationality: _____

Home Address:_____ Tel. No/s. (landline and mobile):_____

College:_____ Course:_____Student No,:_____

Name of ☐ Spouse ☐ Parent ☐ Guardian:_____

Address:_____ Tel. No/s. (landline and mobile):_____

MEDICAL HISTORY (Do not leave blank areas. Write either : NA or Not Applicable; Unrecalled; or, None)

Disease	Specific Disease / Remarks	Date Diagnosed	Medications Taken	Hospital Confinement	Date/s of hospitalization, if confined
Allergy, food / medication				☐ Yes ☐ No	
Asthma, bronchial / skin				☐ Yes ☐ No	
Blood dyscrasia				☐ Yes ☐ No	
Cancer / Tumor				☐ Yes ☐ No	
Endocrine disorders (diabetes mellitus, thyroid disorders,…)				☐ Yes ☐ No	
ENT disorders (ear, nose, throat)				☐ Yes ☐ No	
Gastrointestinal disorders				☐ Yes ☐ No	
Genito-urinary (STD, UTI)				☐ Yes ☐ No	
Head / Neck injury				☐ Yes ☐ No	
Hypertension				☐ Yes ☐ No	
Kidney disease (polycystic kidney, lithiasis,…)				☐ Yes ☐ No	
Liver disease (hepatitis, cirrhosis,…)				☐ Yes ☐ No	
Lung disease (PTB, COPD, pneumonia…)				☐ Yes ☐ No	
Neurologic disorders (fainting spells, seizures, mental disorders,…)				☐ Yes ☐ No	
Viral infections (chicken pox, measles,…)				☐ Yes ☐ No	
Others				☐ Yes ☐ No	

OPERATIONS

CURRENT MEDICATIONS TAKEN

IMMUNIZATIONS *(Indicate month & year given)*
☐ Chicken pox _____ ☐ Hepatitis A _____ ☐ Influenza _____ ☐ Pneumonia_____ ☐ Tetanus toxoid_____ ☐ Others
☐ HPV vaccine_____ ☐ Hepatitis B _____ ☐ MMR _____ ☐ Rabies _____ ☐ Typhoid_____ _____

FAMILY HISTORY

☐ Asthma ☐ Diabetes mellitus ☐ Thyroid disease
☐ Blood dyscrasia ☐ Heart disease ☐ Tuberculosis
☐ Cancer ☐ Hypertension ☐ Others

PERSONAL AND SOCIAL HISTORY:

☐ Smoking *(_____ sticks/day for _____ year/s)*
☐ Drinking *(_____ beer per _____; _____ shots per _____)*

MENSTRUAL HISTORY

•Menarche	•Duration	•Interval ☐ Regular ☐ Irregular	•Pads/day	•Menstrual Symptoms

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

_____ _____
Patient's Signature *Date Signed*

DO NOT WRITE BELOW THIS LINE ***(to be accomplished by the medical staff only)***

VITAL SIGNS

BP: 1st _____/_____mmHg 2nd_____/_____mmHg
PR: _____/minute RR: _____/minute
Temp: _____°C

ANTHROPOMETRICS

Height: _____meters
Weight:_____kgs
BMI:_____

VISUAL ACUITY

	Uncorrected		Corrected	
	OD	OS	OD	OS
Near Vision				
Far Vision				
Ishihara Test	☐ Adequate		☐ Inadequate	

CHEST X-RAY FINDINGS

Health Facility:

Radiologist:

Impression:

CBC RESULTS

Laboratory Facility:
Results:
- Hemoglobin (120-160 g/L)……
- Hematocrit (M: 0.40 – 0.54 / F: 0.37 – 0.47)……
- White Blood Cell Count (5 – 10 x 10^{12}/L)……..
  - Neutrophils (0.50 – 0.70)……..
  - Lymphocytes (0.20 – 0.40)……..
  - Eosinophils (0.01 – 0.03)……
  - Monocytes (0.02 – 0.06)……..
  - Basophils (0.00 – 0.01)……
  - Stab (0.03 – 0.05)……
- Platelet Count (150 – 450 x 10^{12}/L)……..

Name:_____ Date of Birth:_____ Age:____ Sex:____ UHS ID No.: _____
(Last) (First) (Middle) *(c/o UPLB-UHS)*

PHYSICAL EXAMINATION

Findings	E/N	Findings	Description & Other Findings
General appearance, body built	☐		
Skin	☐	☐ Discoloration ☐ Congenital marks ☐ Lesion ☐ Deformity	
Head	☐	☐ Deformity ☐ Lesion (acne)	
Eyes	☐	☐ Inflammation	
Ears	☐	☐ ↓ Hearing Acuity: R_____ L_____ ☐ Deformity ☐ Discharge ☐ Dryness	
Nose	☐	☐ Deformity ☐ Bleeding ☐ Ulcer/Lesion ☐ Discharge	
Mouth & Tongue	☐	☐ Inflammation ☐ Ulcer/Lesion ☐ Tongue Deviation ☐ Deformity	
Throat, Pharynx & Tonsils	☐	☐ Foul odor ☐ Ulcer/Lesion ☐ Inflammation ☐ Swelling	
Neck & Lymph Nodes	☐	☐ Rigidity ☐ Tenderness ☐ Swelling/Mass ☐ Fistula	
Thyroid	☐	☐ Diffuse enlargement ☐ Mass/es	
Heart	☐	☐ Abnormal Rate ☐ Irregular beat / rhythm ☐ Murmur	
Chest	☐	☐ Tenderness ☐ Deformity ☐ Bulges/Depression ☐ Retraction	
Lungs	☐	☐ Wheezing ☐ Stridor ☐ Rales/Crackles	
Breast & Axilla	☐	☐ Retraction/Dimpling ☐ Mass/Nodule ☐ Enlarged lymph nodes ☐ Discharge	
Abdomen	☐	☐ Striae ☐ Mass/es ☐ Tenderness ☐ Distention	
Back & Shoulder	☐	☐ Tenderness ☐ Deformity ☐ Scoliosis ☐ Kyphosis ☐ Lordosis	
Extremities	☐	☐ Deformity ☐ Edema ☐ Clubbing of nails ☐ Tremors	
Anus & Rectum	☐	☐ Lesion ☐ Mass/es ☐ Tenderness ☐ Stricture	
FOR MALES: Penis	☐	☐ Deformity ☐ Lesion ☐ Phimosis ☐ Edema ☐ Profuse Discharge ☐ Circumcised	
Scrotum	☐	☐ Maldescended testis ☐ Lesion ☐ Edema ☐ Tenderness ☐ Hernia	
FOR FEMALES: Genitalia	☐	☐ Developmental anomalies ☐ Lesion ☐ Inflammation ☐ Discharge ☐ Purulent Discharge ☐ Swelling	
Other significant findings			

FITNESS CERTIFICATION

☐ Fit for enrollment ☐ Not fit for enrollment ☐ Pending, reason: _____

Impression/s:	**Recommendation/s:**

_____ _____ _____ _____
Signature Above Printed Name of Attending Physician *License No.* *PTR No.* *Date of Examination*

NOTE: Please issue a separate Medical Certificate using your official letterhead.

FOR UHS PHYSICIAN'S VALIDATION ONLY

The above findings are certified correct and are based on the physical examination, diagnostic results available, and the disclosure of the patient's pertinent medical history at the time and date of examination.

_____ _____ _____
Signature Above Printed Name of Attending Physician *License No.* *Date of Examination*