University of St. La Salle BACOLOD | HEALTH SERVICES CENTER

Standard 2x2 Photo **(White Background)**

PHYSICAL EXAMINATION RECORD

(Please write legibly)

NAME _____ Dept. /Course: _____
LAST FIRST MIDDLE NAME

Date of Birth: _____ Age: _____ Sex: (M) (F) Civil Status: (S) (M)

Religion: _____ Height: _____ Weight: _____

Home Address: _____ Tel No.: _____

Father's Name: _____ Mother's Name: _____

Person to notify in case of Emergency: _____ Relation: _____

Contact No.: _____ Address: _____

Past History:

( ) Seizures ( ) UTI ( ) Heart Ailment
( ) PTB/ Primary Complex ( ) Pneumonia ( ) Asthma
( ) Hepatitis ( ) Migraine ( ) Tonsillitis
( ) Dengue Fever ( ) Gastroenteritis ( ) Others: _____
( ) COVID 19 ( ) Blood Dyscrasia/Bleeding Problems

( ) Allergies: Please specify: _____

Maintenance medications: _____

Hospitalizations: _____

Person with Disability: ( ) No ( ) Yes *Diagnosis: _____

Diseases in the family: Please check

	Father side	**Mother side**
Hypertension	_____	_____
Diabetes	_____	_____
Cancer/ Others	_____	_____

Personal History:

( ) Smoking **( )** Alcohol **( )** Others: _____

Immunizations: Please check to indicate compliance.

( ) BCG	( ) DPT	( ) Polio	( ) Hepatitis B
( ) Influenza	( ) Typhoid Fever	( ) Measles	( ) Chicken Pox
( ) Hepatitis A	( ) HIB	( ) MMR	( ) Pneumococcal
( ) Meningococcal	( ) Rotavirus	( ) Japanese Encephalitis	

( ) COVID-19 *** Please attach copy of COVID-19 vaccination card**

Physical Examination: **(For Physicians ONLY)**

Head ( ) Essentially Normal _____

Eyes ( ) Essentially Normal _____

Ears ( ) Essentially Normal _____

Nose ( ) Essentially Normal _____

Throat ( ) Essentially Normal _____

Neck ( ) Essentially Normal _____

Chest/ Lungs ( ) Essentially Normal _____

Heart ( ) Essentially Normal _____

Abdomen ( ) Essentially Normal _____

Extremities ( ) Essentially Normal _____

Remarks: _____

Medical Officer **Date examined**