UNIVERSITY OF ST. LA SALLE
BACOLOD CITY, PHILIPPINES
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: _____

FOR PHYSICIAN ONLY:
Past History:

( ) Seizures	( ) UTI	( ) Heart Ailment
( ) PTB/ Primary Complex	( ) Pneumonia	( ) Asthma
( ) Hepatitis	( ) Migraine	( ) Tonsillitis
( ) Dengue Fever	( ) Gastroenteritis	( ) Others: _____

( ) Allergies: Please specify: _____
Maintenance medications: _____
Hospitalizations: _____

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

Physical Examination:

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: _____

PHYSICIAN'S PRINTED NAME AND SIGNATURE **License Number** **Date examined**