SILLIMAN UNIVERSITY CLINIC
SENIOR HIGH/COLLEGE STUDENT'S MEDICAL HISTORY FORM

Name: _____ Age: _____ Sex: _____
Address: _____ Contact No.: _____
Birthdate: _____ Citizenship: _____ Religion: _____
Father's Name: _____ Mother's Name: _____
Contact person in case of emergency: _____ Contact No.: _____
Spouse (if married): _____

PAST MEDICAL HISTORY
General Condition for the past year: _____

ILLNESS	NO	YES	YEAR	ILLNESS	NO	YES	YEAR
Allergy				Heart Disorder			
Anemia				Hyperacidity			
Asthma				Indigestion			
Behavioral Problem				Insomnia			
Bleeding Problem				Kidney Problem			
Blood Abnormality				Liver Problem			
Chickenpox				Measles			
Convulsion				Mumps			
Dengue				Parasitism			
Diabetes				Pneumonia			
Ear Problem				Primary Complex			
Eating Disorder				Scoliosis			
Epilepsy				Skin Problem			
Eye Problem				Tonsillitis			
Fracture				Typhoid Fever			
Hearing Problem				Vision Defect			
Others				Others			

Any history of hospitalization or surgical operation (Yes/No, specify)? _____
_____
Special Medical Concerns: _____
Any FOOD Allergies? _____ Any DRUG Allergies? _____

IMMUNIZATION RECORD

VACCINES	NO	YES	VACCINES	NO	YES
BCG			Chicken pox		
OPV			Hepatitis A		
DPT / Td / T.T.			Hepatitis B		
Measles			Others (Pls. Specify)		
MMR (measles, mumps, rubella)					

FOR FEMALES
Age of First Menstruation: _____ Days of Dysmenorrhea: _____
Is it Regular (Monthly)? _____ Duration of Menses: _____
If irregular, pls. indicate the month interval and medications taken: _____

FOR MATERNAL/OBSTETRICAL HISTORY (for women only)
First Sexual contact (Age) : _____
Gravida (no. of times pregnant) : _____
Parity (no. of times you gave birth): _____
Full Term: _____ Abortion/Miscarriage: _____ Pre Term: _____ Children currently living: _____
Year of Pap Smear done: _____ Cervical Immunization: _____
Hormonal Medications Maintained: _____
Reason for taking: _____

Please check and indicate how many times per week

_____ coffee drinker _____ smoker _____ sexually active

_____ alcohol drinker _____ illicit drug use (pls. specify)

FAMILY HISTORY

DISEASE	NO	YES	RELATION(S) TO STUDENT
Asthma			
Bleeding tendency			
Cancer			
Diabetes			
Heart Disorder			
High Blood Pressure			
Kidney Problem			
Mental Disorder			
Obesity			
Seizure Disorder			
Stroke			
Thyroid Problem			
Tuberculosis			
Others (pls. specify)			

Is your house screened? _____

What is your source of potable water? _____

PHYSICIAN'S REPORT

Name : _____

General Appearance:

Excellent _____ Good _____ Fair _____ Poor _____

Vital Signs

BP _____ RR _____ PR _____ T _____ Ht _____ Wt _____ BMI _____

Any health issues today? _____

Skin / Lesions : _____

Head/Scalp : _____

Eyes, Visions, and Other conditions : _____

Ears, Hearing, and Other condition:_____

Nose, Nasal passage, and sinuses : _____

Mouth, Pharynx : _____

Neck, Thyroid, Cervical Lymph Nodes : _____

Chest and Lungs : _____

Breast and Axilla : _____

Cardiovascular : _____

Abdomen : _____

Genitourinary Tract : _____

Gynecologic Findings / Abnormalities :

_____

_____

Back and Posture : _____

Extremities : _____

Nervous System :

Cranial nerves : _____

Motor : _____

Sensory : _____

Reflexes : _____

MSE:_____

Results of required tests: CBC _____

Chest X-ray _____

Urinalysis_____

Recommendations: _____

_____

Physician's Name & Signature

License Number: _____

Date: _____