Republic of the Philippines

UNIVERSITY OF SOUTHEASTERN PHILIPPINES

HEALTH SERVICE DIVISION

PERSONAL HEALTH STATE DECLARATION FORM

NAME _____Date of Birth_____ Status ( ) S ( ) M ( ) W

Family Name First Name Middle Name (DD-MM-YY) Religion_____

Home Address _____

_____

Contact Person in case of emergency _____

Name of Person Contact No./Nos. Student Contact No.

The patient/student must respond to all details of the health declaration with the help of his/her parent and/or a Physician.

Check the answer YES or NO in the questionnaire. And affix your signature at the end of the form as required.

GENERAL QUESTIONS	NO	YES
1. Have you ever been admitted in a hospital or medical institution/clinic?		
When?		
Reason?		
2. Have you ever had an operation or have been advised to have an operation?		
What kind?		
When?		
Reason?		
3. Have you ever been injured in an accident?		
Do you have any disability? Please elaborate.		
4. Have you undergone routine tests? (Were the tests normal?) Please submit results if available.		
Blood tests?		
Urine tests?		
EKG?		
5 Have you had imaging tests? Such as various types of X-rays? Please submit results		
Chest X-ray?(Please submit results) Should be taken within the last 3 months		
Intestinal? (if any) Kidneys? (if any) Bones? ( )		
Computerized Tomography (CT SCAN) state reason, date and result (if any)		
MRI?		
6. Do you have any CURRENT ILLNESS or DISEASE and have you received and/or are receiving treatment or medication?		
State what kind of sickness>?		
What medication are you taking? Dosage and duration of treatment?		
7. FOR WOMEN ONLY - Do you suffer from any women's disease such as:		
Menstrual irregularity		
DYSMENORRHEA		
Unusually heavy menstruation		
Cysts (Ovarian)		
Hemorrhages		
Breast Masses		

Uterus/Ovarian problems		
8. Do you smoke?		
If Yes - how many sticks a day?		
9. Do you drink alcohol, beer or wine?		

PERSONAL HEALTH STATE DECLARATION FORM cont….

(Past Illnesses & Present Illness)

QUESTIONS ON ILLNESSES (HAVE YOU SUFFERED FROM OR ARE YOU SUFFERING NOW?)	NO	YES
11. Cardiovascular (Heart & Blood Vessels)		
A. Heart Disease		
B. Chest Pains		
C. Shortness of Breath		
D. Palpitations		
E. Angina Pectoris		
F. Arrhythimias (irregular heartbeat)		
G. Congenital Heart Defect or diseases (state what kind)		
H. Hypertension		
I. Leg Pain while walking		
12. Nervous System. Do you have the following?		
A. Dizziness		
B. Headaches		
C. Loss of consciousness		
D. Convulsions/Seizures (Epilepsy)		
E. Memory disorders		
F. Tremors		
G. Balance disorders		
H. Mental Exhaustion		
I. Vertigo		
13. Mental Disorders. Do you have the following?		
A. Mental diseases		
B. Depression		
C. Schizophrenia		
D. Anxiety Disorders		
E. Suicide Attempt		
14. Respiratory Tract. Did you ever had or have the following in the past or at present?		
A. Asthma		
B. Bronchitis		
C. Pneumonia		
D. Tuberculosis (TB)		

E. Hemoptysis (coughing out of blood)		
F. Recurrent Respiratory tract infections		
G. Persistent Cough		
H. Difficulty in Breathing		
15. Digestive Tract & Liver. (do you have the following?)		
A. Ulcer (gastric or peptic)		
B. Heartburn		
C. Intestinal problems - hookworm, Ascariasis		
D. Hemorrhoids & anal problems		
E. Liver Disease - Schistosomiasis		
F. Hepatitis A		
G. Hepatitis B		
H. Jaundice		
I. Gallbladder Stones		
J. Vomiting		
K. Pancreatitis		
16. Kidneys & Urinary Tract		
A. Kidney Stones		
B. Nephritis		
C. Urinary Tract defects		
D. Blood or protein in the urine		
E. Renal Cysts		
F. Recurrent UTI		
17. Endocrine (metabolic disorders)		
A. Diabetes Mellitus I or II		
B. Disorders of the Thyroid		
C. Endemic/Toxic Goiters		
D. Thyroid Tumor		
E. Pituitary Gland Tumor		
F. High Blood cholesterol & Triglycerides		
18. Skin & Genital Tract		
A. Herpes		
B. Psoriasis		
C. Eczema		
D. Tinea Cruris		
E. Atopic Dermatitis		
F. Contact Dermatitis		
G. Warts		
19. Malignant Diseases		

A. AIDS			
B. Cancer (pls specify)			
20. Joints & Bones			
A. Arthritis			
B. Gout			
C. Back & Neck pain			
D. Joint Pains			
21. Eyes - Please state your present condition			
A. Cataract			
B. Glaucoma			
C. Strabismus (squint)			
D. Colorblindness			
G. Visual disorders (near or far sightedness)			
22. Ear, Nose & throat			
A. Recurrent throat infection - Tonssillitis			
B. Ear Inflammation/Infections - Otitis Media, Ear discharges			
C. Sinusitis - Acute or Chronic			
D. Hearing Disorders - DEAFNESS			
E. Allergic RHINITIS			
23. Hernia - of the abdominal wall, groin, Surgical scar, umbilicus(navel), Diaphragm			
24. Other Diseases			
A. Chicken Pox			
B. German measles			
C. Mumps			
D. Measles			
QUESTIONS ON FAMILY ILLNESSES			
25. Have any of your family members, parents, siblings, grandparents or relatives, ever suffered from any of the	NO	YES	
following conditions?			
A. Heart Disease			
B. High Blood Pressure			
C. Kidney disease			
D. Stroke			
E. Diabetes mellitus			
F. Epilepsy			
G. Asthma			
H. Hepatitis B			
I. Arthritis			
J. Allergies (specify what type of drugs or food)			
K. Cancer (specify what type)			

DECLARATIONS AND SIGNATURES

I / We hereby declare that we have fully understood the questions in the declaration and further declare that the answers given by me/us to all the questions in the form are true and complete in every respect and that I/We have not WITHELD any material information or suppressed any material fact that may in any way affect my acceptance or enrolment into this University. Furthermore, any false information given in relation to this document will not hold the University liable for any consequence of the falsity of the declaration.

Date _____

_____ _____

Date/month/year Signature of student over printed name

_____

_____ _____

Signature of Physician over printed name Signature of Parent over printed name

_____

License No.