UNIVERSITY OF THE PHILIPINES VISAYAS
HEALTH SERVICES UNIT
Miagao, Iloilo
Tel. Nos.: (033) 315-8301
Email: hsumiagaomedical@upv.edu.ph

ENTRANCE HEALTH EXAMINATION

A complete Medical History and Physical Examination is compulsory to complete your admission to the University of the Philippines Visayas and must be on file before your registration. This is your responsibility as applicant and not that of your physician. Please type or complete in ink. This record will be treated with utmost confidentiality.

Important: Please bring accomplished form with you to the UPV Health Services Unit when you come for a physical examination.

PLEASE KEEP THIS FORM NEAT AND CLEAN

A. Complete this form if you are enrolling during a regular semester and if you are:
   1. A beginning undergraduate or a beginning graduate student.
   2. A transfer student from a regional campus or another school or university.
   3. A re-entry student (undergraduate or graduate) who has been out of the University of the Philippines for at least one semester.

B. Completion of this form is not required if:
   1. You are a foreign student sponsored by a government agency whose files provided a complete health record signed by a physician. A copy of the health record should be submitted in lieu of this form.
   2. Enrolling for a Midyear Session only.

PLEASE PRINT LEGIBLY. USE BLACK OR BLUE INK. MARK APPROPRIATE BOXES WITH CHECK (✓). PRINT ON A4 PAPER BACK-TO-BACK.

Name: _____
(Last) *(First)* *(Middle)*

Age: _____ Sex: ☐ Male ☐ Female Citizenship: _____ Civil Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Date of Birth (MM/DD/YYYY): _____ Place of Birth: _____

College/School: _____ Degree/Course: _____ Student No.: _____

☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior ☐ Graduate ☐ Special

Home Address: _____ Tel. No.: (_____) _____

_____ Mobile No.: _____ Network: _____

Father's Name: _____ Mobile No.: _____ Network: _____

Mother's Name: _____ Mobile No.: _____ Network: _____

Name & Address of Dormitory/Boarding House: _____ Tel. No.: (____)_____

Name of Landlord/Landlady/Dorm Head: _____

Contact No. of Boarding House/Dormitory Tel. No.: (_____) _____ Mobile No.: _____ Network: _____

GUARDIAN OR PERSON(S) TO BE CONTACTED IN CASE OF EMERGENCY (PREFERABLY WITHIN ILOILO CITY/PROVINCE):

Name: _____ Contact No.: _____

Address: _____ Relationship: _____

Name: _____ Contact No.: _____

Address: _____ Relationship: _____

PAST OR CURRENT MEDICAL CONDITIONS (Do not leave blanks. Write either: **NA or Not Applicable**; **Unrecalled**; or **None**)

Medical Condition	When identified	Maintenance Medications If Any

Allergies: Food _____ Drugs _____ Environmental Agents/Factors _____

Hospitalizations _____ Operations _____

IMMUNIZATIONS (Please indicate booster doses. Do not leave blanks. Write either: **NV for No Vaccination; GU for Given but Unrecalled**)

Vaccine	Given When (MM/YY)	Vaccine	Given When (MM/YY)	Vaccine	Given When (MM/YY)
Influenza		MMR		HPV	
Pneumonia		Varicella/Chicken Pox		Typhoid	
Hepatitis A		DTaP/Tetanus		Rabies	
Hepatitis B		COVID19 1° Series (Name/Date)		COVID19 BOOSTER (Name/Date)	

FAMILY HISTORY (Do not leave blanks. Write either: **NA or Not Applicable**; **Unrecalled**; or **None**)

Among your blood relatives, is there a history of any of the following:

	Yes	No	Relationship		Yes	No	Relationship
Cancer				Bronchial Asthma			
Heart Disease				Allergies/Allergic Rhinitis			
High Blood Pressure				Mental Disorder/Problem			
Stroke				Digestive Disturbances			
Tuberculosis				Convulsions/Neurologic Problems			
Kidney Disease				Bleeding Problems/Blood Disorders			
Diabetes				Others: _____			

LIFESTYLE EVALUATION (Please check your appropriate answer)

Lifestyle	Check all that applies.
Diet	□ High Carbohydrate/Sugar □ High Fat □ High Fiber □ High Salty □ Low Water Intake
Tobacco/Smoking	□ Never □ Used to but stopped □ Currently using, specify # of sticks/day:
Alcohol	□ Never □ Occasional □ Periodic, specify # and type of drinks/session:
Physical Activity/Sports Activity	□ Sedentary □ Regularly exercise/sports activity, specify average # of hours/week:
Sexuality & Gender	Having difficulty with sexuality or gender orientation? □ Yes □ No
Personal Hygiene	Daily bath? □ Yes □ No Oral Hygiene? □ Yes □ No
Sleep	Average # hours/day: Do you feel refreshed? □ Yes □ No
Others	

PERSONAL HISTORY (Do not leave blanks. Write either: **NA or Not Applicable**; **Unrecalled**; or **None**)

Give the appropriate age to which you have the following:

	AGE		AGE		AGE
Anemia/Blood Disorder		Hernia		Poliomyelitis	
Asthma		High Blood Pressure		Rheumatic Fever	
Cancer		Influenza A (H1N1) (indicate date)		Skin Disease	
Chickenpox		Joint Pains/Arthritis		Smallpox	
Convulsions		Kidney Disease		Syphilis	
Dengue		Malaria		Thyroid Disease	
Diabetes		Measles		Tonsilitis	
Diphtheria		Mental Problems/Disorders		Tuberculosis/Primary Complex	
Ear disease/defect		Mumps		Typhoid	
Eye disease/defect		Neurologic Problems/Disorders		Ulcer (Peptic)	
Gonorrhea		Pertussis (Whooping Cough)		Ulcer (Skin)	
Heart Disease		Pleurisy		Other Conditions:	
Hepatitis (indicate type)		Pneumonia			

Have you ever had, or do you have any of the following? Check each item, Yes or No.

	Yes	No		Yes	No		Yes	No
Headaches (frequent)			Sore throat (frequent)			Diarrhea/Constipation (specify)		
Dizziness (frequent)			Chest pain			Joint pains		
Fainting/Loss of Consciousness			Back pain			Muscle pain (frequent)		
Insomnia			Easily gets tired			Frequent urination		
Depressed mood (>2 weeks)			Difficulty of breathing			Eczema/Skin problems		
Eye/Visual Problems			Palpitations			Fracture		
Hearing Problems			Swelling of feet			Accident/Injuries		
Cough (>2 weeks)			Nausea (frequent)			Hospitalization (reason)		
Colds/Nasal Congestion			Vomiting			Operation (specify)		
Fever (frequent/recurrent)			Abdominal pain/discomfort			Others (specify)		
Frequent early morning sneezing			Loss of appetite					
Nosebleed (frequent)			Weight loss/gain (specify)					

If answer is YES, please give details: _____.

Date of last dental check-up: _____ Date of last eye refraction: _____

Do you consider yourself in good health? ☐ YES ☐ NO. If not, give details _____.

Are you taking any medicines regularly? ☐ YES ☐ NO. If so, what are these medicines? _____

_____.

Do you have any physical condition or handicap which requires special treatment, diet or other special consideration? ☐YES ☐NO. Please specify _____

_____.

FOR FEMALE STUDENTS ONLY

Menstrual History: Age of Onset/Start _____ Duration: _____ days Interval: ☐ Regular (monthly) Irregular (skips in months)

Flow: ☐ Moderate ☐ Excessive ☐ Scanty Pain: ☐ YES ☐ NO, Incapacitating: ☐ YES ☐ NO Bleeding between periods? ☐ YES ☐ NO

1st day of Last Menstrual Period (MM/DD/YYYY): _____ Other Menstrual Symptoms: _____

OBGyne History (TO BE FILLED UP WITH THE CLINIC NURSE/DOCTOR ON DUTY DURING INTERVIEW): G _____ P _____ (F _____ P _____ A _____ L _____)

Have you had any trouble with your breasts, such as lumps, tumor, surgery? ☐ YES ☐ NO If so, give details _____

_____.

I certify that the above answers and statements are true and complete, and to the best of my knowledge. I have fully disclosed all medical conditions that may affect my performance as a student of the University.

_____	_____	_____
Student's Signature	Parent/Guardian's Signature Above Printed Name (If student is below 18 years of age.)	Date

PLEASE PRINT LEGIBLY. USE BLACK OR BLUE INK. MARK APPROPRIATE BOXES WITH CHECK (✓). PRINT ON A4 PAPER BACK-TO-BACK.

Name _____ Date of Birth _____ Age _____ Sex _____ Civil Status _____

VITAL SIGNS	**ANTHROPOMETRICS**	**VISUAL ACUITY**	**UNCORRECTED**		**CORRECTED**	
BP: 1ST ____/____ MMHG	WEIGHT: _____ KGS		OD	OS	OD	OS
2ND ____/____MMHG	HEIGHT: _____ M	NEAR VISION (SNELLEN)				
PR: _____/MINUTE RR:_____/MINUTE	BMI: _____	FAR VISION (JAEGER)				
T°: _____°C SPO2: _____%	[BMI: UNDERWEIGHT (<18.5), GOOD/NORMAL (18.5-22.9), OVERWEIGHT (23-24.9), OBESE (25-29.9), EXTREMELY OBESE (>30)] *TAKEN FROM WHO-WPR, 2000, ASIA-PACIFIC PERSPECTIVE: REDEFINING OBESITY AND ITS TREATMENT*	COLOR VISION (ISHIHARA)	☐ POSITIVE		☐ NEGATIVE	

(DO NOT WRITE BELOW THIS LINE. TO BE FILLED OUT BY THE MEDICAL STAFF ONLY.)

CHEST X-RAY FINDINGS	**CBC RESULTS**	**URINALYSIS**	**FECALYSIS**
IMPRESSION:	**RESULTS:**		

PHYSICAL EXAMINATION

AREAS	**E/N**	**FINDINGS**	**DESCRIPTION & OTHER FINDINGS**
GENERAL APPEARANCE, BODY BUILT	☐		
SKIN	☐	☐ DISCOLORATION ☐ LESION ☐ CONGENITAL MARKS ☐ DEFORMITY	
HEAD	☐	☐ DEFORMITY ☐ LESION (ACNE) ☐ FACIAL ASYMMETRY	
EYES	☐	☐ INFLAMMATION ☐ LESIONS ☐ EN/EXOPHTHALMUS/PTOSIS OF LIDS ☐ STRABISMUS/NYSTAGMUS	
EARS	☐	☐ DEFORMITY ☐ DISCHARGE ☐ ↓HEARING ACUITY	
NOSE	☐	☐ DEFORMITY ☐ DISCHARGE ☐ LESION/ULCER ☐ BLEEDING	
MOUTH & TONGUE	☐	☐ INFLAMMATION ☐ TONGUE DEVIATION ☐ LESION/ULCER ☐ DEFORMITY	
THROAT, PHARYNX & TONSILS	☐	☐ FOUL ODOR ☐ INFLAMMATION ☐ ULCER/LESION ☐ SWELLING	
NECK & LYMPH NODES	☐	☐ RIGIDITY ☐ SWELLING/MASS ☐ TENDERNESS ☐ FISTULA	
THYROID	☐	☐ DIFFUSE ENLARGEMENT ☐ MASSES	
HEART	☐	☐ ABNORMAL RATE ☐ IRREGULAR RHYTHM ☐ MURMUR	
CHEST	☐	☐ TENDERNESS/SPASM ☐ BULGES/DEPRESSION ☐ DEFORMITY ☐ RETRACTION	
LUNGS	☐	☐ WHEEZING ☐ RALES/CRACKLES ☐ RHONCHI ☐ STRIDOR	
BREAST & AXILLA	☐	☐ DIMPLING/RETRACTION ☐ MASS/NODULE ☐ DISCHARGE ☐ SKIN CHANGES☐ ENLARGED LN	
ABDOMEN	☐	☐ STRIAE ☐ TENDERNESS ☐ MASS/ES ☐ DISTENTION	
BACK & SHOULDER	☐	☐ TENDERNESS ☐ SCOLIOSIS ☐ LORDOSIS ☐ KYPHOSIS ☐ DEFORMITY	
EXTREMITIES	☐	☐ DEFORMITY ☐ CLUBBING OF NAILS ☐ EDEMA ☐ TREMORS	
ANUS & RECTUM	☐	☐ LESION ☐ TENDERNESS ☐ MASS/ES ☐ STRICTURE	
FOR MALES: PENIS	☐	☐ DEFORMITY ☐ PHIMOSIS ☐ PROFUSE DISCHARGE ☐ LESION ☐ EDEMA ☐ CIRCUMCISED	
SCROTUM	☐	☐ MALDESCENDED TESTIS ☐ EDEMA ☐ HERNIA ☐ LESION ☐ TENDERNESS	
FOR FEMALE: GENITALIA	☐	☐ DEVELOPMENTAL ANOMALIES ☐ INFLAMMATION ☐ PURULENT DISCHARGE ☐ LESION ☐ DISCHARGE ☐ SWELLING	
OTHER SIGNIFICANT FINDINGS:			

FITNESS CERTIFICATION

☐ **FIT FOR ENROLLMENT WITHOUT ACTIVITY RESTRICTIONS** ☐ **FIT FOR ENROLLMENT WITH ACTIVITY RESTRICTIONS** ☐ **NOT FIT FOR ENROLLMENT**

☐ **FIT FOR ENROLLMENT PENDING, REASON:** _____

IMPRESSION/S:	**RECOMMENDATIONS:**

_____ _____ _____ _____

SIGNATURE ABOVE PRINTED NAME OF EXAMINING PHYSICIAN *LICENSE NO.* *PTR NO.* *DATE OF EXAMINATION*

FOR UPV-HSU PHYSICIAN'S VALIDATION ONLY

The above findings are 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 Examining Physician *License No.* *Date of Examination*

UNIVERSITY OF THE PHILIPPINES VISAYAS
HEALTH SERVICE UNIT
Miagao, Iloilo City

MENTAL HEALTH SCREENING TOOL

Name: _____

Student No.: _____ Date Accomplished (*mm/dd/yyyy*): _____

Part A (GAD-7): Please mark (**X**) the box to your corresponding answer.

Over the **last 2 weeks**, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly everyday
1. Feeling nervous anxiety, or on the edge				
2. Not being able to stop or control worrying.				
3. Worrying too much about different things.				
4. Trouble relaxing.				
5. Being so restless that it is hard to sit still.				
6. Becoming easily annoyed or irritable.				
7. Feeling afraid as if something awful might happen.				
SCORE =				

Part B (PSQ-9): Please mark (**X**) the box to your corresponding answer.

Over the **last 2 weeks**, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly everyday
1. Little interest or pleasure in doing things.				
2. Feeling down, depressed, or hopeless.				
3. Trouble falling asleep, staying asleep or sleeping too much.				
4. Feeling tired or having little energy.				
5. Poor appetite or overeating.				
6. Feeling bad about yourself – or that you're a failure or have let yourself or your family down.				
7. Trouble concentrating on things, such as reading the newspaper or watching television.				
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite – being so fidgety or restless that you have been moving around a lot more than usual.				
9. Thoughts that you would be better off dead or of hurting yourself in some way.				
SCORE =				
If you checked off any of the problems on this questionnaire, **how difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?				

	YES	NO
In the past year, have you felt depressed or sad most days, even if you felt okay sometimes?		
If you checked off any of the problems on this questionnaire, **how difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?		
Has there been a time in the past month when you have serious thought about ending your life?		
Have you ever in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?		

UNIVERSITY OF THE PHILIPPINES VISAYAS
HEALTH SERVICE UNIT
Miagao, Iloilo City

Name of Student: _____ Birthdate: _____
(*Last Name, First Name, M.I.*) (*mm/dd/yyyy*)

DATA SUBJECT CONSENT FORM

In compliance with Data Privacy Act of 2012 and its Implementing Rules and Regulations, we execute reasonable and appropriate security measures for the protection of personal data that we collect. Your personal data will be collected, processed, and stored for the purpose/s of health assessment, treatment, and/or research (following research ethics guidelines) for the improvement of healthcare services. The UPV Health Services Unit operates and holds personal data with utmost security and confidentiality.

☐ **I authorize and give my consent to the UPV Health Services Unit for the purpose/s stated above. I understand that this consent will remain in full force until I revoke it in writing.**

CONSENT FOR PHYSICAL EXAMINATION

PLEASE CHECK ONE (1):

☐ For Minors (18 years of age and below)

I, _____ hereby voluntarily consent to any of
(Name of Parent/Guardian)
the staff of the UP Visayas - Health Services Unit to conduct a thorough physical/medical examination, mental health screening, to perform diagnostic procedures, and to administer treatment as deemed necessary prior to my son/daughter/ward's _____ university admission.
(Student's Name)

☐ For those of legal age (19 years of age and above)

I voluntarily consent to the staff of the UP Visayas – Health Services Unit to conduct a thorough physical/medical examination, mental health screening, to perform diagnostic procedures, and to administer treatment as deemed necessary as a pre-requisite for admission to UP Visayas.

_____
Name and Signature of Student/ Date Signed

_____
Name and Signature of Parent or Guardian/
Date Signed
(Note: Both student and guardian will affix their signatures, if the former is aged below 18 years old.)