PALAWAN STATE UNIVERSITY
HEALTH SERVICES

ENTRANCE HEALTH EXAMINATION

(Please print all data)

(Family Name)                                                (First Name)                                                (Full Middle Name)

Date & Place of Birth: ________________________________________ Age: _____ Sex: ___________________________

Religion: ____________________________________ Occupation: __________________________________ Civil Status: ______________________

Course: ____________________________________ Contact Number: ____________________________________

Home Address: ____________________________________________

Present Address: __________________________________________

MEDICAL HISTORY:
(Please check '✓' to affirm and write 'N' for No)

Hospital Confinement
Insomnia
Fainting
Frequent Nose Bleeding
Chronic Nose Discharge
Deafness
Ear Discharge
Ringing of Ears
Severe Headache
Frequent Dizziness
Blurring of Vision
Golter
Palor
Cyanosis
Yellow Skin
Allergies
Easy Fatigability
Asthma
Severe Chest pain
Shortness of Breath
Rheumatic Heart Disease
Backache
Spitting of Blood
Bleeding Tendency
Prolonged Coughing
Other health problems:

IMMUNIZATION:

BCG               Tetanus 1
DPT1              Tetanus 2
DPT2              Tetanus 3
DPT3              Tetanus Booster
DPT Booster  Hepa B1
Polio1            Hepa B2
Polio2            Hepa B3
Polio3            Chicken pox
Polio Booster

FAMILY HISTORY:

Father (living)  (dead)  Mother (living)  (dead)

Cause/Age at death: __________________________________________

No. of brothers: ____________________________________________ No. of sisters: ________________________________________

(living)  (dead)  (living)  (dead)

Cause of death: ____________________________________________ Cause of death: ________________________________________

Age at death: ____________________________________________ Age at death: ________________________________________

Were/are there any member of your family/relatives with any of the following?

High blood pressure ____________________________ Hepatitis ____________________________


PERSONAL HISTORY:
Cigarette smoking
Alcoholic drinks
Coffee
Prohibited drugs

OB/GYN HISTORY: (for females only)
Number of pregnancies
(Full term)
(Preterm)
(Abortion)
(Living)
Date of last delivery
Type of last delivery
Ectopic pregnancy
H mole
No. of cesarean section
Last menstrual period
Menarche
Age of menopause
Duration of menstrual bleeding
Days of interval between menstruation
Painful menstruation
Abnormal menstruation

Date: __________________________

Name and signature of examinee/guardian (for minors)

> DO NOT FILL BEYOND THIS LINE <

CLINICAL NOTES & ASSESSMENT

HT: _______ WT: _______ BP: _______ HR: _______ VA: _______

Breast Exam: