**Bukidnon Philippines**

**Student Health Form**

**Identity:**

Last name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle :\_\_\_\_\_\_\_\_\_\_Home phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Medical**

**information:**

Name of insurance carrier:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration date: D\_\_\_\_\_\_M\_\_\_\_\_\_Y\_\_\_\_\_\_\_

Brief description of coverage :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In case of emergency contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Street/Box:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City/Town:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_ Country:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health history:**

(Answer all questions.

Explain positive answers below or on a separate piece of paper.)

Do you now have, or have you ever had, any of the following? Yes No Yes No Yes No [ ] [ ] 1-Skin condition [ ] [ ] 15-Heart trouble [ ] [ ] 25-Jaundice [ ] [ ] 2-Eye trouble [ ] [ ] 16-High blood pressure [ ] [ ] 26-Hepatitis [ ] [ ] 3-Ear trouble [ ] [ ] 17-Low blood pressure [ ] [ ] 27-Intestinal troubles [ ] [ ] 4-Head injury [ ] [ ] 18-Rheumatism/Arthritis [ ] [ ] 28-Recurrent diarrhea [ ] [ ] 5-Recurrent headache [ ] [ ] 19-Back problems [ ] [ ] 29-Diabetes [ ] [ ] 6-Epilepsy [ ] [ ] 20-Dislocation of joints [ ] [ ] 30-Kidney disease [ ] [ ] 7-Fainting spells [ ] [ ] 21-Broken bones [ ] [ ] 31-Anemia [ ] [ ] 8-Mental/Nervous disorders [ ] [ ] 22-Stomach/Duodenal ulcer [ ] [ ] 32-Gall bladder problems [ ] [ ] 9-Depression [ ] [ ] 23-Sexually transmitted disease [ ] [ ] 33-Cancer/Tumors [ ] [ ] 10-Paralysis [ ] [ ] 24-Surgery [ ] [ ] 34-Female conditions [ ] [ ] 11-Insomnia [ ] [ ] Appendectomy [ ] [ ] Irregular periods [ ] [ ] 12-Shortness of breath [ ] [ ] Tonsillectomy [ ] [ ] Severe cramps [ ] [ ] 13-Hay fever/Asthma [ ] [ ] Hernia repair [ ] [ ] Excessive flow [ ] [ ] 14-Allergies [ ] [ ] Other [ ] [ ] Now pregnant Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other illnesses or conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Explanations for above :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you presently under a doctor’s care? [ ]Yes [ ]No Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you presently taking any medication? [ ]Yes [ ]No Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to any drugs/medications? [ ]Yes [ ]No Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you now receiving or did you ever receive compensation for disability from any source? [ ]Yes [ ]No Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any physical impairments, handicaps or health conditions which require special attention? [ ]Yes [ ]No Specify :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How would you rate your overall health condition? [ ]Excellent [ ]Good [ ]Fair [ ]Poor**

**Disease history:**

Have you ever had any of the following COMMUNICABLE DISEASES? Yes No Yes No [ ] [ ] 1-Chickenpox [ ] [ ] 5-Pertussis [ ] [ ] 2-Measles (rubella) [ ] [ ] 6-Scarlet fever [ ] [ ] 3-Measles (rubeola) [ ] [ ] 7-Tuberculosis [ ] [ ] 4-Mumps [ ] [ ] 8-Other

**Family history:**

 **Bukidnon Philippines**

Have any of your immediate family members ever had any of the following? Yes No Yes No [ ] [ ] 1-Tuberculosis [ ] [ ] 6-Arthritis [ ] [ ] 2-Diabetes [ ] [ ] 7-Stomach disease [ ] [ ] 3-Kidney disease [ ] [ ] 8-Asthma/Hay fever [ ] [ ] 4-Heart disease [ ] [ ] 9-Epilepsy/Convulsions [ ] [ ] 5-Hypertension [ ] [ ] 10-Cancer **Immunizations:** DISEASE BASIC (year) BOOSTER (year) 1st dose 2nd dose 3rd dose 1st dose 2nd dose 3rd dose Diphtheria: \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ Tetanus: \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ Pertussis: \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ Polio: \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ Rubella: \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ Mumps: \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ Hepatitis A: \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ Hepatitis B: \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_