Republic of the Philippines
Department of Science and Technology
PHILIPPINE SCIENCE HIGH SCHOOL
CORDILLERA ADMINISTRATIVE REGION CAMPUS
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MEDICAL CLINIC

HISTORY AND DATA SHEET

Students should accomplish this form properly. Information indicated herein will be held confidential.

PLEASE PRINT ALL DETAILS LEGIBLY.

1. NAME: _____
   Surname *First Name* *Middle Name*
2. BIRTHDATE: _____ BIRHTPLACE: _____
3. PERMANENT ADDRESS:

_____
House No./Street *Sitio / Subdivision* *Barangay* *Municipality/ City* *Province*

4. ADDRESS IN BAGUIO CITY/ BENGUET: _____
   House No./Street *Sitio / Subdivision* *Barangay*
5. RELIGION: _____
6. FAMILY PHYSICIAN: _____
   ADDRESS: _____
   HOSPITAL AFFILIATION: _____
   TEL. NO.: _____
7. FAMILY HISTORY:
   FATHER'S NAME: _____
   ADDRESS: _____
   TEL. / C.P. NOS.: _____
   AGE: (indicate whether living or deceased): _____
   IF DECEASED, INDICATE CAUSE: _____

   MOTHER'S NAME: _____
   ADDRESS: _____
   TEL. / C.P. NOS.: _____
   AGE: (indicate whether living or deceased): _____
   IF DECEASED, INDICATE CAUSE: _____
   NUMBER OF SIBLINGS LIVING: ____ DECEASED: ___ CAUSE OF DEATH: _____
   ORDER OF BIRTH IN THE FAMILY: _____

   Check (✓) which of the following diseases that previously inflicted your family or relatives within the first degree.

___ Cerebral Hemorrhage	___ Nervous Trouble
___ High Blood Pressure	___ Psychiatric Problems
___ Heart Disease	___ Diabetes
___ Tuberculosis	___ Bleeding Tendency
___ Asthma	___ Eczema
___ Allergy	___ Convulsion
___ Headache / Migraine	___ Digestive Problem

8. PAST MEDICAL HISTORY
Check (✓) which of the following diseases that inflicted you in the past. Put X mark if it did not.

___ Chickenpox	___ Measles	___ German Measles
___ Mumps	___ Typhoid	___ Hepatitis
___ Amoebiasis	___ Br. Asthma	___ Allergy
___ Convulsion	___ Tetanus	___ Dengue/H-Fever
___ Tonsilitis	___ Pneumonia	___ Primary Complex
___ Headache/Migraine	___ Prolonged Cough	

Other diseases not mentioned: _____
Hospitalization (indicate illness and year happened): _____

9. IMMUNIZATION HISTORY
Check (✓) if you have been immunized against the following diseases and indicate the year when it was administered. Put X mark if it was not administered.

___ _____ DPT	___ _____ Hepatitis
___ _____ Mumps	___ _____ Typhoid
___ _____ Measles	___ _____ Chickenpox
___ _____ German Measles	___ _____ Hepatitis B

10. Menstrual History (for female students)
Age of onset _____ Duration: _____
Amount (scanty, moderate, profuse): _____
Occurrence: (regular, irregular): _____
Pain (before, during): _____
Intensity of pain (mild, moderate, severe): _____
Medications usually taken: _____

_____ Date: _____
Signature Over Printed Name of Scholar

_____ Date: _____
Signature Over Printed Name of Parent / Legal Guardian