PHILIPPINE SCIENCE HIGH SCHOOL SYSTEM
CAMPUS: CENTRAL MINDANAO CAMPUS

Paste your 1 x 1 picture here. **DO NOT STAPLE.**

HEALTH HISTORY AND PERSONAL DATA SHEET

(Grade 7 and Lateral Enrollees)

Instructions:
Students should fill this up carefully **IN INK.** The answers to the questions will help the Medical Clinic in rendering effective treatment regarding your health problems. **ALL ANSWERS SHALL BE HELD CONFIDENTIAL.**

1. Name: ____
   First Name Middle Name Surname
2. Permanent Home Address: ______________________________
   City Address: ______________________________
3. Date of Birth: ____________ Place of Birth: ____________ Age: ________
4. Citizenship: ____________ Religion: ____________
5. Family Physician: ____________ Contact No: ____________
   Address: ______________________________
6. **Family History**
   Father's Name: ____________ Contact No: ____________
   Address: ______________________________
   Age: ________ ( ) Living ( ) Deceased Cause of death: ____________
   Mother's Name: ____________ Contact No: _ ____________
   Address: ______________________________
   Age: ________ ( ) Living ( ) Deceased Cause of death: ____________
   Number of siblings: ______ Living ______Deceased Cause of Death: ____________
   Order of Birth in the Family: ( ) First ( ) Second ( )Third ( ) Fourth ( ) Others: ____________
   Person to notify in case of emergency ______________________________
   Address ____________ Contact ____________

Check (□) which of the following diseases any of your relatives (up to first degree only) have had:

_____ Cerebral Hemorrhage _____ Kidney Disease _____ Hypertension _____ Heart Disease
_____ Tuberculosis _____ Asthma _____ Migraine _____ Diabetes
_____ Rheumatism _____ Digestive Upset _____ Allergy _____ Bleeding Tendency
_____ Cancer _____ Nervous Trouble _____ Mental Illness
_____ Others (Please Specify): ______________________________

7. **Past History**

Check (□) which of the following diseases/ illnesses you have had and write the age at which you had it. Put a cross (X) mark on those illnesses/ diseases which you have not had.

Chickenpox ____________ Mumps ____________ Amoebiasis ____________
Measles ____________ German Measles ____________ Typhoid Fever ____________
Hepatitis ____________ Convulsion ____________ Tetanus ____________
Primary Complex ____________ Dengue Fever ____________ Tonsilitis ____________
Pneumonia ____________ Diphtheria ____________ Whooping Cough ____________
Influenza ____________ Poliomyelitis ____________ Diabetes ____________
Appendicitis ____________ Digestive Upset ____________ Nervous Breakdown ____________
Nosebleed____________ Bleeding Tendencies: ____________

Allergy ____________ Pls. specify the triggering factors (allergen)____________
Asthma____________ Triggering factors of asthma: ____________
Other illness/injury/surgical procedure sustained (Please specify.):____________

Have you ever been confined due to an illness/injury ? ( ) Yes Reason for confinement: ____________
What year? ____________
( ) No

8. **Immunization History**

Check (□) if you have been immunized against the following diseases and indicate the year it was administered.

______ DPT (Diphtheria, Pertussis and Tetanus Date: ____________
______ Poliomyelitis Date: ____________
______ Measles Date: ____________
______ Mumps: Date: ____________
______ German Measles Date: ____________
______ Hepatitis A Date: ____________
______ Hepatitis B Date: ____________
______ Chickenpox Date: ____________
______ Influenza Date: ____________

9. **Menstrual History (for FEMALE STUDENTS)**
Age of Onset: ______________ Average Duration of Menstruation (in days): ___________________
Amount ( ) scanty ( ) moderate ( ) profuse Occurrence: ( ) Regular ( ) Irregular
Presence of pain: ( ) before menstruation ( ) during menstruation ( ) after menstruation ( ) none
Intensity of Pain: ( ) mild ( ) moderate ( ) severe
Medications usually taken (list all): ____

10. Indicate your answers with a check (□) mark.
a. Do you feel any of the following manifestations during stressful situations? ( ) YES ( ) NO
If yes, please check all that apply:
( ) stomach ache ( ) difficulty of breathing ( ) difficulty in swallowing
( ) dizziness ( ) palpitations ( ) immobility of hands and legs
( ) fainting ( ) allergy attacks ( ) nausea and vomiting
( ) loose bowel movement ( ) frequent urination
b. In what event do you usually experience the above mentioned symptoms?
( ) before exam ( ) contests ( ) quarrel with family/ friends/ significant others
( ) break-ups ( ) any classroom activity ( ) any activity facing a crowd of people
( ) hearing of bad news( ) Others (pls. specify): ____
c. Is the manifestation usually manageable? ( ) YES ( ) NO
d. If NO, do you seek medical attention? ( ) YES ( ) NO
e. Do you feel like someone is watching you even when there are no people around? ( )YES ( ) NO
f. Do you experience stage fright or fear of facing a crowd of people? ( ) YES ( ) NO
g. When you are in a sad/ depressed mood, how long does it usually last?
( ) 1 day ( ) 2-3 days ( ) 1 week ( ) 2-3 weeks ( ) 1 month ( ) more than a month
h. Do you usually share your problems / secrets to other people? ( ) YES ( ) NO

11. Vitamins/Medications being taken ____

12. Are you allergic to any medications? ( ) YES If yes, to what medications: ______________________________
( ) NO

I hereby give permission for release and exchange of information from this form, its attachments, and any other form related to my health history, with confidential use, between the School Nurse, School Physician, and other health care provider in meeting my health needs

_________________________________ ____

Printed Name and Signature of Student **Printed Name and Signature of Parent/Guardian**

Date Accomplished:________________