UPHS FORM NO. 2

UNIVERSITY OF THE PHILIPPINES
HEALTH SERVICE

ENTRANCE HEALTH EXAMINATIONS

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

Important: Please mail completed form to the University Health Service, U.P. Diliman, Quezon City or bring accomplished form with you to the U.P. Health Service when you come for 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
4 A graduate student employed under the classification of "Graduate Assistant" or "Graduate Instructor"

B. Completion of this form is not required if:

1 You are a foreign student sponsored by a government agency whose files provides 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 Summer Session only.

2x2 picture
ID photo
taken within
the last
3 months

Allergic to: ____________________ Entrance Date to U.P. ____________________

Please print

Last Name First Name Middle Sex Age

☐ Single ☐ Married ☐ Widowed ☐ Divorced

Date of Birth: ____________________ Place : ____________________

College/ School of Registration in the University of the Philippines : ____________________

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

Home Address : ____________________ Tel. No. ____________________
No Street City Province Country

Address while in School: ____________________ Tel. No. ____________________

Name of Parent/Guardian/Spouse: ____________________

Address: ____________________ Tel. No. ____________________

Family History

Mother Living ____________ (Age) If deceased, ____________ (Age at death) Cause of death ____________________

Father Living ____________ (Age) If deceased, ____________ (Age at death) Cause of death ____________________

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

	Yes	No	Relationship		Yes	No	Relationship
Cancer				Diabetes			
Heart Disease				Mental Disorder/Problem			
High Blood Pressure				Asthma or Hay Fever			
Stroke				Convulsions/Neurologic Problems			
Tuberculosis				Bleeding Problems/Blood Disorders			
Kidney Disease				Digestive disturbances			
Arthritis/Rheumatism				Skin Disease			

Personal History. Give the appropriate age to which you had 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		Syphillis	
Dengue		Malaria		Thyroid Disease	
Diabetes		Measles		Tonsilitis	
Diphtheria		Mental Problem/Disorder		Tuberculosis/Primary Complex	
Ear disease/defect		Mumps		Typhoid	
Eye disease/defect		Neurologic Problem/Disorder		Ulcer (peptic)	
Gonorrhea		Pertussis (Whooping cough)		Ulcer (skin)	
Heart disease		Pleurlsy		Other conditions (please list)	
Hepatitis (indicate type)		Pneumonia			

Have you ever had or do you have any of the folowing. 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, give details ______________________________

Do you worry too much? ___________ Does your self-consciousness interfere with your getting along with others easily? ______________________________
Are you bothered by a feeling that people are watching you or talking about you? ________________ Are you concerned about alternating period of gloom and cheerfulness? _______________ Is it difficult for you to pull out of a depressed mood? ___________
Are you inclined to be secretive or seclusive? ______________________________

Date of last dental check up ______________________________ Date of last eye refraction ______________________________

Do you consider yourself in good health? Yes ____ No ____ If not, give details______________________________

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 _______

FOR FEMALE STUDENTS:
Menstruation: Have not begun __________ or Age at onset __________ Periods occur every ____ to ____ days
Duration ____ days Flow: ____ Moderate ____ Excessive ____ Scanty Painful: _______ Incapacitating: ____________
Bleeding between periods: Yes _____ No _____
Have you had any trouble with your breasts, such as lumps, tumor, surgery? No ____ Yes _____. If so, give details ______________________________

I certify that the above history is true to the best of my knowledge.

____
Signature