

	MEDICAL HEALTH RECORD	Document No.	WVSU-MDC-SOI-01-F02
		Issue No.	1
		Revision No.	1
	WEST VISAYAS STATE UNIVERSITY	Date of Effectivity:	August 29, 2018
		Issued by:	Medical Dental
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MEDICAL HEALTH RECORD

Campus: _____		College/Unit/Department: _____			
Category _____		____ Faculty		____ Non-teaching	
				____ Student	
PERSONAL DATA					
Name _____					
Date of Birth: _____	Age: _____	Sex: _____		Civil Status: _____	
Address _____		Phone No.: _____			
Parent's/ Guardian's Name: _____					
Course & Year level: _____					
Person to Contact in case of Emergency _____					
MEDICAL HISTORY					
	NO	YES, please specify			
Recent Illness					
resent Medications					
Hospitalization					
Surgery					
Allergy					
Immunization					
Illness in the Family					
For Females	Age of onset: _____. Date of last menses: _____				
PHYSICAL EXAMINATION (to be filled up by the Physician)					
BP= _____	T= _____	PR= _____	RR= _____	Ht (in) _____	Wt (kg) _____
Snellen Test OD _____ OS _____		Corrected OD _____ OS _____			
	Normal	Findings			
General Appearance					
Skin					
Head and Neck					
Lungs					
Breasts					
Heart					
Abdomen					
Back & spine					
Genitals					
Rectum					
Extremities					
Neuro					
Remarks _____					
COVID-19 Related Information					
	NO	YES			
Travel history in the past 14 days		When: _____ Where: _____			
RT-PCR Test/Swab Test		When: _____ Where: _____			
Hospitalized for COVID19		When: _____ Where: _____			
Quarantine		When: _____ Where: _____			
Isolate		When: _____ Where: _____			
Have you received Covid-19 Vaccine?		When: _____ Where: _____ Brand: _____ No. of dose/s _____			

RECOMMENDATION/S: _____

Examining Physician

License No. _____