U.P. HEALTH SERVICE

J.P. Laurel Avenue, Diliman, Quezon City

NAME OF STUDENT: _____ **BIRTHDATE:** _____

Last Name, First Name, M.I. *MM/DD/YYYY*

DATA SUBJECT CONSENT FORM

For your Pre-enrollment Health Assessment, we will be collecting and processing the following personal information:

a. Personal Details such as name, birthdate, sex assigned at birth, civil status
b. Contact Information
c. Educational Information such as, but not limited to, your college, course, and student number
d. Health Information such as existing health conditions, medical and dental procedures received
e. Contact Information of person to be contacted in case of emergency

Your personal information will be collected and processed for health assessment/treatment purposes as a precondition for determining your fitness to be admitted in your selected degree program and to participate in academic activities.

☐ I grant my consent for the UP Health Service to collect and process my personal and health information for the purpose/s stated above. I understand that this consent will remain in full force until I revoke it in writing.

INFORMED CONSENT

The purpose of this form is to obtain your consent for assessment and treatment (if deemed necessary), and to use your personal information in research for the improvement of healthcare services and facilities.

PLEASE CHECK ALL THAT APPLY:

☐ **For Minors (below 18 years of age):**

I, _____ hereby voluntarily consent to the
(Name of Parent/ Guardian)
UP HEALTH SERVICE staff to conduct thorough physical examination and mental health screening, to perform diagnostic procedure/s, and to administer treatment as deemed necessary prior to my child's university admission.

☐ **For those of Legal Age (18 years old and above):**

I voluntarily consent to the UP HEALTH SERVICE staff to conduct thorough physical examination and mental health screening, to perform diagnostic procedure/s, and to administer treatment as deemed necessary prior to my university admission.

☐ I voluntarily consent to be contacted by the UPHS to participate in research for the improvement of its healthcare services and facilities. In the event that I decide to opt out, I shall immediately inform the UPHS at uhs.updiliman@up.edu.ph in order for them to remove my contact information from its pool of respondents.

☐ I do not want to be contacted by the UPHS to participate in research for the improvement of its healthcare services and facilities.

_____

Name and Signature of Student/
Date Signed

_____

Name and Signature of Parent or Guardian/
Date Signed

Both student and guardian will affix their signatures,
if the student is aged below 18 years old.

UPD Student No. _____

UNIVERSITY OF THE PHILIPPINES HEALTH SERVICE
PRE-ENROLLMENT HEALTH ASSESSMENT (PEHA)

A complete Medical History and Physical Examination is compulsory to complete your admission to the University of the Philippines (UP) 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 **BLACK OR BLUE** ink. This form will be part of the Pre-Enrollment Medical files and will be treated with confidentiality. Prior ethics approval will be solicited, in the event that UP may use relevant data for research purposes.

Important: Please bring accomplished form with you to U.P. Health Service (UPHS), when you come for Physical Examination.

PLEASE KEEP THIS FORM NEAT AND CLEAN

You are required to fill-out this form if you are a:

1. Newly admitted undergraduate, graduate, or post-graduate student of UP Diliman/ UPDEPP
2. New student admitted through other screening processes/ special progams (VAAS, Talent Test, etc.)
3. Transfer student from a regional campus or another school/university
4. Returning student from Leave of Absence (LOA) or Absence Without Leave (AWOL) of *at least two (2) semesters* , for whatever reason
5. Cross-enrolling from a regional campus or another school or university

2"x2" or passport-size colored ID photo taken within the last 3 months

☐ Allergic to: _____

☐ No known allergies

Please PRINT

Last Name | First Name | Full Middle Name | Sex Assigned at Birth | Age

Civil Status: ☐ Single ☐ Married ☐ Widowed ☐ Legally Separated

Birthdate: (Month) (Day) (Year) Birth Place: _____

UPD College of: _____ Department/ Institute of: _____

☐ Freshman ☐ Graduate ☐ Post Graduate ☐ Transferee ☐ Cross-Registrant ☐ Returning from LOA/ AWOL

Permanent Address : _____

Contact Number: _____

PERSON TO CONTACT IN CASE OF EMERGENCY (Parent/Guardian/Spouse): _____

Address: _____ Contact 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
				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 approximate **AGE** to which you had the following, otherwise write NA.

	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		Syphillis	
Convulsions		Kidney disease		Thyroid Disease	
Dengue		Malaria		Tonsilitis	
Diabetes		Measles		Tuberculosis/Primary Complex	
Diphtheria		Mental Problem/Disorder		Typhoid	
Ear disease/defect		Mumps		Ulcer (peptic)	
Eye disease/defect		Neurologic Problem/Disorder		Ulcer (skin)	
Gonorrhea		Pertussis (Whooping cough)		COVID-19	
Heart disease		Pleurisy		Other dangerous, communicable, contagious,	
Hepatitis (indicate type)		Pneumonia		infectious conditions (please list below)	

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			Surgery/ 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 to any, please give details _____

IMMUNIZATION RECORD	Date given*		Date given*
BCG		Hepa A dose 1	
Hepa B dose 1		dose 2	
dose 2		Typhoid	
dose 3		Others (specify)	
Measles, Mumps, Rubella dose1		COVID-19	
dose 2		Dose 1	
Varicella dose 1		Dose 2	
dose 2		Booster 1	
Tdap		Booster 2	
**** Please write ND if vaccine was given but date unrecalled; write NV for no vaccination.***			

Date of Last Dental Check-up _____ Date of Last Eye Refraction _____

Do you wish to discuss anything regarding your health, family history, sex or personal habit with a physician. Yes _____ No _____
Are you taking any medicines regularly? Yes ____ No ____ If so, what are these medicines? _____
Do you have any physical condition or handicap that requires special treatment, diet or other special consideration? Yes _____ None _____
If answer to previous question is YES, give details: _____

FOR FEMALE STUDENTS:

Menstruation: Have not begun _____ or Age at Onset _____ Periods occur every _____ to _____ days (interval between menses)
Duration: _____ days Flow: Moderate _____ Excessive _____ Scanty _____ Painful: _____ Incapacitating: _____
Last menstrual period (month and year): _____
Have you had any trouble with your breasts, such as lumps, tumor, surgery? No _____ Yes _____ If so, give details _____

I certify that all the abovementioned personal data and information I provided for PEHA are true and correct to the best of my knowledge. I have fully disclosed all medical conditions that may affect my performace as a student of the University.

_____
Signature and Date
Both student and guardian will affix their signatures, if the student is BELOW 18 years

U.P. HEALTH SERVICE
J.P. Laurel Avenue, Diliman, Quezon City

MENTAL HEALTH SCREENING TOOL

Name:

Student No.: **Date Accomplished** *(MM/DD/YYYY)* **:**

This questionnaire is an important part of providing you with the best health care possible. Your HONEST answers will help in understanding health problems that you may have. PLEASE ANSWER EVERY QUESTION TO THE BEST OF YOUR ABILITY. Thank you.

Part A: Check the box corresponding to your answer.

Over the **last 2 weeks**, how often have you been bothered by any of the following problems?		**Not at all**	**Several Days**	**More than half days**	**Nearly everyday**
1.	Feeling nervous anxiety, or on the edge				
2.	Not being able to stop or control worrying				
3.	Worrying too much about different things				
4.	Trouble relaxing				
5.	Being so restless that it is hard ro sit still				
6.	Becoming easily annoyed or irritable				
7.	Feeling afraid as if something awful might happen				

SCORE =

Part B: Check the box corresponding to your answer.

Over the **last 2 weeks**, how often have you been bothered by any of the following problems?		**Not at all**	**Several Days**	**More than half days**	**Nearly everyday**
1.	Little interest or pleasure in doing things				
2.	Feeling down, depressed, or hopeless				
3.	Trouble falling or staying asleep, or sleeping too much				
4.	Feeling tired or having little energy				
5.	Poor appetite or overeating				
6.	Feeling bad about yourself - or that you are a failure or have let yourself or your family down				
7.	Trouble concentrating on things such as reading the newspaper or watching television				
8.	Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual.				
9.	Thoughts that you would be better off dead or hurting yourself in some way				

SCORE =

If you checked off any problems on this questionnaire, **how difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?	**Not difficult at all**	**Somewhat difficult**	**Very difficult**	**Extremely difficult**

Name: _____ Age: _____ Sex Assigned at Birth: ☐ **M** ☐ **F**
Last Name *First Name* *FULL Middle Name (if applicable)*

(Do not write below this line. To be filled out by the physician.)

Vital Signs and Anthropometric Measurements:

Pulse Rate: _____ beats/min. Blood Pressure: _____ mmHg Respiratory Rate: _____ breaths/min. Temperature: _____ °C

Height: _____ cm. Weight: _____ Kg. Body Mass Index: _____
[wt. in Kgs/ (ht. in m.)^2]

General Health Appearance: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Visual Acuity:

	Without Glasses		*With Glasses/ Contact Lens*	
	FAR	*NEAR*	*FAR*	*NEAR*
Right:	_____ :	_____	_____ :	_____
Left:	_____ :	_____	_____ :	_____
Color Vision:	_____			

Asia-Pacific BMI Cut-Offs

Underweight	
___ Severe Thinness	<16.00
___ Moderate Thinness	16.00-16.99
___ Mild Thinness	17.00-18.49
___ **Normal**	18.50-22.99
___ Overweight	23.00-24.90
Obese	
___ Obese 1	25.00-29.90
___ Obese 2	>30.00

Please check the appropriate box whether findings are normal or abnormal for each organ/system; if with abnormal findings, please describe below:

Organ/ Systems:	Normal	Abnormal	If abnormal, please describe findings
Skin			
Head/ Scalp			
Eyes			
Ears			
Nose			
Mouth/ Oropharynx			
Neck			
Heart			
Lungs			
Back/ Spine			
Abdomen			
Extremities			
Genito-urinary/Ano-rectal			
Neurologic			

Diagnostics/Laboratory Results:

☐ Normal chest findings
☐ CBC - within normal limits
☐ UA - within normal limits

Activity: ☐ Unlimited ☐ Unlimited with Observation ☐ Restricted and Corrective ☐ Reconstructive ☐ No Activity

ASSESSMENT

_____
_____
_____
_____
_____

RECOMMENDATIONS

_____
_____
_____
_____
_____

☐ **FIT TO ENROLL**

This is to acknowledge that I have been advised to seek mental health evaluation and support by the undersigned examining physician.

_____
Signature over Printed Name

Examined by: _____
PRC License No.: _____
Hospital Address: _____
Date Examined: _____

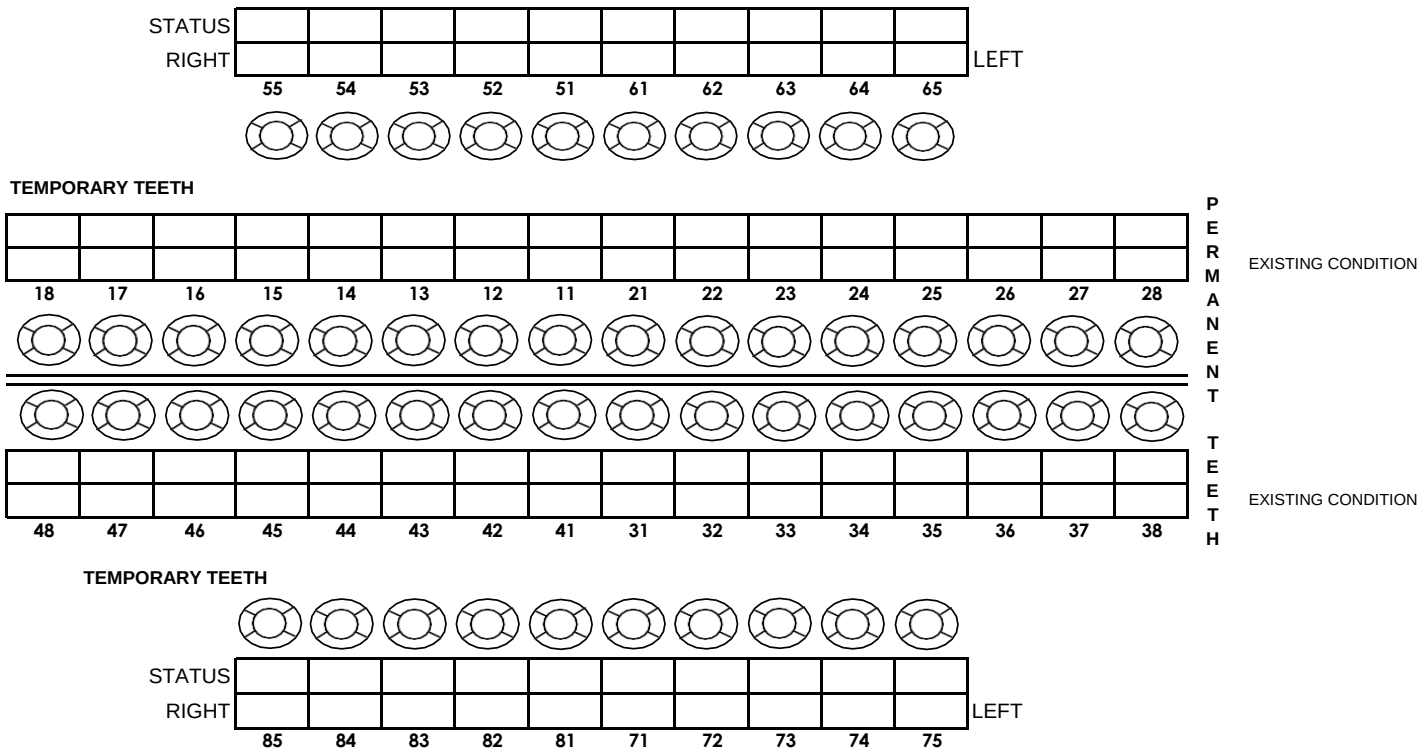
UP HEALTH SERVICE
University of the Philippines
Diliman, Quezon City

DENTAL RECORD
INTRAORAL EXAMINATION FOR PRE-ENROLLMENT HEALTH ASSESSMENT (PEHA)

FULL NAME: _____
Last Name *First Name* *FULL Middle Name (if applicable)*

Present Address: _____

Date of Birth (MM/DD/YYYY): _____ Age: _____ Sex Assigned at Birth: _____



LEGEND:

CONDITION
- ✓ - Present Teeth
- D - Decayed (Caries Indicated for Filling)
- M - Missing due to Caries
- MO - Missing due to Other Causes
- Im - Impacted Tooth
- Rf - Root Fragment
- Un - Unerupted

RESTORATIONS & PROSTHETICS
- Am - Amalgam Filling
- Co - Composite Filling
- JC - Jacket Crown
- Ab - Abutment
- Att - Attachment
- P - Pontic
- In - Inlay
- Imp - Implant
- S - Sealants
- Rm - Removable Denture

SURGERY
- X - Extraction due to Caries
- XO - Extraction due to Other Causes

X-ray Taken:
- ___ Periapical (Tth No: _____)
- ___ Panoramic
- ___ Cephalometric
- ___ Occlusal (Upper/ Lower)
- ___ Others: _____

Other Clinical Findings

_____
_____
_____

Name of Dentist: _____
PRC License No.: _____
Date Examined: _____

Name of Student: _____

UP Student No.: _____

Dear Parent/ Guardian:

Please request the dentist who will perform your child's intraoral examination to fill out this form as a summary of their recommendations. The student has the option to come to the UP Health Service for any of the services and dental procedures mentioned below; most of which may be availed of at discounted rates.

Pre-enrollment Health Assessment Committee

DENTAL RECOMMENDATION FORM

Patient is for:

- ☐ Oral Prophylaxis _____
- ☐ Restoration of tooth # _____
- ☐ Extraction of tooth # _____
- ☐ Others _____

Remarks: Teeth: _____

Gingiva: _____

Examined by Dentist: _____

PRC License No.: _____

Dental Clinic Address: _____

Date of Examination: _____