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 to any, please give details _____

IMMUNIZATION RECORD*	**Birth**	**Weeks**	**Months**	**Years**
BCG				
Hepa B				
DPT				
Influenza				
IPV or OPV				
Measles (and Mumps, Rubella)				
Varicella				
Hepa A				
HPV				
*** Please write the date when the vaccine was given, or ND for NO IMMUNIZATION DATA available.**				

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

Do you wish to discuss any question 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 _____ No _____

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 the above history is true to the best of my knowledge. I have fully disclosed all medical conditions that may affect my performance as a student of the University. I/my guardian hereby give/s consent for Physical Examination to the accredited Government Physician.**

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

Signature/s and Date