**HSS-OSA Form No.14**

**01 June 2022**

**UNIVERSITY OF THE PHILIPPINES MINDANAO**

1. Office of Student Affairs

## HEALTH SERVICES SECTION

### HEALTH DECLARATION FORM

*For School Year \_\_\_\_\_\_\_\_\_\_\_\_\_, in lieu of the usual Physical Examination and laboratory test, incoming students are required to complete the Health Declaration Form for admission. This form will be part of your medical records as a student and will be treated with utmost confidentiality. Please type or write in black or blue ink only.*

PERSONAL DATA:

Student No. Last Name First Name Middle Name Sex Civil Status

Complete Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student’s Contact No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Religion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Place of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_\_\_\_

If cultural minority, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

College: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Course : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Classification: Freshman \_\_\_\_\_\_ Sophomore \_\_\_\_\_\_\_ Junior \_\_\_\_\_\_\_ Senior \_\_\_\_\_\_

 Graduate \_\_\_\_\_\_\_ Special \_\_\_\_\_\_\_\_\_\_ Non-degree \_\_\_\_\_\_\_

Name of Parent/Guardian/Spouse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Complete Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Contact No. \_\_\_\_\_\_\_\_\_\_\_\_\_

Complete Employment Address/Position/Tel. No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAMILY HISTORY: (Kindly check your answer to the following)

Mother: Living \_\_\_\_\_\_\_ Deceased \_\_\_\_\_\_\_ Cause of Death \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father: Living \_\_\_\_\_\_\_\_ Deceased \_\_\_\_\_\_\_ Cause of Death \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has any member of your family attended any Campus of the University of the Philippines?

Yes \_\_\_\_No \_\_\_\_Relation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ UP Campus \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHILHEALTH MEMBERSHIP: (Please check)

Mother : Member Yes \_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_

Father : Member Yes \_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_

Student : Member \_\_\_\_\_ Dependent \_\_\_\_\_\_\_\_

Covid-19 Vaccination Status:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Vaccination Shot | Brand of Vaccine | Date of Vaccination | Place | Remarks |
|  1st Dose  |  |  |  |  |
|  2nd Dose  |  |   |  |  |
| 1st Booster  |  |   |  |  |
| 2nd Booster |  |  |  |  |
| Not Yet ( State the reason) |  |  |  |  |

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Disease | *Yes* | *No* | *Relationship* | Disease | *Yes* | *No* | *Relationship* |
| Asthma |  |  |  | Kidney trouble |  |  |  |
| Cancer |  |  |  | Mental disorder |  |  |  |
| Convulsion |  |  |  | Rheumatism |  |  |  |
| Diabetes |  |  |  | Skin disorder |  |  |  |
| Digestive problems |  |  |  | Bleeding tendencies |  |  |  |
| Heart problems |  |  |  | Stroke |  |  |  |
| High blood pressure |  |  |  | Tuberculosis |  |  |  |

Have you ever been diagnosed with any of the following?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Disease | *Age* | *Disease* | *Age* | *Disease* | *Age* |
| Anemia |  | High blood pressure |  | Rheumatic fever |  |
| Amoebiasis |  | Influenza |  | Skin disease (specify) |  |
| Chicken pox |  | Dysmenorrhea |  | Small pox |  |
| Convulsions |  | Joint pains |  | Syphilis |  |
| Diabetes |  | Kidney diseases |  | Thyroid disorder |  |
| Diphtheria |  | Malaria |  | Tonsillitis |  |
| Ear disorder/defect |  | Measles |  | Tuberculosis |  |
| Eye disorder/defect |  | Mumps |  | Typhoid fever |  |
| Gonorrhea |  | Mental problems |  | Ulcer (peptic/gastric) |  |
| Heart disease |  | Pleurisy |  | Skin ulcers |  |
| Hepatitis |  | Pneumonia |  | Whooping cough |  |
| Hernia |  | Poliomyelitis |  | Other conditions |  |

Have you ever had or do you now have any of the following? Please check.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| *Symptom* | *Yes* | *No* | *Symptom* | *Yes* | *No* | *Symptom* | *Yes* | *No* |
| Asthma attacks |  |  | Frequent urination |  |  | Nausea(frequent) |  |  |
| Chest pain |  |  | Fainting spells |  |  | Nosebleed |  |  |
| Cough |  |  | Hay fever |  |  | Rapid pulse rate |  |  |
| COVID-19 |  |  | Headache |  |  | Palpitations |  |  |
| Depression |  |  | Indigestion |  |  | Sore throat |  |  |
| Diarrhea |  |  | Influenza |  |  | Swollen feet |  |  |
| Difficulty breathing |  |  | Insomnia |  |  | Vomiting |  |  |
| Dizziness |  |  | Joint pains |  |  | Others: |  |  |
| Eczema |  |  | Loss of weight |  |  |  |  |  |

If your answer is “Yes” on the above mentioned symptoms, give details (add paper if needed) \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical and surgical History, serious illness, operation, fractures, injuries, and accident. Please give details (add paper if needed) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If your tonsils have been removed, indicate condition of health since operation. Improved \_\_\_\_\_\_ Same\_\_\_\_\_\_ worse \_\_\_\_\_\_.

Do you worry too much? \_\_\_\_\_\_\_ Does your self-consciousness interfere with your getting along easily? \_\_\_\_\_\_\_\_\_ Are you bothered by a feeling that people are watching or talking about you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to any food, serum, drug, or medicines (penicillin, antitoxins, etc.) No \_\_\_\_ Yes \_\_\_\_\_\_\_If so, list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last eye check-up: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last Eye check-up: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wish to discuss any questions with regards to your health, family history, sex or personal habits with a physician or nurse? No\_\_\_\_\_\_\_ Yes\_\_\_\_\_\_\_\_

Are you taking any medicines at present? No \_\_\_\_\_\_\_\_ Yes \_\_\_\_\_\_\_ if so, what medicines? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any special conditions or handicap, which requires special treatment, diet, or other special consideration? No\_\_\_\_\_\_ Yes \_\_\_\_\_; if so, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FEMALE STUDENT TO ANSWER THE FOLLOWING:

Menstruation: has begun or age of onset (menarche) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Periods: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occurs every \_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_ days. Duration \_\_\_\_\_\_\_\_\_\_\_\_ days.

Flow: Moderate \_\_\_\_\_\_\_\_\_\_\_ Excessive \_\_\_\_\_\_\_\_\_\_\_\_ Scanty \_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Dysmenorrhea \_\_\_\_\_\_\_\_\_\_\_, Incapacitating \_\_\_\_\_\_\_\_\_\_\_. Bleeding between periods; No\_\_\_\_\_\_ Yes\_\_\_\_\_\_\_\_

Have you had any trouble with your breast? Lumps, tumor, surgery, etc. No\_\_\_\_\_\_\_\_\_ Yes \_\_\_\_\_\_\_ If so, kindly explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

MALE STUDENT TO ANSWER THE FOLLOWING:

Have you now or had hernia or rupture? Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any trouble with your testicles (infection, injury, surgery, etc)? No \_\_\_\_\_\_ Yes \_\_\_\_\_\_\_

Have you had any trouble in urinating? Yes \_\_\_\_\_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IMMUNIZATIONS RECEIVED: ( please check if complete; specify number of shots if not completed)

\_\_\_\_\_\_ DPT (complete) \_\_\_\_\_\_\_\_ OPV (complete) \_\_\_\_\_\_\_BCG \_\_\_\_\_\_\_Measles

\_\_\_\_\_\_MMR \_\_\_\_\_\_\_chicken pox \_\_\_\_\_\_\_Hepatitis-B (complete) \_\_\_\_\_\_\_Hepatitis-A

\_\_\_\_\_\_Tetanus toxoid (complete) Others: (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **DECLARATION AND DATA SUBJECT CONSENT FORM**

*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.*

*Also understand that the UP Mindanao Health Services Section will not be liable to any untoward incident that may arise due to the deferral of the physical examination and other laboratory test.*

*In compliance with the Data Privacy Act of 2012 and its Implementing Rules and Regulation, I voluntarily consent to the collection, processing, and the storage of my personal and heal information for the purpose/s of health assessment, treatment, and / or research (following research ethics guidelines) for the improvement of health care services.*

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 SIGNATURE OVER PRINTED NAME / DATE

 *NOTE : Both student and guardian will affix their signature,*

*if the former is aged bellow 18 years old*