Republic of the Philippines
CATANDUANES STATE UNIVERSITY
Virac, Catanduanes

Name: ______________________________________ Age: ______ Sex: _____ Date: ____________________
College: _____________ Contact Number: _________________

MEDICAL HISTORY

GENERAL QUESTIONS	YES	NO	REMARKS
1. Are you in good health?	YES	NO	
2. Do you have an ongoing medical condition (like diabetes, asthma, anemia, infarctions, allergy)?	YES	NO	
3. Are you currently taking any prescription or non-prescription (over-the-counter) medicines or pills?	YES	NO	
4. Have you taken any medications in the past 4 weeks?	YES	NO	
5. Do you have allergies to medicines, pollens, foods or stinging insects?	YES	NO	
6. Have you ever spent the night in a hospital? If Yes, what is the cause of hospitalization?	YES	NO	
7. Have you ever had surgery?	YES	NO	
HEART HEALTH QUESTIONS ABOUT YOU			
8. Have you ever had chest pain and or/shortness of breath, dizziness, light headedness, or passed out during or after strenuous activity/exercise?	YES	NO	
9. Have you ever been told that you have a heart murmur?	YES	NO	
10. Do you have a history of high blood pressure?	YES	NO	
11. Have you ever had an electrocardiogram (EKG) and/or echocardiogram (ECHO) of your heart?	YES	NO	
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY			
12. Has any family member or close relative had heart problems and/or died of sudden death before the age of 50?	YES	NO	
13. Has anyone in your family had unexplained fainting, unexplained seizures or near drowning?	YES	NO	
14. Does anyone in your family have a history of high blood pressure?	YES	NO	
BONE AND JOINT QUESTIONS			
16. Have you ever had an injury, like sprain, muscle or ligament tear or tendonitis?	YES	NO	
17. Have you had any broken or fractured bones or dislocated joints?	YES	NO	
18. Have you ever had an injury that requires x-ray for neck instability?	YES	NO	
19. Do you regularly use a brace or other assistive device?	YES	NO	
20. Do you have a bone, muscle or joint injury that bothers you?	YES	NO	
MEDICAL QUESTIONS			
21. Has a doctor ever told you that you have asthma or allergies?	YES	NO	
23. Is there anyone in your family who has asthma?	YES	NO	
24. Have you ever used an inhaler or taken asthma medicine?	YES	NO	
25. Were you born without or are you missing kidney, an eye, a testicle (males) or any other organ?	YES	NO	
26. Do you have groin pain or painful bulge or hernia in the groin area?	YES	NO	
27. Have you ever had Dengue hemorrhagic fever infection?	YES	NO	
28. Do you have any rashes, pressure sores or other skin problems?	YES	NO	
29. Have you ever had a head injury or concussion?	YES	NO	
30. Have you ever had a hit or blow to the head that caused confusion prolonged headache or memory problem?	YES	NO	
31. Have you ever had a history of seizure (convulsion)?	YES	NO	
32. Do you have headache, dizziness?	YES	NO	

33. Have you ever had muscle cramps, numbness, tingling or weakness in your arms or legs?	YES	NO	
34. Have you had any problems with your eyes or vision?	YES	NO	
35. Have you had any eye injuries?	YES	NO	
36. Do you wear glasses or contact lens?	YES	NO	
37. Do you have any concerns that you would like to discuss with a doctor?	YES	NO	
38. Do you have G6PD (Glucose 6 Phosphate Dehydrogenase) condition?	YES	NO	
FEMALES ONLY			
39. Have you ever had a menstrual period? If yes, when was your last menstrual period? ________________________________	YES	NO	
40. Have you ever had menstrual cramps?	YES	NO	
41. Do you take medication during menstrual period? If yes, what? ________________	YES	NO	
42. How old were you when you had your first menstrual period? __________________			
43. How many menstrual periods have you had in the last year?___________________			
MEDICATION			
Please list ALL Prescription & over-the-counter medications that you are CURRENTLY TAKING or HAVE TAKEN in The PAST Two (2) Years and for what purpose:			

NOTES: ____

I certify that the answers to the above questions are true and accurate.

____
Patient Signature over Printed Name

____
Date