HSS-OSA Form No.03
May 2025

UNIVERSITY OF THE PHILIPPINES MINDANAO
Office of Student Affairs
HEALTH SERVICES SECTION

2x2 photo

STUDENT'S MEDICAL HISTORY

A. Complete Medical History and Physical Examination is compulsory to complete your enrollment to the University on the Philippines Mindanao and must be submitted as instructed below. PLEASE TYPE OR COMPLETE IN INK THIS FORM. This record is to be treated confidentially.

Instruction: Fill out and insert accomplished form in the Medical Folder, which will be given to you during the Physical and Dental Examination.

PLEASE KEEP THIS FORM NEAT AND CLEAN

Complete this form if you are enrolling during a regular semester and you are :

1. A beginning undergraduate or a beginning graduate student.
2. A transfer student from a regional campus or another school or university.
3. A re-entry student (undergraduate or graduate) who has been out of the University of the Philippines Mindanao for at least one semester.

B. Do not complete this form if you are enrolling for summer class 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:_____
Specify Ethnic /Tribal Group : _____(none)_____
College (UP): _____ 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*: (please present your Vaccination Card)*

Vaccination Shot	Brand of Vaccine	Date of Vaccination	Place	Remarks
1st Dose				
2nd Dose				
1st Booster				
2nd Booster				
None (State the reason)				

Among your relative medical history, have you 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		Arthritis		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	

Are you having any signs and symptoms of illness at present or a week ago? (yes)_____(No)_____ if yes, please indicate details: _____

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: _____.

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) _____
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 had hernia or swelling? 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 below 18 years old)