**HEALTH CONSULTATION FORM**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** | | **Division/Section/Unit:** | |
| **Age:** | | **Position/Designation** | |
| **Birthday (Day/Month/Year)** | | **Address** | |
| Date Accomplished | | Contact No. | |
| Vital Signs | BP | HR | RR |
| Height (cm) | Weight (kg) | BMI |
| Abdominal Circumference (cm) | Hip circumference | WHR |
| Past Health History |  | Year of Onset | Medications |
| Hypertension |  |  |
| Diabetes Mellitus |  |  |
| Cardio Vascular Disease |  |  |
| Tuberculosis |  |  |
| Allergy |  |  |
| Surgical Operations |  |  |
| Hospitalization |  |  |
| Laboratory  Examinations | CXR |  |  |
| Sputum Result |  |  |
| Urinalysis |  |  |
| Drug Testing |  |  |
| Neuropsychiatric Exam |  |  |
| Blood Type |  |  |
| Others |  |  |
| Fasting Blood Sugar |  |  |
| Ultrasound |  |  |
| Cholesterol |  |  |
|  | Non-Smoker? | Previous Smoker?  (Sticks/day x years) | Current Smoker  (Sticks/day x years) |
|  | Non-Drinker? | Previous Drinker?  (#bottles x frequency x years) | Current Drinker?  (#bottles x frequency x years) |
| Family Health History (indicate relationship) | Hypertension |  |  |
| Diabetes Mellitus |  |  |
| Cardiovascular Disease |  |  |
| Tuberculosis |  |  |
| Allergy |  |  |
| Kidney Disease |  |  |
| Cancer |  |  |
| Asthma |  |  |
| Others: |  |  |
| Sexual History | Menarche |  |  |
| Parity Code |  |  |
| Paps Smear (Date/Result) |  |  |
| Self-Breast Examination |  |  |
| Digital Rectal Exam (for male) |  |  |
| Review of Systems (Please Check) | Cough | Blurring of vision | Syncope/Fainting |
| Dizziness | Wearing eyeglasses | Convulsions |
| Dyspnea | Vaginal Discharge/Bleeding | Malaria |
| Chest/Back Pain | Mass | Goiter |
| Easy Fatigability | Painful Urination | Anemia |
| Difficult of breathing | Poor/Loss of Hearing | Others (specify) |

|  |  |  |
| --- | --- | --- |
| **PEARL OLIVETH S. INTIA**  Medical Officer IV  (Signature Over Printed Name) | PRC: LICENSE: | Date Examined:(mm/dd/yyyy) |