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PHILIPPINE GENERAL HOSPITAL
The National University Hospital
University of the Philippines Manila
DEPARTMENT OF FAMILY & COMMUNITY MEDICINE
U P H e a l t h S e r v i c e
Taft Avenue, Manila

"PHIC Accredited Health Care Provider"
ISO 9001 : 2008 Certified

PERIODIC HEALTH EXAM FOR UP MANILA STUDENTS

YEAR OF EXAM _____

Name	**Age/Sex:**	**College:**
Year Level for the coming school year: ☐ Freshman ☐ 2nd and up ☐ Graduate student		

Medical Problems	**Date Identified** (Month/ Year)	**Maintenance Medications if any** (Include vitamins or supplements)

Family History: Check diseases present in family members & indicate relation to student		
☐ Hypertension	☐ Bronchial asthma	☐ Others: *please specify*
☐ Diabetes Mellitus	☐ Tuberculosis	
☐ Mental Illness	☐ Cancer: *please specify*	

Lifestyle Check: Check all that applies.	
Diet	☐ high carbohydrate/sugar ☐ high fat ☐ high salt ☐ high fiber ☐ low water
Tobacco use	☐ never ☐ used but stopped ☐ currently using, *specify #sticks/day:*
Alcohol intake	☐ never ☐ occasional ☐ periodic, *specify # & type of drinks/session:*
Physical activity	☐ sedentary ☐ regular exercise/ sports activity, *specify average # hours/week:*
Sexuality & Gender	Difficulty with sexuality or gender orientation? ☐ yes ☐ no
Stressor/s, *if any*	
Coping mechanism	
Sleep	Ave # hours/day: Do you feel refreshed after sleep? ☐ yes ☐ no

Vaccination History: Check all vaccines received and indicate month and/or year when it was last given	
☐ Hepatitis A	☐ Tdap/ Tetanus toxoid
☐ Varicella	☐ Pneumococcal (PCV13 _____ / PPSV 23 _____)
☐ MMR	☐ Hepatitis B Dose 1 _____ Dose 2 _____ Dose 3 _____ Booster _____
☐ Flu	☐ Others, *specify*

Review of Systems: Check all symptoms that are present.			
☐ Headache	☐ Difficulty of breathing	☐ Chest pain	☐ Menstrual problems
☐ Abdominal pain	☐ Bowel irregularity	☐ Palpitation	☐ Weight changes
☐ Anxiety attacks	☐ Urinary problem	☐ Others:	

Menstrual History *(for females)***:** Age at first menstruation ____ Date of last menstrual period _____
Age at first pregnancy *(if applicable)* _____

PHQ-9: Patient Health Questionnaire for Mental Health	Not at all (0)	Several Days (1)	More than half the days (2)	Nearly Every Day (3)
Instructions: How often have you been bothered by each of the following symptoms during the **past two weeks**? For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling				
Feeling down, depressed, irritable, or hopeless?				
Little interest or pleasure in doing things?				
Trouble falling asleep, staying asleep, or sleeping too much?				
Poor appetite, weight loss, or overeating?				
Feeling tired, or having little energy?				
Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
Trouble concentrating on things like schoolwork, reading, or watching TV?				
Moving or speaking so slowly that other people could have noticed? … Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
Thoughts that you would be better off dead, or of hurting yourself in some way?				
In the past year have you felt depressed or sad most days, even if you felt okay sometimes? ☐Yes ☐No				
If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people? ☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult				
Has there been a time in the past month when you have had serious thoughts about ending your life? ☐Yes ☐No				
Have you EVER, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt? ☐Yes ☐No				
PHQ-9 Score: _____ ☐ No referral (0-4) ☐ Refer to Office of Student Affairs/ Family Health Unit/ Psychiatry				

Chest X-ray Result & Date:	
*HbsAg Result & Date:	*Anti-Hbs Result & Date:
**Varicella IgG Result & Date:	**RPR/VDRL Result & Date:
**Date of HICU Clearance:	
For LU3 to LU7 students of CM and undergraduate students of CD, CN, CP, CAMP & CPH only* * For LU6 & LU7 students of CM only*	

--- *To be filled by examining physician* ----

Physical Examination			
Blood Pressure	Heart Rate	Respiratory Rate	Temperature (°C)
BMI (Wt in kg/(Ht in m)^2)	Weight (kg)	Height (cm)	Waist Circumference (cm)
HEENT			
Chest/ Lungs			
Heart			
Abdomen			
Extremities			
Skin			
Other Findings			

Classification			
A	Physically fit for study	C	Allowed to enroll but requires periodic follow up at the UPHS
B	With correctible defects but otherwise fit for study	D	Not physically fit for study

Summary of medical problems identified & recommendations:

Name of Examining Physician *(in print)*	**Signature**	**License Number**	**Date Signed**