



UST ANGELICUM COLLEGE, INC.

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MEDICAL EXAMINATION REPORT

PART ONE: MEDICAL HISTORY CHECKLIST

Name: _____ Date of Birth: _____
Last Name First Name Middle Name
Age: _____ Sex: M F Phone Numbers _____ Cell _____

PERTINENT HISTORY

Any history of previous hospitalizations or surgical operations?
 No Yes Please specify* _____

Any history of accidents/ injuries?
 No Yes Please specify* _____

Any history of mental or psychological problems?
 No Yes Please specify* _____

Any history of allergies/ asthma?
 No Yes Please specify* _____

Any recent or current medical problems?
 No Yes Please specify* _____

Any history of heart disease?
 No Yes Please specify* _____

Current medication: _____

Immunizations: Hepatitis A: 1st 2nd Hepatitis B: 1st 2nd
Varicella: 1st 2nd MMR: 1st 2nd
Tetanus Toxoid booster (within the last 10 years): _____
Others: _____

I hereby certify that the above statements are true and correct to the best of my knowledge.

SIGNATURE OVER PRINTED NAME

PART TWO: HEALTH HISTORY

Weight: _____ Height: _____ BMI: _____ Date: _____

Vital Signs: BP _____ CR _____ RR _____ Temp _____

	Normal	Abnormal	Comments*		Normal	Abnormal	Comments*
General				Chest & Lungs			
Skin				Breast			
Head				Heart			
Eyes				Abdomen			
Ear/Nose/ Throat				Pulses			
Teeth & Gums				Spine			
Neck & Thyroid				Neurologic			

*Please use back of this page for additional comments.

PHYSICALLY FIT FOR ADMISSION

YES NO

REMARKS: _____

Attending Physician's Name: _____ PRC License Number: _____

Clinic Address: _____ Contact Number: _____

Physician's Signature: _____

Non-disclosure of sickness/ health condition/ false information on health record or documents is a grave offense under the UST Angelicum College Revised Discipline Policy series 2018.