STUDENT HEALTH CARD

Student Number _____

Course _____

Year Level _____

Name _____ _____ _____
(Family Name) (Given Name) (Middle Name)

Address: _____

Birthday _____ Age : _____ Nationality _____
(Month/Day/Year) Religion _____

Height _____ Weight _____ Blood Pressure _____

A. Family History:

	Yes	No	(Please check one)
• Asthma	____	____	
• Cancer	____	____	
• Heart Problems	____	____	
• Hypertension	____	____	
• Diabetes Mellitus	____	____	
• Goiter/Thyroid Problems	____	____	
• Hemorrhoids	____	____	
• Obesity	____	____	
• Others (Please specify)	____	____	_____

B. History of Allergy

• Pennicillin	____	____
• Tetracycline	____	____
• Cold Medicine	____	____
• Cough Medicine	____	____
• Merthiolate	____	____
• Other Medicines (specify)	____	____ _____

C. History of past ailments and hospitalization

(Please check one)	Yes	No
• Asthma	____	____
• Bronchopneumonia	____	____
• Hepatitis	____	____
• Typhoid Fever	____	____
• Diabetes Mellitus	____	____
• Gastroenteritis	____	____
• Gastritis	____	____
• Anemia	____	____
• Hypertension	____	____
• Bleeding	____	____
• Loss of consciousness	____	____
• Surgery (specify)	_____	
• Others (specify)	_____	