Ateneo de Manila University
Loyola Heights, Quezon City

Higher Education Office of Health Services
Loyola Schools

MEDICAL ASSESSMENT FORM

Name: _____ ID Number _____ Year & Course _____
Last First Middle

This medical assessment form is a requirement for entry into the university. For students with active comorbid condition, it is best for the medical assessment to be completed by the physician directly managing the condition.

Section 1: Medical and Family History [To be completed by the parent or guardian.] **This section needs to be reviewed by the physician.**

Please check if the student or his/her siblings, parents or grandparents has/have or had any of the following. [Legend: STU-Student SIBS-Siblings PAR-Parents GPS-Grand Parents]

ILLNESS	STU	SIBS	PAR	GPS
Allergy, Hives (Specify)				
Allergic Rhinitis				
Asthma (Date of Last Attack)				
Tuberculosis				
Other Lung Problems (Specify)				
Hypertension or High Blood				
High Cholesterol, Lipids or Fats				
Stroke or Heart Disease before the age of 40 yrs. old				
Other Heart Disease before the age of 40 yrs. old				
Anemia				
Bleeding Problems				
Thyroid Problems				
Diabetes				
Hepatitis/ Jaundice				
Other Liver Problems (Specify)				
Acid Peptic Disease/ Ulcers				
Other Stomach/ Intestinal Problem (Specify)				
Kidney or Urinary Problems (Specify)				
Dizziness/Fainting				
Recurrent Headache/ Migraine				
Convulsions or Seizures				
Eating or Nutritional Problems				
Alcohol or Drug Abuse				
Other psycho-emotional Problems				
Anxiety & Mood Problems				
Suicidal Thoughts				
Depression				
Cancer (Specify)				
Surgeries Undertaken (Specify)				
Any Other Active medical conditions (Specify)				

If the student is diagnosed with any medical condition, please provide details below. For any active conditions, a medical certificate with an update of the current status of the patient is required.

_____

History of Confinement: (Pls. specify date, diagnosis, and any pertinent details.)

_____
_____
_____
_____
_____

Alcohol History
How often do you drink alcoholic beverages _____

Smoking History – Please encircle answer:
Is the student a CURRENT or PREVIOUS smoker? ☐ YES ☐ NO
Age of onset of smoking: _____
How many sticks per day? _____

For Female Students:
Menarche: _____
Last Menstrual Period: _____
OB Score (if with previous pregnancy): _____

Does your son/daughter currently have special needs that can affect his or her academic performance or social adjustment in the University?
___ Yes ___ No

If yes, what are these? *Please check the appropriate space and kindly specify the condition.*

___ Physical limitations (e.g. Cerebral palsy, paraplegia, problems with ambulation, heart problems, others)
Please specify: _____

___ Emotional or behavioral conditions (e.g. obsession-compulsion, personality problems, anxiety, depression, Asperger's syndrome, others)
Please specify: _____

___ Conditions related to attention or concentration (e.g. ADHD, others)
Please specify: _____

___ Ongoing or long-standing medical conditions (e.g. seizures or epilepsy, diabetes, others)
Please specify: _____

___ Other special needs
Please specify: _____

For any of the conditions above, please specify details and provide any documentation/work-up and clearance from your certified healthcare provider.

Is your son/daughter receiving professional services for this condition?
___ Yes ___ No

If yes, may we ask your permission to contact the health professional so we can coordinate with him/her the care and services for your son/daughter if it is necessary? ___ Yes ___ No

Name of Health Professional: _____
Field of Specialization: _____
_____
Office Address: _____
Office Contact No. _____
Mobile No.: _____ **Phone No.:** _____

Current medicines being taken by student:
_____
_____
_____

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Section 2: Physician's Assessment [This section should be completed by the examining physician.]

Section 2.1: Physical Examination

1. Height: _____ cm or _____ ft& in
2. Weight: _____ kg or _____ lbs
3. BMI: _____
4. PR: _____
5. RR: _____
6. Blood Pressure: _____
7. Temperature: _____
8. Vision

	Uncorrected	Corrected
Right (OD)		
Left (OS)		
Both Eyes (OU)		

9. Hearing (Gross Examination): _____

Note: For the physical exam, please check the correct column or write **NE** if not examined.

	Organ System	Normal	Abnormal	Remarks or Details (If Abnormal)
10	Eyes			
11	Ears			
12	Nose			
13	Throat			
14	Mouth			
15	Teeth & Gums			
16	Neck			
17	Thyroid			
18	Breast			
19	Chest			
20	Lungs			
21	Heart			
22	Abdomen			
23	External Genitalia			
24	Back/ Spine			
25	Upper Extremities			
26	Lower Extremities			
27	Muscles & Joints			
28	Skin			
29	Neurologic Exam			

30. Blood Type (optional) _____

Section 2.2: Immunization *(Required*) please provide documentation so the examining physician can complete this section.

Vaccines	Date (mo-day-yr)	Date (mo-day-yr)	Date (mo-day-yr)	Other forms of Documentation (Date & Result of Serology or Date of Actual Disease)
Required Immunizations:				
Hepatitis B (Three doses)				
Measles-Mumps-Rubella (Two doses)				
Chicken Pox (Two doses)				
Tetanus-Diphtheria Booster (Td, Tdap) (within 6-10 yrs)				
COVID-19 Vaccination				
Additional Immunizations: (Optional)				

RECENT CHEST X-Ray (**Required; within 6 months from the submission date. For any abnormal findings, clearance from your attending physician is required.)**

Please attach official chest x-ray result

Date Done: _____

Name of clinic/hospital: _____

_____

Impression/ Recommendation: _____

_____

_____

_____

_____

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Section 3: General Assessment and Recommendations [To be completed by the examining physician.]

Please provide an assessment of the health and well-being of the student based on your history and examination:

_____

_____

_____

Please check:

___ Medically cleared to register for college education.

___ Limited clearance to register for college education (Please explain below*) **Please provide separate Medical Certificate***

_____

_____

_____

Please check:

___ Medically cleared to participate in physical education classes and in sports and athletic activities.

___ Limited clearance for P.E., sports and athletic activities. (Please specify and explain below) ***Please provide separate Medical Certificate***

_____

_____

_____

Please check:

___ No special health and medical needs in school.

___ Requires special health and medical needs in school. (Please specify and explain below) ***Please provide separate Medical Certificate***

_____

_____

_____

Section 4: Certification by Examining Physician

I have reviewed the above sections on Medical and Family History and the Student's Immunization Record. The information in these sections is accurate and correct to the best of my knowledge. I have also done a complete health assessment and physical examination of the student on _____ (**date of examination**) and certify to the veracity of the findings documented above.

Signature over Printed Name of Physician: _____ License No: _____

Complete Address of Clinic: _____

Landline: _____ Mobile Number: _____ E-mail: _____

Please check:

___ This is the first time I am seeing the student for his/her health examination.

___ The student has been under my care since _____ (*Please state duration of doctor-patient relationship*).