CITY GOVERNMENT OF LIGAO
LIGAO COMMUNITY COLLEGE
Tomolin, Ligao City, 4504
Email – Address: ligaocommunitycollege@gmail.com
Tel Nos.: 0926 – 772 - 1213 / (052) 431-4124

LiComCoClinic_Form No.01
Rev: 04_2024

2x2 picture with nametag

STUDENT'S MEDICAL INFORMATION

A.Y. 2026-2027

NAME	Last Name:		First Name:		Middle Name
ADDRESS				PWD: ___YES	TYPE OF DISABILITY:
SEX		AGE		___NO	_____
YEAR/BLOCK		COURSE/MAJOR			PWD ID NO :
BIRTHDAY		STATUS		CITIZENSHIP	
REGISTERED TO PHILHEALTH	_____ YES _____ NO		If yes, write your PHILHEALTH NUMBER_____ *(indicate the PHILHEALTH NUMBER of parents if beneficiary of parents)*		

In case of emergency, person to contact:

NAME	RELATIONSHIP	ADDRESS	CP #

Please put a check mark on the appropriate column/box below.

MEDICAL HISTORY: *Present and past illness.*

A	YES	NO	B	YES	NO
Eye Disease			Hypertension (High Blood)		
Ear Infection			Hypotension (Low Blood)		
Hearing Defect			Anemia (Low Blood Count)		
Sinusitis			Heart Disease (Sakit sa Puso)		
Nose Bleeding			Diabetes		
Frequent cough/cold			Ulcer		
Tonsillitis/Pharyngitis			Hyperacidity		
Neck Mass/ Goiter			Kidney Disease/ UTI		
Asthma			Skin Disease		
Tuberculosis			Allergies		
Bronchitis			Loss of Consciousness (Hinimatay)		
Pneumonia			Frequent Headache/Migraine		
C	**YES**	**NO**	**D**	**YES**	**NO**
Dizziness/Vertigo			Chest Pain		
Depression			Breast Cyst/Mass		
Epilepsy/Convulsion			Abdominal Mass		
Weakness/Paralysis			Hernia (Luslos)		
Arthritis			Genital Abnormality/Deformity		
Fracture (Bali)			Spine Injury/Deformity		
Measles (Tigdas)			Thigh Injury/Deformity		
Chicken Pox (Bulutong)			Hemorrhoids (Almoranas)		
Mumps (Beke)			Past/Present Medication(s)		
Hepatitis			Previous Accident(s)		
Malaria			Previous Hospitalization(s)		
Sexually Transmitted Disease (STD)			Previous Operation(s)		

REMARKS:

FAMILY HEALTH HISTORY *(pls. list pertinent illness/diseases)*	
MOTHER	
FATHER	
SISTER(S)/BROTHER(S)	
GRANDPARENTS	

OB-GYNE HISTORY: *For female students only*

MENSTRUAL PATTERN: **____ Monthly** **____Irregular**	**PREGNANT NOW?** **___ Yes** **___ No**	**MYOMA** **___ Yes** **___ No**	**LAST MENSTRUAL PERIOD** *(first day of menstruation)* _____
NUMBER OF PREGNANCIES : _____	**OVARIAN CYST:** **___ Yes** **___ No**	**DYSMENORRHEA:** **___ No** **___ MODERATE** **___ SEVERE**	**NUMBER OF MISCARRIAGES** **(*ilang beses na nakunan*)** _____
Others:		**Remarks:**	

SOCIAL HISTORY *(please specify year below*)

A. **SMOKING** ___ YES ___ NO If Yes, since _____, # of sticks per day _____
B. **DRINKING ALCOHOLIC BEVERAGES** ___ YES ___ NO If Yes, since _____, # of bottles _____; Daily ___ Weekly ___ Occasional ___
REMARKS:

Please list any drugs, medicines, birth control pills, vitamins and minerals (prescribed and non-prescribed) you use and indicate how often you use it.

NAME OF MEDICINE	USE	DOSAGE

PREFERRED HOSPITAL IN CASE OF EMERGENCY	

CERTIFICATION AND CONSENT	
I certify that the answers and statements above are all true and correct to the best of my knowledge.	
_____ **STUDENTS NAME**	_____ **DATE ACCOMPLISHED**

****** Attach photocopy of medical certificate or other important papers if with present medical condition.***