INDIVIDUAL HEALTH PROFILE FORM

SANTA ROSA CITY HEALTH OFFICE II

Print legibly. Mark appropriate boxes c with " / "

PIN:

Patient Name:

(Last Name) | (First Name) | (Middle Name) | (Extension: Sr., Jr., etc.)

Note: If this is a follow-up consult or 2nd visit, please indicate if there are any changes in the Basic Demographic Data.

Address:

Age: ☐ 0 – 1 year ☐ 2 - 5 years ☐ 6 - 15 years ☐ 16 - 24 years ☐ 25 – 59 years ☐ 60 years and above

Birthdate: (mm/dd/yyyy) / /

Sex: ☐ Male ☐ Female

Religion:

Civil Status: ☐ Single ☐ Married ☐ Annuled ☐ Widowed ☐ Separated ☐ Others, specify _____

PHIC Membership:

- ☐ Member
- ☐ Dependent
- ☐ Non-Member

Type of Membership

- ☐ Sponsored
  - ☐ NHTS ☐ LGU
  - ☐ NGA ☐ Private
- ☐ Individually Paying Program (IPP)
  - ☐ Organized Group
  - ☐ OFW
- ☐ Employed
  - ☐ Government
  - ☐ Private
- ☐ Lifetime

Occupation: _____

Highest Completed Educational Attainment:

☐ College degree,post graduate ☐ High School ☐ Elementary ☐ Vocational ☐ No Schooling

Past Medical History:

- ☐ Allergy, specify _____
- ☐ Asthma
- ☐ Cancer, specify organ_____
- ☐ Cerebrovascular disease
- ☐ Coronary artery disease
- ☐ Diabetes mellitus
- ☐ Emphysema
- ☐ Epilepsy/Seizure disorder
- ☐ Hepatitis, specify type _____
- ☐ Hyperlipidemia
- ☐ Hypertension, highest BP _____
- ☐ Peptic ulcer disease
- ☐ Pneumonia
- ☐ Thyroid disease
- ☐ Tuberculosis, specify organ _____
  If PTB, what category? _____
- ☐ Urinary tract infection
- ☐ Others: _____

Past Surgical History:

Operation: _____ Date: _____

Operation: _____ Date: _____

Family History:

- ☐ Allergy, specify _____
- ☐ Asthma
- ☐ Cancer, specify organ_____
- ☐ Cerebrovascular disease
- ☐ Coronary artery disease
- ☐ Diabetes mellitus
- ☐ Emphysema
- ☐ Epilepsy/Seizure disorder
- ☐ Hepatitis, specify type _____
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Peptic ulcer disease
- ☐ Thyroid disease
- ☐ Tuberculosis, specify organ _____
  If PTB, what category? _____
- ☐ Others: _____

Personal/Social History:

Smoking: ☐ Yes ☐ No ☐ Quit No. of pack years? _____

Alcohol: ☐ Yes ☐ No ☐ Quit No. of bottles/day? _____

Illicit drugs: ☐ Yes ☐ No

Immunizations:

For children: ☐ BCG ☐ OPV1 ☐ OPV2 ☐ OPV3 ☐ DPT1 ☐ DPT2 ☐ DPT3 ☐ Measles ☐ Hepatitis B1 ☐ Hepatitis B2 ☐ Hepatitis B3 ☐ Hepatitis A ☐ Varicella (Chicken Pox)

For young women: ☐ HPV ☐ MMR

For pregnant women: ☐ Tetanus toxoid

For elderly and immunocompromised: ☐ Pnuemococcal vaccine ☐ Flu vaccine

Others: Specify _____

Menstrual History:

Last Menstrual Period: _____ Birth control method: _____

Menopause? ☐ Yes ☐ No If yes, at what age?: _____

Pregnancy History:

Gravity(no. of pregnancy): _____ Parity(no. of delivery): _____ Type of Delivery: _____