PNP HS MS FORM NO. 2014-01

Republic of the Philippines
NATIONAL POLICE COMMISSION
Philippine National Police
HEALTH SERVICE
Camp BGen Rafael T Crame, Quezon City

MEDICAL HISTORY REPORT
Medical Prescreen Questionnaire

2x2 colored picture with white background and the name should appear below the picture (LAST, FIRST, M.I.)

PICTURE SHOULD BE WITHOUT HEADGEAR, MOUSTACHE , EYE GLASSES OR SUN GLASSES.

DATE:_____ **CONTROL NO.**

RANK	LAST NAME	FIRST NAME	MIDDLE NAME	AGE	SEX	CIVIL STATUS

PERMANENT HOME ADDRESS (NUMBER,STREET,CITY OR TOWN PROVINCE)	CONTACT NUMBER

DATE OF BIRTH	PLACE OF BIRTH	RELIGION	PURPOSE OF EXAMINATION

NEXT OF KIN (NAME, RELATIONSHIP, ADDRESS, CONTACT NO.)

INSTRUCTION: *The instructions contained hereto and in the other medical forms are pertinent and vital. They shall be part of the personnel's medical records. The information you will give shall constitute an official statement. They are to be filled-up properly, honestly and with outmost integrity. If you are accepted into the PNP based on a false statement herein you can be recommended for summary dismissal proceedings in the future.*

PLEASE CHECK AND WRITE YOUR ANSWERS ON THIS QUESTINNAIRE ON THE SPACE PROVIDED *may use additional sheet/s if necessary.*

1. FAMILY MEMBERS	**NAME**	**DATE OF BIRTH**	**STATE OF HEALTH**			
			Good	**Stable w/ known medical condition/s**	**Seriously ill**	**If deceased** please indicate cause of death
a. FATHER'S NAME						
b. MOTHER'S NAME						
c. SIBLINGS						
d. SPOUSE'S NAME						
e. CHILDREN'S NAME						

2. FAMILY MEDICAL HISTORY

a. Have anyone in your family suffered from the following:

CONDITIONS	YES	NO	RELATIONSHIP	CONDITIONS	YES	NO	RELATIONSHIP
Diabetes				Hepatitis			
Stroke				Kidney Disease			
Heart Disease				Leukemia/Blood Cancers			
High Blood Pressure				Bleeding Disorders			
Asthma				Mental Disorder			
Pulmonary Tuberculosis				Drinking Problem			
Goiter/Thyroid Disease				Smoking Problem			

b. Do you have any family member who died of heart disease? ☐ **YES** ☐ **NO** If *YES,* indicate relationship and age at the time of death_____

3. PERSONAL SOCIAL HISTORY

Describe	YES	NO
Smoking *sticks* _____*per day since*_____		
Stopped Smoking *when*_____		
Alcohol _____ *x per month*		
Stopped Drinking Alcohol *when*_____		
Prohibited Drugs		
Exercise _____min/s per day _____x per month		
Right-handed		
Left-handed		
Usual Physical Activities/Sports Played (how often)		

4. WOMEN'S HEALTH HISTORY

No. of Pregnancies		Age at start of Menses:		
No. of deliveries		*REGULAR*	ف YES	ف NO
No. of abortions		*DYSMENORRHEA*	ف YES	ف NO
No. of miscarriages		Menses Interval _____ days	Menses Duration _____ days	
Date of Last Mentrual Period:		Last Pap Smear: Normal: ف YES ف NO		
Current Method of Contraception, if there's any:				

5. VACCINATION HISTORY

Vaccine	YES	NO	When	No. of doses	Vaccine	YES	NO	When	No. of doses
Hepatitis A					Typhoid				
Hepatitis B					Varicella (Chicken pox)				
Influenza (Flu)					Tetanus				
Pneumonia					Measle, Mumps, Rubella				
Others:					Others:				

6. MEDICATION HISTORY

a. Current Medications you are taking if there are any:

b. Allergies to Medications, drugs or food, if there are any:

7. PAST MEDICAL HISTORY, HOSPITALIZATION & SURGERY: If YES, please describe in the separate portion)

Have you ever had or do you now have the following:	YES	NO	Have you ever had or do you now have the following:	YES	NO
1. Asthma, wheezing, or inhaler use			35. Epilepsy, fits, seizures, or convulsions		
2. Tuberculosis			36. Sleepwalking		
3. Collapsed lung or other lung condition			37. Fainting spells or passing out		
4. Pneumonia			38. Bed wetting at age 12		
5. Whooping cough			39. Heat Exhaustion		
6. Diptheria			40. Absence or disturbance of the sense of smell		
7. Anemia			41. Recurrent nose bleeding		
8. Rheumatic Fever			42. Detached retina or surgery for a detached retina		
9. Malaria			43. Wear contact lenses		
10. Chicken Pox			44. Night blindness		
11. Typhoid Fever			45. Any other eye condition, injury or surgery		
12. Measles			46. Double vision		
13. Mumps			47. Perforated ear drum or tubes in ear drum/s		
14. Passing out of worms (parasitic infections)			48. Recurrent ear infection		
15. Ulcer			49. Frequent or severe headaches		
16. Hepatitis A or B			**50.** Recurrent neck or back pain		
17. Jaundice (yellow discoloration of the skin and eyes)			51. Arthritis or frequent joint pains		
18. Anorexia or other eating disorders			52. Fracture in any part of the body		
19. Intestinal obstruction *(locked bowels*)			53. Pain or swelling at the site of an old fracture		
20. Gall bladder disease or gall stones			54. Swelling of joints		
21. Kidney Disease, including kidney stones			55. Lower extremity weakness		
22. Sexually-Transmitted Infections			56. Paralysis of any part of the body		
23. Recurrent Urinary Tract Infections			57. Used any form of body support or braces		
24. Missing a kidney			58. Donated blood		
25. *(Females only)* Dysmenorrhea			59. Received blood transfusion		
26. *(Males only)* Missing a testicle, testicular implant, or undescended testicle			60. Eye surgery, including radial keratotomy, lens implant or other eye surgery to improve your vision		
27. Goiter or thyroid disease or with thyroid medications			61. Ear surgery, to include repair of perforated ear drum, hearing loss or need/use a hearing aid		
28. High blood sugar (diabetes) or with diabetes medications			62. Head injury, including skull fracture, resulting in concussion, loss of consciousness, headaches, etc.		

29. High blood pressure or with hypertension medications			63. Dislocated joint, including knee, hip, shoulder, elbow, ankle or other joint		
30. Irregular heartbeat, including abnormally rapid or slow heart rates			*64.* Broken bone requiring surgery to repair *(w/ or w/o pins, plates, screws or other metal fixation devices)*		
31. Heart murmur, valve problem or mitral valve prolapse			*65.* Surgery to remove a portion of the intestine (other than the appendix)		
32. Discharged from military service for medical reasons			66. Any illnesses, surgery, or hospitalization not listed above		
33. Been rejected for military service *(temporary or permanent)* for medical or other reasons			67. Evaluation, treatment, or hospitalization for alcohol abuse, dependence, or addiction		
34. Seen a psychiatrist, psychologist, social worker, counselor or other professional for any reason *(inpatient or outpatient)*			68. Evaluation, treatment, or hospitalization for substance use, abuse, addiction or dependence *(including illegal drugs, prescription medications)*		

Describe in detail every YES answer, including how it was known, treatment done, etc.

8. REVIEW OF SYSTEMS

Have YOU had problems with any of the following within the past year?

GENERAL	**Yes**	**No**	***LUNGS***	**Yes**	**No**	***GENITOURINARY***	**Yes**	**No**	***NEUROLOGIC***	**Yes**	**No**
Weight Loss or Gain			Coughing Up Blood			Incomplete Urination			Headaches		
Fever			Shortness of Breath			Loss of Urine			Dizziness		
Chronic Fatigue			Chronic Cough			Painful Urination			Seizures		
Excessive Bleeding			Blood Clot in Lungs			Bloody Urine			Numbness		
Easy Bruising			Painful Breathing			Frequent Urination			Memory Loss		
Increased Appetite			Wheezing			Night time Urination			Fainting Spells		
Increased Thirst			***CARDIOVASCULAR***	**Yes**	**No**	Discharges: Penis/Vagina			Tremors		
Excessive Sweating			Chest Pain/Discomfort			Unusual Vaginal Bleeding			Loss of coordination		
EYES, EARS, NOSE	**Yes**	**No**	Irregular Heart Beat			Sexual Function Problems			***MENSTRUAL PROBLEMS***	**Yes**	**No**
Itchy, Red Eyes			Palpitations			***MUSKULOSKELETAL***	**Yes**	**No**	Cramps/Pain		
Vision Problems			Ankle/Hand Swelling			Muscle Weakness			Heavy Bleeding		
Frequent Colds			Leg pain on walking			Muscle Pain			Too Frequent Periods		
Nasal Congestion			***GASTROINTESTINAL***	**Yes**	**No**	Joint Pains			Bleeding Between Periods		
Ear Pain			Frequent Diarrhea			Joint Swelling			Missed Periods		
Ringing in Ears			Constipation			Clot in Leg Vein/Leg Pain			***BREAST PROBLEMS***	**Yes**	**No**
Hearing Loss			Blood in the Stools			Varicosities			Breast Pain		
Sinus Problems			Nausea/Vomiting			Low Back Pain			Breast Lump		
Nose Bleeds			Hemorrhoids			***SKIN***			Nipple Discharge		
THROAT	**Yes**	**No**	Abdominal pain			Acne			***EMOTIONAL***	**Yes**	**No**
Sore Throat			Bloating			Rash			Excessive Worrying		
Mouth Sores			Indigestion			Oily Skin			Depression		
Dental Problems			Heartburn/Reflux			Dry Skin			Problems with sleep		
Trouble swallowing			Change in bowel movement			Change in Mole characteristic			Serious thoughts of harming yourself or others		

I certify that the above information are true and correct to the best of my knowledge. I understand that failure to disclose pertinent personal medical information may affect the assessment and evaluation of any medical officer to my physical fitness to perform my duties and functions.

I hold myself liable for perjury, falsehood, misrepresentation or omission, or act of dishonesty, if there is willful failure to disclose pertinent medical information. I attest to the truthfulness of this undertaking and submit to the legal and administrative consequences thereof if ever the statements above are wanting in truth and substance.

_____ _____

Date Signature Over Printed Name

Applicant

EVALUATOR:

_____

Signature Over Printed Name

MEDICAL OFFICER