Republic of the Philippines
University of Rizal System
Province of Rizal
MEDICAL-DENTAL HEALTH SERVICES

MEDICAL RECORD

Date: ________________

Name: ____
(Surname) (Given Name) (M.I.)

Birthday: ________________ Age: ____ y/o Sex:_____

Civil Status: _______________ Religion: _________________

College: ___________ Course/Dept.:___________Student/Employee No.: ________________

Address: ____

Contact Person & # in case of emergency:_________________________________

MEDICAL HISTORY

☐Bronchial Asthma ☐Epilepsy ☐Hernia ☐Heart Dse.
Last attack:_______________ Last attack:_______________

☐Allergies

☐Meds: ___________ ☐Hospitalization/Surgery: _____________________

**FOR FEMALE ONLY*

1st day of last menstrual period (LMP): (mm/dd/year)

To be filled-out by University Physician/Nurses

Height	Weight	BMI	BP	PR	Temp
HEENT:					
Chest/Lungs:					
Heart:					
Abdomen:					
Extremities:					
Others:					

Remarks: ____

Recommendation/s: ______________________________________

_______________________ _______________________
Patient's Signature Medical Officer III / Nurse I