ACADEMIA SAN IGNACIO DE LOYOLA
STUDENT HEALTH HISTORY

Name _____ Grade _____
Parent or Guardian _____ Phone _____ Office _____
Address _____
Date of Birth _____ Age _____ Sex ____
In case of emergency notify _____ Phone _____

Health History (Check & Specify)

Diseases	Allergies	Chronic or Recurring Illness	
Chicken pox _____	High Fever _____	Visual Problems _____	Endocrine Disorders _____
Measles _____	Asthma _____	Ear Infections _____	Behavioral Problems _____
German Measles _____	Drugs _____	Heart Disease _____	Learning Disabilities _____
Mumps _____	Insecticides _____	Seizure Disorders _____	Other _____
	Food _____		

Menstruation: Menarche _____ Regular or Irregular _____ Duration _____ Dysmenorrhea_____
Operations or serious injuries (Dates) _____
Hospitalizations _____
Other diseases or details of above _____
_____
Specific activities to be restricted _____
Special medical or dietary regimen to be continued (Specify)_____
_____

PHYSICAL EXAMINATION

Date of Examination _____
Heigth _____ Weight _____ BP _____ Heart Rate _____ Respiratory Rate _____
Appearance-Nutrition _____

Without Glasses:	With Glasses:
Eyes _____ R20/ _____ L20/ _____	R20/ _____ L20/ _____
Ears _____ Hearing _____ R _____	L _____
Nose _____	Abdomen _____
Throat _____	Genitalia _____
Teeth _____	Hernia _____
Heart _____	Skin _____
Lungs _____	Musculoskeletal _____
Analysys: CBC _____	U/A _____

Suggestions and/or comments from physician _____
_____

I hereby certify that this person is in satisfactory condition

_____ _____
Print Dr.'s Name Signature
Address _____ Licence # _____
_____