(Name of Hospital)

(Address)
DOH Accreditation No. _____
Accredited by _____
Tel. No.: _____

photo

Last Name	First Name	M.I.	Intended Occupation
Civil Status / Age / Sex	Address		Tel. No.

SSS #

I. MEDICAL HISTORY – Has applicant suffered from, or been told he had any of the following:

	YES	NO		YES	NO		YES	NO
1. Nose or throat trouble	[ ]	[ ]	11. Cancer or tumor	[ ]	[ ]	21. Sexually Transmitted disease	[ ]	[ ]
2. Ear trouble or deafness	[ ]	[ ]	12. Mental Disorders	[ ]	[ ]	22. Genetic or familial disorders	[ ]	[ ]
3. Asthma	[ ]	[ ]	13. Head or Neck injury	[ ]	[ ]	23. Malaria, if yes, date	[ ]	[ ]
4. Tuberculosis	[ ]	[ ]	14. Hernia (ruptured)	[ ]	[ ]	24. Operations	[ ]	[ ]
5. Other Lung diseases	[ ]	[ ]	15. Rheumatism, joint or back trouble	[ ]	[ ]	25. Tropical diseases	[ ]	[ ]
6. High blood pressure	[ ]	[ ]	16. Typhoid/ paratyphoid fever	[ ]	[ ]	26. Chronic cough	[ ]	[ ]
7. Heart trouble	[ ]	[ ]	17. Trachoma or other eye trouble	[ ]	[ ]	27. Fainting spells, fits or seizures	[ ]	[ ]
8. Rheumatic fever	[ ]	[ ]	18. Stomach pain or ulcer	[ ]	[ ]	28. Frequent headaches	[ ]	[ ]
9. Diabetes Mellitus	[ ]	[ ]	19. Other abdominal trouble	[ ]	[ ]	29. Dizziness	[ ]	[ ]
10. Endocrine disorders	[ ]	[ ]	20. Kidney or bladder trouble	[ ]	[ ]	30. Allergies	[ ]	[ ]

I hereby permit the DOH/ MARINA/ POEA and the undersigned to furnish such information the company may need pertaining to my health status and other pertinent medical findings and do hereby release them from any and all legal responsibility by doing so. I also certify that my medical history contained above is true and any false statement will disqualify me from my employment benefits and claims.

_____ Signature of Examinee

_____ Name of Employer

II. PHYSICAL EXAMINATION to be completed by examining physician

HEIGHT	WEIGHT	BLOOD PRESSURE	PULSE	RESPIRATION	BODY BUILD
VISUAL ACUITY	FAR VISION	NEAR VISION	COLOR VISION	HEARING	CLARITY OF SPEECH
Uncorrected	OD 20/ OS 20/	ODJ OSJ	[ ] Adequate	AD	
Corrected	OD 20/ OS 20/	ODJ OSJ	[ ] Defective	AS	

	Normal		Findings		Normal		Findings
	Yes	No					
9. Skin				19. Heart			
10. Head, Neck, Scalp				20. Abdomen			
11. Eyes, External				21. Back			
12. Pupils Opthalmoscopic				22. Anus-rectum			
13. Ears				23. G-U System			
14. Nose, Sinuses				24. Inguinal, Genital			
15. Mouth, Throat				25. Reflexes			
16. Neck, Lymph Node, Thyroid				26. Extremities			
17. Breast Axilla				27. Dental (teeth)			
18. Lungs				28. UPPER 87654321 LOWER 87654321			123456789 123456789

III. X-RAY ECG AND LABORATORY EXAMINATION REPORT

A. CHEST X-RAY NO. _____ [ ] PA [ ] LORDOTIC VIEW
ESSENTIALLY NORMAL CHEST [ ]
SIGNIFICANT FINDINGS _____

B. ECG REPORT [ ] Within Normal Limits [ ] Significant Findings

C. COMPLETE BLOOD COUNT
Findings: Hgb _____ [ ] Normal Type _____

D. URINALYSIS: Findings pus cells _____ /hpf [ ] Normal

E. STOOL EXAMINATION: Positive _____ /hpf [ ] Normal

F. SY-SEROLOGICAL TEST (VDRL):
[ ] Reactive [ ] Not Required [ ] Non-Reactive

G. HEPATITIS B SURFACE ANTIGEN TEST:
[ ] Reactive [ ] Not Required [ ] Non-Reactive

H. AIDS CLEARANCE TEST:
[ ] Reactive [ ] Not Required [ ] Non-Reactive

I. PSYCHOLOGICAL TEST:
[ ] For further evaluation [ ] NA [ ] Adequate
Adjusted
Personal

J. OTHERS: _____

REMARKS : _____

RECOMMENDATION: [ ] FIT [ ] UNFIT [ ] PENDING

_____ Examining Physician

_____ Date

Note : This certificate does not cover diseases that would require special procedure and examination for their detection such as bronchography, peptic ulcer/ gall bladder diseases which require a GI series, certain kidney problems which requires an IVP and also those which are asymptomatic at the time of examination including pregnancy test. Valid only for 3 months from date of examination.