ACADEMIA SAN IGNACIO DE LOYOLA
STUDENT HEALTH HISTORY

Name _____ Grade _____

Parent or Guardian _____ Phone: Office _____ Home _____

Address _____ Date of Birth _____ Age _____ Sex _____

Street City Zip Code

In case of emergency notify _____ Phone _____

Health History (Check & Specify)

Diseases		Allergies		Chronic or recurring Illness			
Chicken pox	_____	Hay Fever	_____	Visual Problems	_____	Endocrine Disorders	_____
Measles	_____	Asthma	_____	Ear Infections	_____	Behavioral Problems	_____
German Measles	_____	Drugs	_____	Heart Disease	_____	Learning Disabilities	_____
Mumps	_____	Insecticides	_____	Seizure Disorders	_____	Other	_____
		Ivy, Oak, Etc	_____				
		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 _____

Height _____ 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

Street _____

City _____ State _____ Zip _____

License # _____