UPLB CREDIT AND DEVELOPMENT COOPERATIVE
College, Laguna

Every question must be asked the applicant by the Medical Examiner and the applicant 's answers recorded in the Examiner 's own handwriting and in Black Ink. Examination must be gave in private.

I BIO-DATA (First) (Middle) (Last)

1. Name

Date of Birth:

Place of Birth:

2. a. Name and address of your personal physician? (If none, so state)

b. Date and reason last consulted?

c. What treatment was given or medication prescribed?

Civil Status:
( ) Single ( ) Married
( ) Widowed ( ) Separated
( ) Divorced

Sex: ( ) Male ( ) Female

Residence Address:

Occupation:

II PAST HISTORY (IDENTIFY)

	YES	NO
1. Have you ever been treated for or ever had any Known indication of:		
a. Disorder of eyes, ears, nose, or throat?	☐	☐
b. Dizziness, fainting, convulsion, headache; Speech defect, paralysis of stroke: mental Or nervous disorder?	☐	☐
c. Shortness of breath, persistent hoarseness or cough, blood spitting; bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder?	☐	☐
d. Chest pain, palpitation, high blood pressure, rheumatic fever, heart aurar, heart attack or other disorder of the heart or blood vessels?	☐	☐
e. Jaundice, intestinal bleeding, ulcer, Hernia, appendicitis, colitis,	☐	☐
Diverticulitis, hemorrhoids, recurrent Indigestion, liver or gallbladder?	☐	☐
f. Sugar, albumin, blood or pus in urine; Venereal disease; stone or other Disorder of kidney, bladder, prostate or Reproductive organs?	☐	☐
g. Diabetes; thyroid or other endocrine Disorder?	☐	☐
h. Neuritis, sciatica, rheumatism, arthritis, Gout or disorder of the muscles or bones, Including the spine, back or joints?	☐	☐
i. Deformity, lameness or amputations?	☐	☐
j. Disorder of skin, lymph glands, cyst, Tumor or Cancer	☐	☐

DETAILS of "Yes" answers.

QUESTION NUMBER, CIRCLE APPLICABLE ITEMS. Include diagnoses, dates, Duration and names and address of all attending physicians and medical facilities.)

k. Allergies, anemia or other disorder of the Blood? ☐ ☐
l. Excessive use of alcohol, tobacco or any ☐ ☐
m. Habit-forming drugs?
n. Any mental or physical disorder not listed Above? ☐ ☐

2. Are you under observation or under treatment? ☐ ☐

3. Have you had any change in weight in the past year? ☐ ☐

4. Other than above, have you within the past 5 years:
   a. Had a checkup, consultation, illness, Surgery or injury? ☐ ☐
   b. Been a patient in the hospital,clinic Sanitarium or other medicsl facility ☐ ☐
   c. Had electrocardiogram, X-ray, other diagnostic test? ☐ ☐

5. Has any life insurance company ever refused your application for reinstatement of a lasped policy or offered you a policy different from that applied for? ☐ ☐
   When? What company?

6. Have you had military service deferment, rejection or discharge because of physical or mental condition? ☐ ☐

7. Have you ever requested or received a pension, benefits, or payment because of an injury, sickness or disability? ☐ ☐

8. FOR WOMEN ONLY:
   a. Are you pregnat? ______________________ months
   b. Date of last delivery? ______________________
   c. Date of last menstruation? ______________________
   d. Are your menstruation irregular? It so, give details
   ____
   e. Any abortion, miscarriage or abnormal labors and pregnancies? If so, give date and causes
   ____
   f. Have you passed the menopause? ______________________
   g. Have you ever had tumor or disease of the breast, Uterus or ovaries? If so, give details ______________
   ____
   ____

III FAMILY HISTORY: Tuberculosis,diabetes,cancer,
high blood pressure,heart or kidney disease,
mental illness or suicide?

	Age of Living	State of Health	Age of Death	Causes of Death
Father				
Mother				
Spouse				
Brothers & Sisters				
No.Living ________ No.Dead ________				
Children No.Living ________ No.Dead ________				

The above statements and answers are true and complete to the best of my knowledge and belief. I agree that said statements and answers shall be an integral part of my application to the UPLB CREDIT AND DEVELOPMENT COOPERATIVE, unless expressly prohibited by law,(1)I authorize any physician or other person to disclose any information pertaining to my health, and (2) I waive all provisions of law forbidding the disclosure of such information.

I agree that if there be any fraud or misrepresentation in the above statement. The cooperative shall have the right to declare my membership null and void, and the benefits (e.g. death benefits) due me or to my legal beneficiary(ies) be forfeited in favor of the UPLB Credit and Development Cooperative.

Signed at__________________________ this ____________ day of __________ 19____

Witness ____________________

(Signature of Examining Physician)

____
Signature of applicant

IV MEDICAL REPORT AND OPINION ON ______________________________

(Applicant/Person proposed for membership)

1. Have you attend the applicant professionally? YES ☐ NO ☐
If so, for what and when?

2. Description (The applicant should be weighed and measured.)	HEIGHT	WEIGHT	Circumference of naked chest		Measure around abdomen
	Have you measured him?	Have you weighed him?	in full Inspiration	in forced expiration	

Change in weight in past

☐ No change Reason for change:

☐ Gain_____ lbs.

☐ Loss_____ lbs.

3. Blood pressures, if initial reading exceeds 140/90 read again later and record all readings in order taken.		(1) (2) (3)	Any history of hypertension or treatment thereof?	Pulse rate
	Systolic		☐ YES ☐ NO	
	Diastolic (Cessation of sound)			

4. Is there :	YES	NO	Please give details of question answered "YES"
a. Abnormality of the oral cavity, eyes, ears, skin(including xanthelasma, exanthemata, arcos, senile)?	☐	☐	
b. Enlargement of the lymph nodes or the thyroid gland?	☐	☐	
c. Deformity of chest or spine? (Please illustrate by line drawing- A.P. and lateral).	☐	☐	
d. Abnormality of lungs on percussion and muscultation? If so, give details and an opinion as to probable cause.	☐	☐	
e. Abnormality of the heart in respect to size and sounds?	☐	☐	
f. Irregurality or peculiarity of the pulse? if so, describe and indicate the effect of exercise.(ten full kneebends in one minute)	☐	☐	
g. Undue shortness of breath on physical exertion?	☐	☐	
h. Edema of the ankles?if so, apparent cause?			
i. Intra-abdominal abnormality (enlarge liver, palpable mass)?	☐	☐	
j. Any surgical scar on abdomen, thorax or Elsewhere	☐	☐	
k. Heraia? If so describe	☐	☐	
l. Abnormality of mentality,personality, or central nervous system (muscular power, reflexes, etc.)? Please describe.	☐	☐	

m. Abnormality of the extremities? ☐ ☐

n. Inequality or inadequacy of the pulsations of the femoral, dorsalis pedis,and posterial tibial arteries? ☐ ☐

5. a. Does the applicant appear older than his stage age? ☐ ☐ — If so, apparent age?______

b. have you observed or suspected any unusual feature not already noted, e.g. intemperate use of liquor, drug addiction, emotional disturbance, mental impairment, etc.? ☐ ☐ — please give details of a yes answer

6. a. Disgrading medical findings describe his general appearance, e.g. vigorous and healthy, pale, sickly, etc.? ☐ ☐

a. ☐ Healthy and unimpaired

b. ☐ other (clarify)

PLEASE RECORD ANY ADDITIONAL INFORMATION OR COMMENT WHICH WOULD ASSIST THE UPLBCDC BOARD OF DIRECTORS TO EVALUATE THIS APPLICANT.

RATING:

( ) CLASS A Physically fit to be a member. No physical defect noted.

( ) CLASS B Physically fit to be a member. Has minor ailment/defect.

( ) Needs treatment of:

- Skin Disease
- Dental Defects
- Anemia
- Mild Hypertension
- Urinary Tract Infection
- Intestinal Parasitism
- Small Hemorrhoids
- Others ______

( ) Treatment Optional for: ______

( ) No Treatment Needed for: ______

( ) CLASS C Physical fit to be member but at the risk of UPLBCDC

______

( ) PENDING UNTIL

-Status of lung infection is established

-Hypertension is treated

-Heart condition is further evaluated

-Further evaluation of X-ray result is done

-Repeat X-ray is done (w/motion)

- others ______

( ) UNFIT ______

OTHERS: ______

______

7. Place of examination: ☐ My office or Company's office ☐ Applicant's residence ☐ Applicant's place of business. ☐ Elsewhere______

Time ☐ am ☐ pm

Signed at ______

This ______ day of ______ 19______

______
SIGNATURE OF MEDICAL EXAMINER