Annex G: Template for Health Screening/First Patient Encounter (FPE)

HEALTH SCREENING/FPE FORM

1. CLIENT PROFILE

○ Walk-in clients ○ With appointment

*Health Screening Date (mm/dd/yyyy):

INDIVIDUAL HEALTH PROFILE

Case Number:

PhilHealth Identification Number:

Client Details

Last Name:	First Name:	Middle Name:	Extension Name:

Age:	Date of Birth (mm/dd/yyyy):	Sex:	Client Type:

2. REVIEW OF SYSTEMS

1. Chief complaint (please describe)

   _____

   _____

2. Do you experience any of the following: loss of appetite, lack of sleep, unexplained weight loss, feeling down/depressed, fever, headache, memory loss, blurring of vision, or hearing loss?
   ○ Yes ○ No
   If yes, please explain:
   _____

3. Do you experience any of the following: cough/colds, chest pain, palpitations, or difficulty in breathing?
   ○ Yes ○ No
   If yes, please explain:
   _____

4. Do you experience any of the following: abdominal pain, vomiting, change in bowel movement, rectal bleeding, or bloody/tarry stools?
   ○ Yes ○ No
   If yes, please explain:
   _____

5. Do you experience any of the following: frequent urination, frequent eating, frequent intake of fluids?
   ○ Yes ○ No
   If yes, please explain
   _____

6. For male and female, do you experience ay of the following: pain or discomfort on urination, frequency of urination, dribbling of urine, pain during/after sex, blood in the urine, or foul-smelling genital discharge?
   ○ Yes ○ No
   If yes, please explain:
   _____

7. For females only,
   a. Last menstrual period (mm/dd/yyyy): _____ b. First menstrual period (mm/dd/yyyy): _____
   Number of pregnancy: _____

8. Do you experience any of the following; muscle spasm, tremors, weakness; muscle/joint pain, stiffness, limitation of movement?
   ○ Yes ○ No
   If yes, please explain:
   _____

If the answer is yes to Questions 1-8, the beneficiary needs to consult a doctor.

3. PERSONAL/SOCIAL HISTORY

1. Do you smoke cigar, cigarette, e-cigarette, vape, or other similar products?
   ○ Yes ○ No Number of years: _____
   Do you drink alcohol or alcohol-containing beverages?
   ○ Yes ○ No Number of years: _____

4. PAST MEDICAL HISTORY

○ Cancer	○ Heart Disease	○ Tuberculosis
○ Allergies	○ Stroke	○ Others
○ Diabetes Mellitus	○ Bronchial asthma	please specify_____
○ Hypertension	○ COPD/emphysema/bronchitis	○ None

3. PERTINENT PHYSICAL EXAMINATION FINDINGS

PERTINENT PHYSICAL EXAMINATION FINDINGS

Blood Pressure:	/	mmHg	Height:	(cm)		(in)	
Heart Rate:		/min	Weight:	(kg)		(lb)	
Respiratory Rate:		/min	BMI:				
Visual Acuity			Temperature:			°C	

Pediatric Client aged 0-24 months

Length:	(cm)	Head Circumference:	(cm)	Skinfold Thickness:	(cm)
Body Circumference: Waist:	(cm)	Hip:	(cm)	Limbs:	(cm)
Middle Upper Arm Circumference (MUAC)	(cm)				

Blood Type (*as available*)

○ A+ ○ B+ ○ AB+ ○ O+ ○ A- ○ B- ○ AB- ○ O-

General Survey: ○ Awake and alert ○ Altered Sensorium

Note: PhilHealth shall issue an advisory when the Konsulta information system has already been updated to incorporate the information on this FPE form. Until them, PhilHealth Konsulta Providers should use the old FPE form.