Republic of the Philippines
Department of Environment and Natural Resources
Visayas Avenue, Diliman, 1106 Quezon City
☎ (632) 929-6626 to 29; 929-6252; 929-6633 to 35; 929-7041 to 43
E-mail: web@denr.gov.ph; Website: www.denr.gov.ph

ADVISORY

FOR/TO : All Officials and Employees
DENR Central Office

In our ongoing commitment to prioritize the health and well-being of our employees, the Human Resource Development Service – Medical Unit is launching a comprehensive Medical Questionnaire Health Profiling initiative across the DENR Central Office. The medical questionnaire aims to gather data that will enable us to tailor the health and wellness programs like vaccination, according to the needs of the DENR employees and staff.

DENR officials, employees, and persons hired under Job Order and Contract of Service are encouraged to participate and answer the medical questionnaire until September 30, 2023, via the following link or QR code:

SCAN ME

https://tinyurl.com/y2kzweea

The accomplished medical questionnaires will be collected by the Medical Unit staff. Rest assured that all information obtained in the medical questionnaire will be treated with utmost confidentiality.

If you have questions, and/or clarifications, you may contact the DENR Medical Unit at VOIP 1178 or telephone no. (02) 89279920.

For your information and guidance.

MIRIAM M. MARCELO
OIC Director, Human Resource Development Service

MEMO NO. 2023 - 788

MEDICAL QUESTIONNAIRE

PLEASE WRITE LEGIBLY					DATE:		
LAST NAME:			FIRST NAME:		MIDDLE NAME:		
PRESENT ADDRESS:							
DATE OF BIRTH:	AGE/SEX:	CIVIL STATUS:	RELIGION:	CONTACT NUMBER		HEIGHT (*cm*)	WEIGHT (*kg*)
DIVISION:					EMAIL ADDRESS:		

Employment Status: Permanent ☐ Contract Of Service ☐ Co-terminus ☐ Casual ☐

MEDICAL HISTORY

Have you been diagnosed with any of the following conditions? *(YES/NO) Please indicate year*

A. HEART/CIRCULATORY	YES/NO	YEAR	B. CANCER TUMORS	YES/NO	YEAR
Anemia			Brain		
Angina			Breast		
Aneurysm			Colon		
Blood Clots			Kidney		
Blood Disorder			Leukemia		
Cardiac Arrhythmia			Liver		
Congestive Heart Failure			Lung		
Cornary Heart Disease			Lymphoma		
Heart Murmur			Melanoma		
Hemophilia			Ovarian		
High blood			Prostate		
Low blood			Stomach		
High Cholesterol			Testicular		
Sickle Cell Anemia			Thyroid		
Stroke/TIA			Pituitary		
Varicose Veins			Stage of Cancer if known____		
Ventricular Tachycardia			Other ______________		
Other ____________________					

C. EYES/NOSE/THROAT	YES/NO	YEAR	D. NEUROLOGICAL	YES/NO	YEAR
Acoustic Neuroma			Alzheimer's Disease		
Cataracts			Cerebral Palsy		
Chronic Sinusitis			Epilepsy		
Cleft Lip/Palate			Migraines		
Detached Retina			Multiple Sclerosis		
Deviated Septum			Neuritis		
Ear Infections			Paralysis/Hemiplegia		
Glaucoma			Parkinson's Diseases		
Retinopathy			Seizures/Convulsions		
Other ____________________			Other ______________		

E. IMMUNE	YES/NO	YEAR	F. ARTHRITIS/BONES/MUSCLES/JOINTS	YES/NO	YEAR
ALDS			Osteoarthritis		
AIDS			Rheumatoid Arthritis		
HIV+			Bulging/Herniated Disk		
Immuno Deficiency			Carpal Tunnel Syndrome		
Lupus			Fibromyalgia/CFS		
Psoriasis			Fractures(Open or Closed)		
Scleroderma			Gout		
Other			Joint Replacement Type:		

F. ARTHRITIS/BONES/MUSCLES/JOINTS	YES/NO	YEAR	G. PSYCHOLOGICAL	YES/NO	YEAR
Muscular Dystrophy			ADD/ADHD		
Spina Bifida			Alcoholism		
Sprain/Strain			Anxiety		
H. DIABETES/ENDOCRINE	**YES/NO**	**YEAR**	Autism		
Diabetes Controlled by:			Bipolar		
a. Diet			Depression		
b. Oral Medication			Drug Abuse		
c. Insulin			Eating Disorder		
d. Other			Schizophrenia		
Goiter			Suicide Attempt		
Growth Hormones			Other ______________		
Hyperthyroidism			**I. REPRODUCTIVE**	**YES/NO**	**YEAR**
Other			Breast Disorder		
J. LUNG/RESPIRATORY	**YES/NO**	**YEAR**	Cervical		
Allergies			Fibroids		
Asthma			Menstrual		
Cystic Fibrosis			Ovarian Cysts		
Pneumonia			Other		
Sarcoidosis			**K. INTESTINAL**	**YES/NO**	**YEAR**
Sleep Apnea			Acid Reflux/GERD		
Tuberculosis			Colitis/IBS		
Other			Colon Disorder		
L. LIVER/KIDNEY/URINARY	**YES/NO**	**YEAR**	Crohn's Disease		
Bladder Disorder			Diverticulitis/Diverticulum		
Cirrhosis			Gallbladder(Cholangitis)		
Hepatitis Type:__________			Gastric Bypass		
Jaundice			Hiatal Hernia/Ulcer		
Kidney Disorder			Pancreatits		
Kidney Stones			Ulcer		
Liver Disorder			Ulcerative Colitis		
Polycystic Kidney			Other ______________		
Prostate					
Renal Failure					
Other					

A. Current Medication/s you are taking if there are any *(including vitamins and supplements)*:

Medicine	Dosage & Frequency of use	Medicine	Dosage & Frequency of use

B. Allergies to Medications, drugs or food, if there are any:

Medicine	Drug or Food

VACCINATION HISTORY

VACCINE	YES/NO	LAST DOSE/BOOSTER *(mm/dd/yyyy)*	VACCINE	YES/NO	LAST DOSE/BOOSTER (mm/dd/yyyy)
CERVICAL			CHICKENPOX		
HEPATITIS A			MEASLE, MUMPS		
HEPATITIS B			RABIES		
INFLUENZA (FLU)			TETANUS		
PNEUMONIA			THYROID		
PSV23 ☐ *PCV13* ☐			Others __________		
Others __________					

COVID-19 VACCINATION HISTORY			
VACCINE	**BRAND**	**DATE** *(mm/dd/yyyy)*	**Vaccination Site or Venue** ***(ex. LGU, DENR)***
Primary Series: 1st Dose			
2nd Dose			
1st Booster			
2nd Booster			

Have you tested positive for COVID-19 *Yes* ☐ *or No* ☐
If YES, please indicate when ____________.

PERSONAL SOCIAL HISTORY		WOMEN'S HEALTH HISTORY			
Describe	**YES/NO**	No. of Pregnancies		Age start of Menses:	
Smoking sticks/e-vape____per day		No. of Deliveries		Regular ___YES ___NO	
Stopped smoking __________		No. of Abortions		MENSES INTERVAL ___Days	MENSES DURATION ____Days
Alcohol ____x per week *(what kind)* __________		No. Miscarriages			
Stopped drinking alcohol when _____		Date of Last Menstrual Period		Last Pap Smear: Normal: ___YES ___NO	
Recreational Drugs		Current Method of Contraception, if there's any:			
Exercise ___ min/s per day __ per week					
Caffeine intake ___none ___coffee ___tea ___cola					
Salt intake ___high ___med ___low					
Fat intake ___high ___med ___low					
Number of meals you eat in an average day? _____					

FAMILY HISTORY *(have any of your first degree relatives experience any of the following)*

CONDITIONS	YES/NO	***Indicate if*** **Parent, Sibling or Child**	CONDITIONS	YES/NO	***Indicate if*** **Parent, Sibling or Child**
ALLERGIC RHINITIS			ANEMIA		
ASTHMA			BLEEDING DISORDERS		
COLLAPSE LUNG			CANCER (Type)		
DIABETES			HEPATITIS A		
GOITER/ THYROID DISEASE			HEPATITIS B		
HEART DISEASE			KIDNEY DISEASE		
HIGH OR LOW BLOOD PRESSURE			LEUKEMIA/BLOOD		
PNEUMONIA (Type)			MENTAL DISORDERS		
PULMONARY TUBERCULOSIS			SMOKING PROBLEM		
STROKE					
Other____________________			Other __________		

SURGICAL HISTORY			
SURGERY PERFORMED	*(mm/dd/yyyy)*	**SURGERY PERFORMED**	*(mm/dd/yyyy)*

IMPORTANT REMINDER: *The information collected on this form will be used by the DENR Medical Clinic and will be maintained as confidential.*

I declare that the information I have given is true, correct, and complete.

____
Signature over printed name

____
Date (mm/dd/yyyy)

Consent

I have read this form, understood its contents, and consent to the processing of my personal data. I understand that my consent does not preclude the existence of other criteria for lawful processing of personal data, and does not waive any of my rights under the Data Privacy Act of 2012 and other applicable laws

In accordance with the Data Privacy Act of 2012, all information obtained will be treated with utmost confidentiality and will be used solely for Medical Unit purposes.