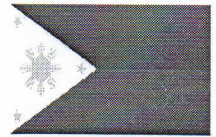




Republic of the Philippines  
OFFICE OF THE PRESIDENT  
NATIONAL COMMISSION ON MUSLIM FILIPINOS  
PHILIPPINE HAJJ MEDICAL MISSION



NAME: \_\_\_\_\_  
AGE: \_\_\_\_\_ SEX: \_\_\_\_\_ TRIBE/ETHNICITY: \_\_\_\_\_  
DATE OF BIRTH: (MM-DD-YY) \_\_\_\_\_  
SHIEK: \_\_\_\_\_

DATE: \_\_\_\_\_  
CASE NO: \_\_\_\_\_  
PASSPORT #: \_\_\_\_\_

**CONSULTATION FORM**

Chief Complaint: \_\_\_\_\_  
History of Present Illness: \_\_\_\_\_

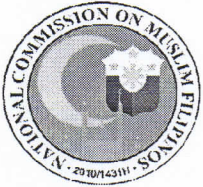
Past Medical / Family History: \_\_\_\_\_

**PHYSICAL EXAMINATION:**

BP: \_\_\_\_\_ TEMP: \_\_\_\_\_ PR: \_\_\_\_\_ RR: \_\_\_\_\_  
Head \_\_\_\_\_  
Chest \_\_\_\_\_  
CVS \_\_\_\_\_  
ABD \_\_\_\_\_  
Ext \_\_\_\_\_

CLINICAL IMPRESSION: \_\_\_\_\_  
EVALUATION / TREATMENT: \_\_\_\_\_

\_\_\_\_\_  
PHYSICIAN



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**CONSULTATION FORM**

Chief Complaint: \_\_\_\_\_  
History of Present Illness: \_\_\_\_\_

Past Medical / Family History: \_\_\_\_\_

**PHYSICAL EXAMINATION:**

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CLINICAL IMPRESSION: \_\_\_\_\_  
EVALUATION / TREATMENT: \_\_\_\_\_

\_\_\_\_\_  
PHYSICIAN