DEPARTMENT OF HEALTH
Integrated Chronic Non-Communicable Disease Registry System

Note: Please, put N/A for Not Applicable fields. Kindly refer to the instruction on how to fill up the form at the back.

1. National Registry Number *

GENERAL DATA

2. Name of Patient: *
Last Name *First Name* *Middle Name*

3. Sex: *
❍ *Male*
❍ *Female*

4. Birth Date: *
mm / dd / yyyy

5. Age: *
Years *Months* *Days*

6. PhilHealth #: *
Format: "00 - 00000000 - 0"

7. With PWD ID: *
❍ Yes ❍ No

7.a. Type of Disability: *

8. Permanent Address: *
Region *Province* *City/Municipality* *Barangay*

8.a. Temporary Address: *
Region *Province* *City/Municipality* *Barangay*

PAST MEDICAL HISTORY / COMORBIDITIES

Note: Please, check all that apply and fill up the specific disease form per illness ticked.

9. Comorbidities: *
❏ Diabetes
❏ Cancer
❏ COPD
❏ Coronary Artery Disease
❏ Dyslipidemia
❏ Stroke
❏ Hypertension
❏ Cataract/Cataract Surgery
❏ Other Eye Diseases, Specify:
❏ Asthma
❏ Mental Illness/Disorder
❏ Neurologic Disorder
❏ Substance Use Disorder
❏ Chronic Kidney Disease

HOSPITAL DATA (PART 1)

10. is the patient referred?: *
❍ Yes ❍ No

11. Name of referring Health Facility: *

12. Reason for referring: *

13. Name of reporting Health Facility: *

14. Type of Patient: * ❍ OPD ❍ In-Patient

15. Date of Consultation/Admission: *
mm / dd / yyyy

16. Chief Complaint: *

HYPERTENSION

17. Type of Hypertension: *
❍ Primary
❍ Secondary

17.1. Treatment: *
❏ Diuretics
❏ Beta Blocker
❏ Ace Inhibitors
❏ Calcium-channel Blocker
❏ Alpha Receptor Blocker
❏ Others, Specify:

17.2 Complications: * ❏ Kidney ❏ Eyes ❏ Blood Vessels ❏ Heart ❏ Brain ❏ Others, Specify:

STROKE

18. Type of Stroke: * ❍ Ischemic ❍ Hemorrhagic ❍ Transient Ischemic Attack

19. Treatment: *
❍ Acute Treatment
❏ Clot Buster tPa
❏ Others, Specify:
❍ Preventive Treatment
❏ Anticoagulants/Antiplatelets
❏ Carotid Endarterectomy
❏ Angioplasty/Stents
❏ Others, Specify:
❍ for Hemorrhagic Stroke
❏ Surgical Intervention
❏ Endovascular Procedures
❏ Others, Specify:

DIABETES MELLITUS

20. Newly or Previously Diagnosed Diabetes: * ❍ Newly Diagnosed ❍ Previously Diagnosed

21. Type of Diabetes: * ❍ Type 1 ❍ Type 2 ❍ GDM ❍ IGT/IFG ❍ Others, Specify:

21.1 Complications: * ❏ Kidney ❏ Eyes ❏ Blood Vessels ❏ Heart ❏ Brain ❏ Others, Specify:

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) and ASTHMA

22. Chronic Respiratory Disease: * ❏ COPD ❏ Asthma

22. Basis for the Final Diagnosis of COPD: * ❍ Clinical Data Without Spirometry ❍ Clinical Data With Spirometry (Previous or During Admission)

22.a. GOLD Classification: * ❍ GOLD 1 ❍ GOLD 2 ❍ GOLD 3 ❍ GOLD 4

22.b. COPD Group: * ❍ Group A ❍ Group B ❍ Group C ❍ Group D

22.c. Treatment: * ❏ Inhaled SABA ❏ Inhaled LAMA ❏ Others, Specify:

22.d. History of Tobacco Use?: * ❍ Yes ❍ No

22.e. History of Prolonged Exposure to Occupational Dust/Noxious Agent (Cement, Dust, Coal, Metal and Paper Mill), Former Construction/Factory Workers, Traffic Enforcers, etc.?: * ❍ Yes ❍ No

22.f. History of Prolonged Exposure to Biomass Fuel for Cooking?: * ❍ Yes ❍ No

22.g. History of Pulmonary Tubercolosis?: * ❍ Yes ❍ No

23. Basis for the Final Diagnosis of Asthma: * ❍ Clinical Data Without Spirometry ❍ Clinical Data With Spirometry (Previous or During Admission)

23.a. Treatment: * ❏ Inhaled SABA ❏ ICS ❏ ICS/Formoterol ❏ ICS/LABA ❏ Others, Specify:

Dated as of July 8, 2020
REC-005-Jan2020-Rev2

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EYE DISEASE

24. Cause of Visual Impairment: *

25. Disorders: *	Right Eye	Left Eye	26. Underlying Causes: *	Right Eye	Left Eye
❑ Refractive Error	❑	❑	❑ Congenital/Neonatal Factor	❑	❑
❑ Phthisical, Disorganized or Absent Globe	❑	❑	❑ Measles/Vitamin A Deficiency	❑	❑
❑ Cataract	❑	❑	❑ Diabetes	❑	❑
❑ Uncorrected Aphakia	❑	❑	❑ Tuberculosis (TB)	❑	❑
❑ Corneal Opacity	❑	❑	❑ Traditional Medicine	❑	❑
❑ Anterior Uveitis	❑	❑	❑ Infection	❑	❑
❑ Glaucoma	❑	❑	❑ Carcinoma	❑	❑
❑ Optic Atrophy	❑	❑	❑ Retinopathy of Prematurity	❑	❑
❑ Retinopathy	❑	❑	❑ Hypertension	❑	❑
❑ Chorioretinitis	❑	❑	❑ Toxicity	❑	❑
❑ Macular Degeneration	❑	❑	❑ Others, Specify:	❑	❑
❑ Retinal Detachment	❑	❑	27. Previous Cataract Surgery: * ❍ Yes ❍ No		
❑ Tumors	❑	❑	If yes: ❑ Right Eye ❑ Left Eye		
❑ Others, Specify:	❑	❑	Date of Surgery (mm / dd / yyyy):		

FOR CATARACT CASE

28. Type of Cataract: *

❍ Primary ❍ Secondary
❑ Senile/Age Related ❑ Uveitis
❑ Congenital ❑ Glaucoma
❑ Developmental ❑ Others, Specify:

	Presenting VA		"BEST" Corrected VA	
	Right Eye	Left Eye	Right Eye	Left Eye
29. Pre-Operative: *	❑	❑	❑	❑
30. Post-Operative: *	❑	❑	❑	❑

31. Date of Surgery (mm / dd / yyyy): *

31.a. Eye Operated: * ❑ Right Eye ❑ Left Eye

28.a. Type of Surgery: *

❑ ICCE
❑ ECCE
❑ SICS
❑ Phaco
❑ LACS Femtosecond Phaco

32. Post-Operative Complications: *

❑ Elevated Intraocular Pressure ❑ Uveitis
❑ Persistent Corneal Edema ❑ Cystoid Macular Edema
❑ Endophthalmitis ❑ Pseudophakic Bullous Keratopathy
❑ Decentered IOL ❑ Hyphema
❑ Retinal Detachment ❑ Others, Specify:

MENTAL, NEUROLOGICAL AND SUBSTANCE USE DISORDERS

CLINICAL HISTORY

33. History of any of the following conditions: *

❑ Suicide Attempts ❑ Overt Psychotic Symptoms ❑ Any Neurologic Disorder, Specify:
❑ Depressive Symptoms ❑ Alcohol Abuse ❑ Others, Specify:
❑ Manic Symptoms ❑ Other Substance Abuse, Specify:

HOSPITAL DATA (PART 2)

34. Working Diagnosis: *

35. Final Diagnosis (ICD-10 Code): *

36. Disposition: * ❍ Admitted ❍ Transferred ❍ Discharged Against Medic Advice ❍ Died
❍ Discharged Stable ❍ Absconded ❍ Refused Admission

37. Patient Status: * ❍ Recovered ❍ Improved ❍ Unimproved ❍ Died

38. if Died, Underlying Cause of Death: *

38.a. if Died, Underlying Cause of Death (ICD-10 Code): *

39. Date of Death (mm / dd / yyyy): *

39.a. Place of Death: *

40. if Transferred, Name of Health Facility: *

40.a. Reason for Referral: *

41. Consultant in-charge: *
Last Name *First Name* *Middle Name* *Department*

41.a. Landline/Mobile #: *

41.b. Email Address: *

42. Completed by: *
Last Name *First Name* *Middle Name* *Designation*

42.a. Landline/Mobile #: *

42.b. Email Address: *

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