UNIVERSITY HEALTH SERVICE
UNIVERSITY OF THE PHILIPPINES
DILIMAN, QUEZON CITY

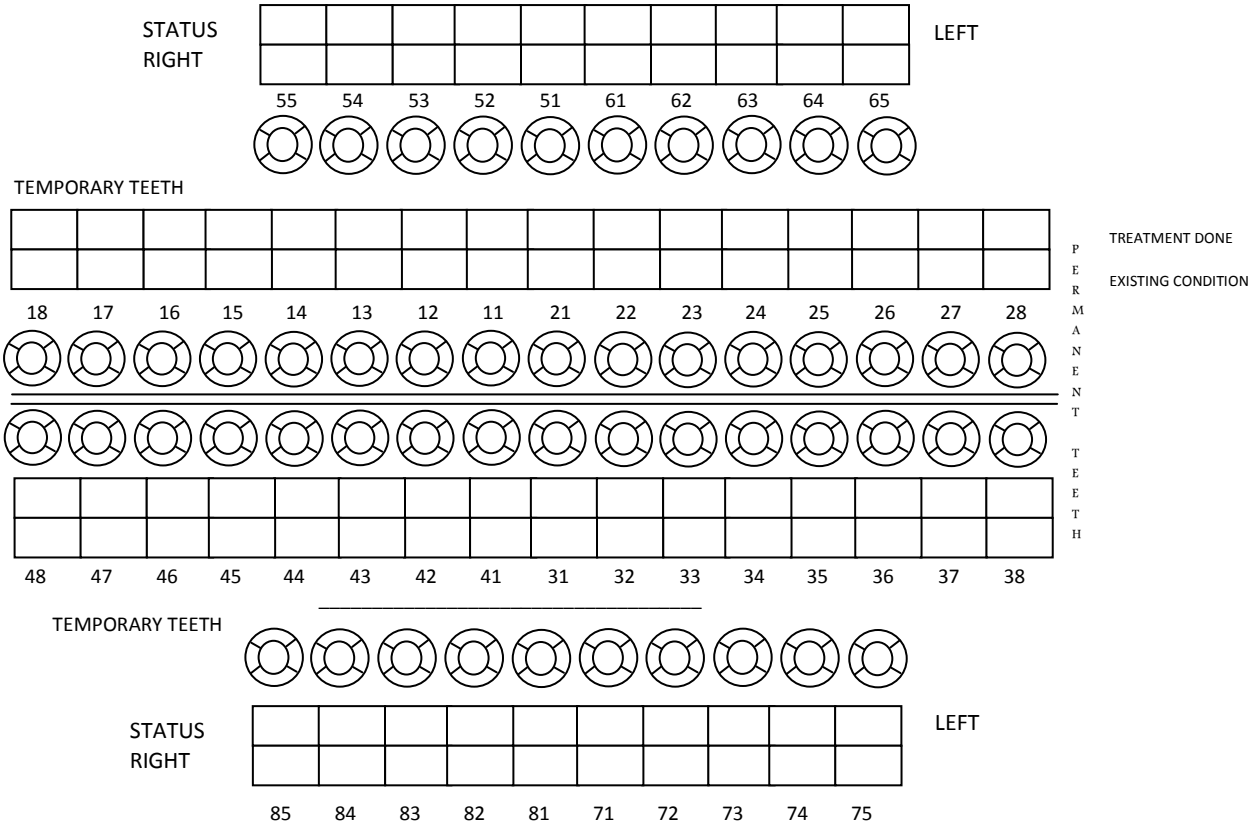
Student /OPD Number: _____
☐ Student ☐ Retired
☐ Faculty ☐ Dependent
☐ Employee ☐ Outsider

ALLERGIC TO _____

DENTAL CLINIC
OUT PATIENT RECORD

LASTNAME_____ Date of Birth _____Age _____Sex _____
FIRSTNAME_____ Contact No:_____Religion _____Civil Status_____
MIDDLENAME_____ School/College/Office/Department_____
PresentAddress _____
PARENT/GUARDIAN_____ RELATIONSHIP_____OCCUPATION_____
PERMANENT ADDRESS _____ CONTACT NO _____

INTRAORAL EXAMINATION



LEGEND:

C –Caries	JC – Jacket Crown (P-Porcelain, M-Metal, G-Gold, A-Acrylic, C-Ceramic)	X – Extraction due to Caries
Am – Amalgam Filling	Co – Composite	Sp – Supermumerary
G – Goldfilling	In – Inlay/On- Inlay (G: Gold; M: Metal; C: Ceramic)	
Im – Impacted Tooth	Frac – Fractured (Co, AM, Tooth)	
PFS – Pit & Fissure Sealant	TF – Temporary Filling	

Gingivitis	Periodontal Condition	Occlusion	Appliances
☐ Mild	☐ calized	☐ ss 1	☐ thodontic
☐ Moderate	☐ Generalized	☐ Class 2	☐ Stayplate
☐ Severe	☐ Chronic	☐ Class 3	☐ RPD
	☐ Acute	☐ Midline Deviation	○ Upper ○ Lower
		○ acial ○ ental	☐ Complete
		☐ Crowding	○ Upper ○ Lower
		☐ TMD	

Other Clinical Findings

_____
_____

_____
Dentist / Date

PATIENT INFORMATION RECORD

Name: _____
Last First Middle

DENTAL HISTORY

Previous Dentist: _____
Last Dentist visit: _____

MEDICAL HISTORY

Name of Physician: Dr. _____Specialty, if applicable: _____
Office Address: _____ Office Number: _____

1. Are you in good health? Yes No
2. Are you under medical treatment now? Yes No
   If so, what is the condition being treated? _____
3. Have you ever had serious illness or surgical operation? Yes No
   If so, what illness or operation? _____
4. Have you ever been hospitalized? Yes No
   If so, when and why? _____
5. Are you taking any prescription/non-prescription medication? Yes No
   If so, please specify _____
6. Do you use tobacco products? Yes No
7. Do you use alcohol, cocaine or other dangerous drugs? Yes No
8. Are you allergic to any of the following: Yes No
   ( ) Local Anesthetic (ex. Lidocaine) ( ) Penicillin, Antibiotics
   ( ) Sulfa drugs ( ) Aspirin ( ) Latex ( ) Other _____
9. Bleeding Time _____
10. For women only: Are you Pregnant? Yes No
    Are you nursing?
    Are you taking birth control pills?
11. Blood Type _____
12. Blood Pressure _____
13. Do you have or have you had any of the following? Check which apply Yes No

( ) High Blood Pressure
( ) Low Blood Pressure
( ) Epilepsy / Convulsions
( ) AIDS or HIV Infection
( ) Sexually Transmitted disease
( ) Stomach Troubles / Ulcers
( ) Fainting Seizure
( ) Rapid Weight Loss
( ) Radiation Therapy
( ) Joint Replacement / Implant
( ) Heart Surgery
( ) Heart Attack
( ) Thyroid Problem
( ) Heart Disease
( ) Heart Murmur
( ) Hepatitis / Liver Disease
( ) Rheumatic Fever
( ) Hay Fever / Allergies
( ) Respiratory Problems
( ) Hepatitis / Jaundice
( ) Tuberculosis
( ) Swollen ankles
( ) Kidney disease
( ) Diabetes
( ) Chest pain
( ) Stroke
( ) Cancer / Tumors
( ) Anemia
( ) Angina
( ) Asthma
( ) Emphysema
( ) Bleeding Problems
( ) Blood Diseases
( ) Head injuries
( ) Arthritis / Rheumatism
( ) Others

_____
Signature / Date

Name of Student: _____
UP Student No.:_____

Dear Parent/Guardian:

Please request the examining physician and dentist to fill out this form as a summary of their recommendations. The student has the option to come to the University Health Service for any of the services and dental procedures mentioned below, most of which may be availed of at discounted rates.

Committee on Pre-enrolment Physical Examination

A. Medical Recommendations

- ☐ Consult an Ophthalmologist (Eye)
- ☐ Consult a Dermatologist
- ☐ Consult an ENT doctor
- ☐ Consult an Orthopedic Surgeon
- ☐ Consult at Nutrition Clinic ☐ Underweight Overweight ☐ Obese ☐
- ☐ Others:_____
- ☐ None

_____
Examining Physician
Date:

B. Dental Recommendations

- ☐ Oral prophylaxis
- ☐ Filling, tooth # _____
- ☐ Extraction, tooth # _____
- ☐ Pit and fissure sealant _____
- ☐ Fluoride treatment _____
- ☐ See specialist for consultation:
  - ☐ Pedodontist
  - ☐ Endodontist
  - ☐ Orthodontist
  - ☐ Periodontist
  - ☐ TMJ Specialist
  - ☐ Prosthodontist
  - ☐ Oral Surgeon
  - ☐ Implantologist
- ☐ Others: _____
- ☐ None

_____
Examining Dentist
Date:

UNIVERSITY OF THE PHILIPPINES
HEALTH SERVICE

ENTRANCE HEALTH EXAMINATIONS

A complete Medical History and Physical Examination is compulsory to complete your admission to the University of the Philippines and must be on file on or before your registration. This is the **responsibility of the applicant** and not your physician. Please type or complete in Ink. This record will be treated with confidentiality.

Important: Please bring accomplished form with you to the U.P. Health Service when you come for physical examination

PLEASE KEEP THIS FORM NEAT AND CLEAN

A. Complete this form if you are enrolling during a regular semester and if you are:

1. A beginning undergraduate or a beginning graduate student
2. A transfer student from a regional campus or another school or university
3. A re-entry student (undergraduate or graduate) who has been out of the University of the Philippines for at least one semester
4. A graduate student employed under the classification of "Graduate Assistant" or "Graduate Instructor"

B. Completion of this form is not required if:

1. You are a foreign student sponsored by a government agency whose files provides a complete health record signed by a physician. A copy of the health record should be submitted in lieu of this form.
2. Enrolling for a Summer Session only.

2x2 or passport-size ID photo taken within the last 3 months

☐ Allergic to: _____ Entrance Date to U.P. _____

☐ No known allergies

Please print

Last Name	First Name	Middle	Sex	Age

☐ Single ☐ Married ☐ Widowed ☐ Divorced

Date of Birth: _____ Place : _____

College/ School of Registration in the University of the Philippines : _____

☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior ☐ Graduate ☐ Special

Home Address : _____ Contact No. _____

No Street City Province Country

Address while in School: _____ Contact No. _____

Name of Parent/Guardian/Spouse: _____

Address: _____ Contact No. _____

Family History

Mother Living _____ (Age) If deceased, _____ (Age at death) Cause of death _____

Father Living _____ (Age) If deceased, _____ (Age at death) Cause of death _____

Among your blood relatives, is there a history of any of the following:

	Yes	No	Relationship		Yes	No	Relationship
Cancer				Diabetes			
Heart Disease				Mental Disorder/Problem			
High Blood Pressure				Asthma or Hay Fever			
Stroke				Convulsions/Neurologic Problems			
Tuberculosis				Bleeding Problems/Blood Disorders			
Kidney Disease				Digestive disturbances			
Arthritis/Rheumatism				Skin Disease			

Personal History. Give the appropriate age to which you had the following:

	AGE		AGE		AGE
Anemia/Blood Disorder		Hernia		Poliomyelitis	
Asthma		High Blood Pressure		Rheumatic Fever	
Cancer		Influenza A (H1N1) (indicate date)		Skin Disease	
Chickenpox		Joint Pains/Arthritis		Smallpox	
Convulsions		Kidney disease		Syphillis	
Dengue		Malaria		Thyroid Disease	
Diabetes		Measles		Tonsilitis	
Diphtheria		Mental Problem/Disorder		Tuberculosis/Primary Complex	
Ear disease/defect		Mumps		Typhoid	
Eye disease/defect		Neurologic Problem/Disorder		Ulcer (peptic)	
Gonorrhea		Pertussis (Whooping cough)		Ulcer (skin)	
Heart disease		Pleurlsy		Other conditions (please list)	
Hepatitis (indicate type)		Pneumonia			

Have you ever had or do you have any of the folowing. Check each item Yes or No.

	YES	NO		YES	NO		YES	NO
Headaches (frequent)			Sore throat (frequent)			Diarrhea/Constipation (specify)		
Dizziness (frequent)			Chest pain			Joint pains		
Fainting/Loss of consciousness			Back pain			Muscle pain (frequent)		
Insomnia			Easily gets tired			Frequent urination		
Depressed mood (> 2 weeks)			Difficulty of breathing			Eczema/Skin problems		
Eye/Visual problems			Palpitations			Fracture		
Hearing problems			Swelling of feet			Accident/Injuries		
Cough (> 2 weeks)			Nausea (frequent)			Hospitalization (reason)		
Colds/Nasal Congestion			Vomiting			Operation (specify)		
Fever (frequent/recurrent)			Abdominal pain/discomfort			Others, specify		
Frequent early morning sneezing			Loss of appetite					
Nosebleed (frequent)			Weight loss/gain (specify)					

If answer is Yes, give details _____

Do you worry too much? _____ Does your self-consciousness interfere with your getting along with others easily? _____
Are you bothered by a feeling that people are watching you or talking about you? _____ Are you concerned about alternating period of gloom and cheerfulness? _____ Is it difficult for you to pull out of a depressed mood? _____
Are you inclined to be secretive or seclusive? _____

Date of last dental check up _____ Date of last eye refraction _____

Do you consider yourself in good health? Yes ____ No ____ If not, give details_____

Do you wish to discuss any question with regards to your health, family history, sex or personal habit with a physician. Yes _____ No _____ Are you taking any medicines regularly? Yes ____ No ____ If so, what are these medicines?_____

Do you have any physical condition or handicap which requires special treatment, diet or other special consideration? Yes _____ No _____

FOR FEMALE STUDENTS:

Menstruation: Have not begun _____ or Age at onset _____ Periods occur every ____ to ____ days

Duration ____ days Flow: ____ Moderate ____ Excessive ____ Scanty Painful: _____ Incapacitating: _____

Bleeding between periods: Yes _____ No _____

Have you had any trouble with your breasts, such as lumps, tumor, surgery? No ____ Yes _____. If so, give details _____

_____

I certify that the above history is true to the best of my knowledge.

_____
Signature and Date

Print

Name _____ Age : _____ Sex : _____ Civil Status : _____

(Last) (First) (Middle)

(Do not write below this line. To be filled out by the physician)

Vital signs and anthropometric measurements:

Pulse rate: _____beats/min. Blood Pressure: _____mmHg Respiratory Rate: _____breaths/min. Temperature: _____

Height : _____ cm. Weight : _____ kg. Body Mass Index : _____ [wt. in kg./(ht. in m.)^2]

Asia-Pacific BMI Cut-Offs

Underweight	
___ Severe Thinness	<16.00
___ Moderate Thinness	16.00-16.99
___ Mild Thinness	17.00-18.49
___ **Normal**	18.50-22.99
___ **Overweight**	23.00-24.90
Obese	
___ Obese 1	25.00-29.90
___ Obese 2	>30.00

General Health Appearance : Excellent, good, fair, poor.

Visual Acuity:

	Without Glasses		With Glasses/Contact L	
	FAR	NEAR	FAR	NEAR
Right:	_____	_____	_____	_____
Left:	_____	_____	_____	_____

Color vision : _____

Please check appropriate box whether findings are normal or abnormal for each organ/system; if with abnormal findings, please describe findings below

Organs/Systems:	Normal	Abnormal	If abnormal, please describe findings
Skin			
Head/Scalp			
Eyes			
Ears			
Nose			
Mouth/Oropharynx			
Neck			
Heart			
Lungs			
Back/Spine			
Abdomen			
Extremities			
Genito-urinary/Ano-rectal			
Neurologic			

Chest x-ray findings: _____

Activity: I Unlimited II Unlimited with observation III Restricted and corrective IV Reconstructive V No Activity

ASSESSMENT

_____

_____

_____

_____

_____

_____

_____

_____

RECOMMENDATIONS

_____

_____

_____

_____

_____

_____

_____

_____

Examined by: _____

PRC license number: _____

Date examined: _____