**MEDICAL and DENTAL EXAMINATION RECORD**

\_\_\_\_\_\_\_\_semester, Academic Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Teaching Personnel □ Non-teaching Personnel □ Student

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| **Name:** |  | | | | | | | | **Age:** | | | |  | | | | **Gender:** |  | |
| **Address:** |  | | | | | | | | **Student Number:** | | | | | | |  | | | |  |
| **Position/Year Level:** | | | | |  | | | **Department:** | | | |  | | | | | | |
| **Civil Status:** | | Married  Single  Divorced  Separated | | | | | | | | | **Date of Birth:** | | | |  | | | | |
| **Emergency Contact** | | | | **Name:** | | |  | | | | | | | | | | | | |
| **Relationship:** | | |  | | | | **Tel/CP No.** | | | |  | | | | | |

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| 1. **MEDICAL RECORD** | | | | | | | | |
| **Review of System** | □ Abdominal pain (pagsakit ng tiyan)  □ Blurring of vision (panlalabo ng mata)  □ Chest pain (pagsakit ng dibdib)  □ Cough and colds (ubo at sipon)  □ Dysuria (masakit na pag-ihi)  □ Easy bruisability (mabilis mag ka pasa)  □ Easy fatigability (mabilis mapagod) | | | | □ Fever (lagnat)  □ LBM (pagtatae)  □ LOC/ Seizure (nawalan ng malay/konbulsiyon)  □ Recurrent Headache (pabalik-balik na sakit ng ulo)  □ Vomiting (pagsusuka)  □ Others: \_\_\_\_\_\_\_\_\_\_\_ | | | |
| □ Deformity (Kapansanan)  □ Clef Lip (Bingot)  □ Exotropia (walleyed / banlag)  □ Poliomyelitis  □ Scoliosis  □ Strabismus (cross-eyed / duling)  □ None | | | | | | | |
| **Vital Signs** | BP \_\_\_\_\_\_\_\_\_\_mmHg  RR \_\_\_\_\_\_\_\_\_\_cpm  HR \_\_\_\_\_\_\_\_\_\_bpm  Temp \_\_\_\_\_\_\_\_\_\_ Celcius | | | | Weight \_\_\_\_\_\_\_\_\_\_kg  Height \_\_\_\_\_\_\_\_\_ m  BMI \_\_\_\_\_\_\_\_\_ | | | |
| **Past Medical History** | □ Allergy  □ Bleeding disorder (Sakit sa dugo)  □ Bronchial asthma (Hika)  □ Cardiovascular Disease (Sakit sa puso)  □ Hypertension (Mataas na presyon (blood pressure)  □ Pulmonary Tuberculosis (Mahinang baga o tuberkulosis) | | | | □ Skin disorder (sakit sa balat)  □ Surgery (operasyon)  □ Urinary Tract Infection (Impeksyon sa ihi)  □ Loss of consciousness (nawalan ng malay)  □ Others: \_\_\_\_\_\_\_\_\_\_\_ | | | |
| **OB/Gyne History**  *For female only* | Menstruation □ Regular □ Irregular  Duration: □ 1-3 days □ 4-6 days □ 7-9 days Dysmenorrhea □ Yes □ No  Have you been pregnant? □ Yes □ No  If yes, number of pregnancies \_\_\_\_\_\_  Last Menstrual Period \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |
| **Chief Complaint** |  | | | | | | | |
| **Present Illness** |  | | | | | | | |
| **Medication** |  | | | | | | | |
| **Have you ever been hospitalized?** | □ Yes  □ No | **Reason:** | | | | | | |
| **Previous Surgeries** | □ Yes  □ No | **Reason:** | | | | | | |
| **Personal & Social History** | Alcoholic drinker: □ Regular □ Occasional □ No  Smoker: □ Yes; Sticks per Day \_\_\_\_\_\_\_\_; Years of Smoking: \_\_\_\_\_\_ □ No  Use of illicit drugs: □ Yes □ No  Eye Disorder: □ Eye glasses □ Contact Lens □ No | | | | | | | |
| **Family History** *(immediate family only)* |  | | *Father* | *Mother* | | *Sister* | *Brother* | *Remarks* |
| Bronchial Asthmas | |  |  | |  |  |  |
| Cancer | |  |  | |  |  |  |
| Diabetes Mellitus | |  |  | |  |  |  |
| Kidney Disease | |  |  | |  |  |  |
| Heart Disease | |  |  | |  |  |  |
| Hypertension | |  |  | |  |  |  |
| Mental Illness | |  |  | |  |  |  |
| **Physical Examination** |  | | | *Normal* | | | *Abnormal* | |
| General Survey | | |  | | |  | |
| Eyes/Ear/Nose/Throat | | |  | | |  | |
| Hearing | | |  | | |  | |
| Vision | | |  | | |  | |
| Lymph Nodes | | |  | | |  | |
| Heart | | |  | | |  | |
| Lungs | | |  | | |  | |
| Abdomen | | |  | | |  | |
| Skin | | |  | | |  | |
| Extremities | | |  | | |  | |
| **Chest X-ray** |  | | | | | | | |
| **Laboratory** | Blood Chemistry: FBS: Uric Acid:  Triglycerides: T. Cholesterol: Creatinine: | | | | | | | |
| **Vaccination Status** |  | | | | | | | |
| **Final Evaluation:** | □ Class A (Physically Fit)  □ Class B (Physically Fit with Minor Illness)  □ Pending (Recommendation/Clearance from other sub-specialties) | | | | | | | |
| **Plan/ Recommendation:** |  | | | | | | | |
| **Data Privacy Notice** | By signing below, I hereby acknowledge that I have acquired the consent from all parties relevant to this activity and that they allow Pamantasan ng Cabuyao to collect, process, store, and share their personal data and hold free and harmless and indemnify Pamantasan ng Cabuyao from any complaint, suit, or damages which any party may file.  *Signature Over Printed Name* | | | | | | | |

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| *Signature Over Printed Name*  *School Nurse*  *License Number: \_\_\_\_\_\_\_\_\_*  *PTR No: \_\_\_\_\_\_\_\_\_\_\_\_* |  | *Signature Over Printed Name*  *School Physician*  *License Number: \_\_\_\_\_\_\_\_\_*  *PTR No: \_\_\_\_\_\_\_\_\_\_\_\_* |

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| 1. **DENTAL RECORD** |

**Dental Record Chart**

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| 55 | 54 | 53 | 52 | 51 | 61 | 62 | 63 | 64 | 65 |
| 85 | 84 | 83 | 82 | 81 | 71 | 72 | 73 | 74 | 75 |
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| 18 | 17 | 16 | 15 | 14 | 13 | 12 | 11 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 |
| 48 | 47 | 46 | 45 | 44 | 43 | 42 | 41 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 |
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**INITIAL PERIODONTAL EXAMINATION**

|  |  |
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| Gingival and Periodontal Status | 🞏 Normal 🞏 Gingivitis (early, moderate, severe)  🞏 Periodontitis (early, moderate, severe) |
| Plaque and Calcular Deposit | 🞏 Light 🞏 Moderate 🞏 Heavy |
| Existing Dentures, Under Orthodontic Treatment, Other Undergoing Treatment: |  |

SYMBOLS FOR MOUTH EXAMINATION Artificial Restoration

X- Carious tooth indicated F2- Permanently Filled tooth JC- Jacket Crown SYMBOLS FOR ACCOMPLISHMENT

for extraction with recurrence of decay AB- Abutment OP- Oral Prophylaxis

C- Carious tooth indicated Heavy shade- Permanent filling P- Pontic Xt- Extracted Permanent tooth

for filling Outline of filling- tooth with I- Inlay Ag F- Amalgan filling

RF- Root fragment Temporary filling RPD- Removable Partial Sy F- Synthetic porcelain

M- Missing Denture GIC- Glass Ionomer Cement

FB- Fixed Bridge ZnO F- Zinc Oxide Filling

CD- Complete Denture R- Referred to private Dentist

**RECOMMENDED TREATMENT:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**TREATMENT RECORD:**

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| **DATE** | **TOOTH #** | **PROCEDURE** | **DENTIST/S** | **REMARKS** |
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| *Signature Over Printed Name*  *School Nurse*  *License Number: \_\_\_\_\_\_\_\_\_*  *PTR No: \_\_\_\_\_\_\_\_\_\_\_\_* |  | *Signature Over Printed Name*  *School Dentist*  *License Number: \_\_\_\_\_\_\_\_\_*  *PTR No: \_\_\_\_\_\_\_\_\_\_\_\_* |