



**PATIENTS MEDICAL AND DENTAL RECORD
SYSTEM**



Sign up

By clicking in this checkbox, **I DO HEREBY AGREE AND GIVE CONSENT** to University of Antique to collect, access, process, transfer or dispose my personal information for its intended purpose stated above.

CONFIDENTIALITY NOTICE:



We value and protect your personal information in compliance with the Data Privacy Act of 2012 (RA 10173). The information you shared will be stored in a database accessible to UA only. These will be used to serve as a reference for your enrollment to the university.

Registration Form

Student ID

Gmail

Name

Course and Year Level

Age

Sex

Contact number

Submit

Search in mail

F

Inbox



UA-TLMC Clinic

1/17/2023

Thanks for filling out the registration form



Google Security



Figma

Welcome to figma! Let's get you set up



Google Forms

Click Link



Log in

Username

Password

HEALTH SERVICES

CONSULTATION FORM

MEDICAL EXAMINATION FORM

MEDICAL FORM

DENTAL FORM

**Laboratory
and
Diagnostic Form**



Republic of the Philippines
UNIVERSITY OF ANTIQUE
TARIO-LIM MEMORIAL CAMPUS
TIBIAO, ANTIQUE

HEALTH SERVICE
tlmc.health@antiquespride.edu.ph

CONSULTATION FORM

Name of Patient: _____ Age: _____
(Last Name) (First Name) (Middle Name)

Address: _____ Date of Birth: _____ Sex: _____ Course: _____

Date/Time	Complaints	Management

Submit

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TIBAO, ANTIQUE

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MEDICAL EXAMINATION FORM

Name: _____ Department: _____ Course & Year: _____
Date of Birth: _____ Place of Birth: _____ Age: _____ Sex: _____
Address: _____ Civil Status: _____
Contact Person in Case of Emergency: _____ Contact No. _____

Height: _____ Purpose (Please check one):
Weight: _____ Enrollment:
Temperature: _____ On-the-Job Training
Pulse Rate: _____ Intramurals/SCUAA
Blood Pressure: _____ Others (pls. specify) _____

1. Head and Neck _____
 2. Respiratory System _____
 3. Cardiovascular System _____
 4. Digestive System _____
 5. Genito-Urinary _____
 6. Nervous System _____
 7. Reproductive System _____
 8. Locomotor System _____
 9. Past Medical History _____
- Remarks: _____

Signature

Physician Signature over Printed Name: _____
License No.: _____

**Please submit this form to the UA-TLMC Medical Clinic together with the laboratory results
after your Medical Examination.**

Submit

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STUDENT HEALTH RECORDS

PERSONAL INFORMATION

Surname	First Name	Middle Name	College	Course and Year Level
Date of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Civil Status <input type="checkbox"/> Single <input type="checkbox"/> Married	Blood Type	
Place of Birth				Religion
Present Address	Contact Number	Home Address		
Father's Name	Occupation			
Mother's Name	Occupation			
Contact Person (in case of Emergency)	Relationship to Student	Contact Number		

MEDICAL INFORMATION

Please check the following questions with openness and sincerity. All data gathered will be treated with CONFIDENTIALITY.

Please check the corresponding box if you have been diagnosed to have any of the following conditions. If YES, please specify medications

Medications: _____
 History of hospitalization: Yes No Date and reason for hospitalization: _____
 surgical operation: Yes No Specify kind of operation: _____
 Do you have any allergies to medication? Yes No If yes, please list _____
 Do you have any allergies to medication? (food/bee strings) Yes No If yes, please list _____

Please check if any blood relatives(children, brothers, sisters, parents, aunts, uncles or grandparents) had or currently have any of the following conditions.
 If YES, please specify the relationship(i.e.father,grandmother).

<input type="checkbox"/> Asthma	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Blood Disorder	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Obesity	<input type="checkbox"/> Mental disorder
<input type="checkbox"/> Cancer/Cyst/Tumor	<input type="checkbox"/> Stroke
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Thyroid Problem
<input type="checkbox"/> Epilepsy/seizure	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Heart disease	<input type="checkbox"/> Others:

Please check if you have any of the following (present or past) medical conditions. (check all that apply)

<input type="checkbox"/> Alcohol/Drugs Dependence	<input type="checkbox"/> Eye Problem	<input type="checkbox"/> Musculoskeletal Problem
<input type="checkbox"/> Anemia/Blood Disease	<input type="checkbox"/> Frequently Headaches	<input type="checkbox"/> Primary Complex/Tuberculosis
<input type="checkbox"/> Arthritis/Joint Pains	<input type="checkbox"/> Head Injury	<input type="checkbox"/> Sexually Transmitted Disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hearing problem	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Cancer/Cyst/Tumor	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Skin problem
<input type="checkbox"/> Chickenpox	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Sleep Problem
<input type="checkbox"/> Dengue Fever	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Thyroid Problem
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hyperacidity/Indigestion/Ulcer	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Disability/Handicap	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Typhoid Problem
<input type="checkbox"/> Dizziness/Fainting	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Urinary Tract Infection
<input type="checkbox"/> Ear and Nose Problem	<input type="checkbox"/> Measles	<input type="checkbox"/> Varicose Veins
<input type="checkbox"/> Eating Problem/Disorder	<input type="checkbox"/> Mental/Emotional Problem	<input type="checkbox"/> Weight Problem
<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Mumps	<input type="checkbox"/> Other/s: _____

If you answered YES to any of the above, please give details: _____

For FEMALES only:
 Age of Menarche: _____ First Day of last Menstruation: _____
 Have you ever been pregnant? _____ If yes, please specify _____
 Have you noticed any breast lump? _____ If yes, please specify _____

I do hereby state that, to the best of my knowledge and belief, the medical history and information that I have provided is complete and accurate.
 I further understand that any medical information withheld, incomplete, or incorrect discharges the University from all medical and Legal liability.
 I authorize the Health Services Unit to provide medical services and therapeutic services to the above named student as may be necessary, and if needed, to refer to private/hospital care when special service is indicated.

Student's Signature
Date: _____

Parent/Guardian's Signature over Printed Name (If under 18 years of age)
Date: _____

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INDIVIDUAL PATIENT'S RECORD & SUMMARY OF SERVICE RENDERED

Patient Name			College	Course and Year Level
Date of Birth	Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Civil Status <input type="checkbox"/> Single <input type="checkbox"/> Married	Citizenship
Address			Contact Number	
Patient's/Guardian's Name			Relationship to Patient	
Occupation			Contact Number	
Family Physician			Contact Number	
Clinic Address				

HISTORY

(Please check the appropriate box below)

1.) Are you now under current medical treatment?

2.) Did you have any bad experiences in any dental clinics?

State if Yes: _____ Yes NO

3.) Have you ever experienced an unusual reaction to Dental Anesthetic? Yes NO

4.) Do you bleed profusely during or after surgery or tooth surgery? Yes NO

5.) Have you undergone any major operation or surgery? Yes NO

6.) Do you have allergic reactions to any foods or medicines? Yes NO

7.) Are you taking any drug or medication? Yes NO

State if yes: _____ Yes NO

8.) Do you have any: _____

- a. Heart condition
- b. Diabetes
- c. High Blood Pressure
- d. Anemia
- e. Tumors or growths
- f. Rheumatic fever
- g. Lung disorders
- h. Kidney disorder
- i. Liver disorder
- j. Stomach or intestinal disorder
- k. Nervous disorders

9.) Do you experience shortness of breath when climbing upstairs?

11.) Do you have wounds or breaks in the skin that does not heal?

12.) Are you on a special diet?

13.) (Women) are you pregnant?

14.) (Women) are you having your monthly period right now?

I, _____ do you hereby consent the performance upon myself/spouse/son/daughter/others of all dental procedures, operations and/or treatment that may be considered necessary to restore my oral and dental health. This consent is given voluntarily and whatever result of any intervention or treatment maybe, I absolve my dentist from all liability.

Witness
Date:

Signature
Date:



Republic of the Philippines
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TIBIAO ANTIQUE

Health Service
tmc.health@antiquespride.edu.ph

SUMMARY OF SERVICES RENDERED

Date	Oral Prophylaxis			Tooth Extraction	Consultaion	Others	Remarks	Signature
	H	M	L					

ORAL HEALTH CONDITION

A. Check (/) If present (X) If absent

Date of Oral Examination					
Dental caries					
Gingivitis					
Debris					
Calculus					
Abnormal Growth					
Cleft Lip/ Palate					
Others (Supernumerary/ mesiodents, etc.)					

B. Indicate Number

No. of Perm. Teeth Present					
No. of Perm. Sound Teeth					
No. of Decayed Teeth (D)					
No. of Missing Teeth (M)					
No. of Filling Teeth (F)					
Total DMF Teeth					
Total of Teeth					

Submit

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Laboratory and Diagnostic Form

Name: _____ Age: _____ Sex: _____
Requested by: _____

Date: _____

- | | | |
|---|--|---|
| <input type="checkbox"/> CBC | <input type="checkbox"/> FBS | <input type="checkbox"/> X-ray: _____ |
| <input type="checkbox"/> Platelet Count | <input type="checkbox"/> Cholesterol | <input type="checkbox"/> UTZ: _____ |
| <input type="checkbox"/> Blood Typing | <input type="checkbox"/> Triglycerides | <input type="checkbox"/> ECG: _____ |
| <input type="checkbox"/> Urinalysis | <input type="checkbox"/> Bilirubin | <input type="checkbox"/> CT Scan: _____ |
| <input type="checkbox"/> Fecalysis | <input type="checkbox"/> Lipid Profile | <input type="checkbox"/> Others: _____ |
| <input type="checkbox"/> HBsAg | <input type="checkbox"/> SGPT/ALT | |
| <input type="checkbox"/> Audiometry | <input type="checkbox"/> SGOT/AST | |
| <input type="checkbox"/> Ishihara | <input type="checkbox"/> Creatinine | |
| <input type="checkbox"/> Serum Pregnancy Test | <input type="checkbox"/> BUN | |
| <input type="checkbox"/> Sputum Exam | <input type="checkbox"/> Uric Acid | |
| | <input type="checkbox"/> HBA 1C | |
| | <input type="checkbox"/> TSH, T3, T4 | |

HS-FM-014

REV.1 / 03-05-20

Submit