

**PATIENTS MEDICAL AND DENTAL RECORD SYSTEM  
UNIVERSITY OF ANTIQUE TARIO-LIM MEMORIAL CAMPUS**

**Sign up**



## **Patient Record Table**

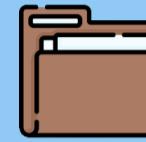




## PATIENT MEDICAL AND DENTAL RECORDS SYSTEM



**Patient Record Table**



**Patient Record**



**Monthly Report**



**Patient's Log's**



**REFERRAL FORM**



**Refusal of Care Against Medical Advice**



**MEDICAL CLEARANCE**



**OVER-THE-COUNTER MEDICINE AND TREATMENT FORM**



**CONSULTATION FORM**



**MEDICAL EXAMINATION FORM**



**Laboratory and Diagnostic Form**

**Admin**

# Patient Record

## Details

Student ID

Name

Gmail

Course and Year Level

Age

Address

Sex

Contact Number



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

Health Service  
[tlimc.health@antiquespride.edu.ph](mailto:tlimc.health@antiquespride.edu.ph)

## STUDENT HEALTH RECORDS

### PERSONAL INFORMATION

Surname	First Name	Middle Name	College	Course and Year Level
Date of Birth	Sex	Civil Status	Blood Type	
	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married		
Place of Birth			Religion	Nationality
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/beverage 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="radio"/> Asthma	_____	<input type="radio"/> High blood pressure	_____
<input type="radio"/> Blood Disorder	_____	<input type="radio"/> Kidney Disease	_____
<input type="radio"/> Obesity	_____	<input type="radio"/> Mental disorder	_____
<input type="radio"/> Cancer/Cyst/Tumor	_____	<input type="radio"/> Stroke	_____
<input type="radio"/> Diabetes	_____	<input type="radio"/> Thyroid Problem	_____
<input type="radio"/> Epilepsy/seizure	_____	<input type="radio"/> Tuberculosis	_____
<input type="radio"/> Heart disease	_____	<input type="radio"/> Other/s	_____

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

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

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

For FEMALES only:

Age of Menarche: \_\_\_\_\_  
Have you ever been pregnant?  Yes  No  
If yes, please specify \_\_\_\_\_  
Have you noticed any breast lump?  Yes  No  
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:



# Print



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<input type="radio"/> Epilepsy/Seizures	_____			<input type="radio"/> Other/s

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

For FEMALES only:

Age of Menarche: \_\_\_\_\_  
Have you ever been pregnant?  Yes  No  
Have you noticed any breast lump?  Yes  No

First Day of last Menstruation: \_\_\_\_\_

If yes, please specify \_\_\_\_\_  
If no, please specify \_\_\_\_\_

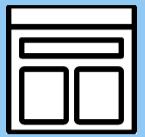
I do hereby state that, to the best of my knowledge and belief, the medical history and information that I have provided is complete and accurate. I further understand that any medical information withheld, incomplete, or incorrect discharges the University from all medical and legal liability. I authorize 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: \_\_\_\_\_



PATIENT MEDICAL AND DENTAL  
RECORDS SYSTEM



Patient Record  
Table



Patient Record



Monthly Report



Patient's Log's



REFERRAL FORM



Refusal of Care Against  
Medical Advice



MEDICAL CLEARANCE



OVER-THE-COUNTER MEDICINE  
AND TREATMENT FORM



CONSULTATION FORM



MEDICAL EXAMINATION FORM



Laboratory and Diagnostic Form

Admin

# Monthly Report



# **Patient's Log's**





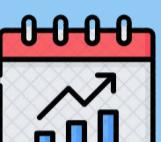
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# REFERRAL FORM



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TIBAO ANTIQUE

HEALTH SERVICE [timc.health@antiquespride.edu.ph](mailto:timc.health@antiquespride.edu.ph)

## REFERRAL FORM

Date: \_\_\_\_\_

Name of Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Course & Year: \_\_\_\_\_  
Address: \_\_\_\_\_  
Complaints: \_\_\_\_\_

Referred to:  
 RHU: \_\_\_\_\_  
 Hospital: \_\_\_\_\_  
 Private Practitioner: \_\_\_\_\_  
Others: \_\_\_\_\_

Referral Form:  
 Hospitalization: \_\_\_\_\_  
 Physical Examination: \_\_\_\_\_  
 X-ray (Specify): \_\_\_\_\_  
Others (Specify): \_\_\_\_\_

Referred By:  
\_\_\_\_\_  
-----

To be detached and send back to referring agency

Date: \_\_\_\_\_

Sir/ Madam:

This is to certify that \_\_\_\_\_, age \_\_\_\_\_, sex \_\_\_\_\_ of  
address \_\_\_\_\_ has been referred to this office/institution and was given  
the following services:

Remarks: \_\_\_\_\_

Name: \_\_\_\_\_

Designation: \_\_\_\_\_

Office: \_\_\_\_\_



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# Refusal of care Against medical Advice



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## Refusal of Care Against Medical Advice

### 1. Acknowledgment of Information

I have been advised by the UA-TLMC Health Service staff of the medical treatment that should be given to me including the nature, purpose, risks, and benefits of the proposed treatment, the possible alternatives thereto, and the risks and consequences of not proceeding. I nonetheless refuse to consent to the proposed treatment.

I acknowledge that I may have a medical problem which may acquire additional medical attention, and that transportation is available to conduct me to the hospital. Instead, I elect to seek alternative medical care and/ or refuse further evaluation, treatment and/ or transport.

### 2. Release of Liability

By signing this form, I am releasing University Health Service, University Of Antique-TLMC, of any liability or medical claims resulting from my decision to refuse care against medical advice.  
I confirm that I have read and fully understand the acknowledgment of Information and Release of Liability.

Patient  
(Signature over Printed Name)  
Name:  
Date:

Witness  
(Signature over Printed  
Name)  
Date:



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## MEDICAL CLEARANCE

TO WHOM IT MAY CONCERN:

Date: \_\_\_\_\_

This is to certify that \_\_\_\_\_ Years old of \_\_\_\_\_ was seen and examined at the Medical Clinic last \_\_\_\_\_ and found to be physically fit for:

Enrollment  
On-the-Job Training  
Employment  
Others (please specify): \_\_\_\_\_

This certificate is being issued upon the request of the above-mentioned for whatever purpose it may serve, except those medico-legal in nature.

NEZA MAY B. KHO YUTE, M.D.  
License No. 0130606

HS-FM-013

REV.1 / 03-16-20



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# OVER-THE-COUNTER MEDICINE AND TREATMENT FORM



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## OVER-THE-COUNTER MEDICINE AND TREATMENT FORM

Date	Name	Age	Sex	Course & year	Complaint/sickness	Medicine/Treatment	remarks	Time in	Time Out	Signature



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## CONSULTATION FORM

Name of patient: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Sex: \_\_\_\_\_ Course: \_\_\_\_\_

Date/ Time	Complaints	Management



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# **MEDICAL EXAMINATION FORM**



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HEALTH SERVICE [tlimc.health@antiquespride.edu.ph](mailto:tlimc.health@antiquespride.edu.ph)

## **MEDICAL EXAMINATION FORM**

Date: \_\_\_\_\_  
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-TLMS Medical Clinic together with the laboratory results after your Medical Examination.



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Laboratory and Diagnostic Form

Admin

# Laboratory and Diagnostic Request Form



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TIBAO ANTIQUE

HEALTH SERVICE [timc.health@antiquespride.edu.ph](mailto:timc.health@antiquespride.edu.ph)

## Laboratory and Diagnostic Request Form

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_  
Requested by: \_\_\_\_\_ Date: \_\_\_\_\_



## **PATIENT MEDICAL AND DENTAL RECORDS SYSTEM**

## ***Admin***

# **Patient's Log's**





## ***Admin***

# Change Password

[Log Out](#)

# **Patient's Log's**





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## Patient's Log's



Student ID

Name

Log Date

Details

Are you sure you want to Logout?

Click "Logout" below if you want to end your current session.

Cancel

Logout



## PATIENTS MEDICAL AND DENTAL RECORD SYSTEM

Sign up

