Republic of the Philippines  
UNIVERSITY OF ANTIQUE  
**TARIO-LIM MEMORIAL CAMPUS**  
TIBIAO ANTIQUE  
  
**HEALTH SERVICE**[**tlmc.health@antiquespride.edu.ph**](mailto:tlmc.health@antiquespride.edu.ph)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **PERSONAL INFORMATION** | | | | |
| Surname First Name Middle Name | | | College | Course and Year |
| Date of Birth | Sex  Male Female | | Civil Status  Single Married | Blood Type |
| 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 | |

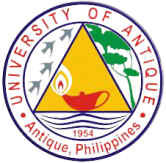
STUDENT HEALTH RECORDS

**MEDICAL INFORMATION**

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

|  |
| --- |
| Please check the corresponding box if you have been diagnosed to have any of the following conditions. . if YES, please specify medications  Hypertension Diabetes Bronchial Asthma Hearth Disease  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 and other allergies?(food/bee stings) 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).** |
| Asthma High Blood Pressure  Blood Disorder Kidney Disease  Obesity Mental Disorder  Cancer/Cyst/Tumor Stroke  Diabetes Thyroid Problem  Epilepsy/Seizure Tuberculosis  Heart Disease Others: |
| **Please check if you have any of the following (present or past) medical conditions. (check all that apply)** |
| Alcohol/DrugsDependence Eye Problem Musculoskeletal Problem  Anemia/BloodDisease Frequent Headaches Primary Complex/Tuberculosis  Arthritis/JointPaints Head Injury Sexually Transmitted Disease  Asthma Hearing Problem Shortness of Breath  Cancer/Cyst/Tumor Hearth Disease Skin Problem  Chickenpox High Blood Pressure Sleep Problem  DengueFever High Sholesterol Typhoid Problem  Diabetes Hyperacidity/Indigestion/Ulcer Tonsillitis  Disability/Handicap Kidney Disease Typhoid Fever  Dizziness/Fainting Liver Disease Urinary Tract Infection  EarandNoseProblem Measles Varicose Veins  EatingProblem/Disorder Mental/Emotional Problem Weight Problem  Epilepsy/Seizures Mumps 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? 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 provide is complete and accurate. I further understand that any medical information with held, 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 Parent/ Guardian’s Signature over Printed Name (if under 18 years of age)  Date: Date |

HS-FM-007 Rev.2/03-16-20



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|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Patient’s Name | | | College | Course & Year: |
| Date of Birth | Age | Sex  Male Female | Civil Status  Single Married | Citizenship: |
| Address Contact No: | | |  | |
| Parent’s/ Guardian’s Name | | | Relationship to Patient: | |
| Occupation: | | | Contact No. | |
| Family Physician | | | Contact No.: | |
| Clinic Address | | | | |

**INDIVIDUAL PATIENT’S RECORD & SUMMARY OF SERVICE RENDERED**

HISTORY

(Please check the appropriate box below)

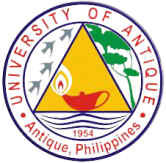
1.) Are you now under current medical treatment? Yes No  
2.) Did you have any bad experiences in any dental clinics? Yes No  
State if Yes:  
3.) Have you ever experienced an unusual reaction to Dental Anesthetic? Yes No  
4.) Do you bleed profusely during or after surgery or tooth surgery? Yes No  
5.) Have you undergone any major operation or surgery? Yes No  
6.) Do oyu have allergic reactions to any foods or medicines? Yes No  
7.) Are you taking any drug or medication?  
State if yes:  
8.) Do you have any:  
 a. Hearth 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 Signature

Date: Date:

HS-FM-005 Rev.2/03-16-20



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Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year and section:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SUMMARY OF SERVICES RENDERED**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Date** | **Oral Prophylasis**  **H M L** | **Tooth extraction** | **consultation** | **Others** | **Remarks** | **signature** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

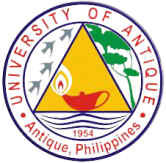
**ORAL HEALTH CONDITION**

**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 |  |  |  |  |  |



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**REFERRAL FORM**

**Date:**

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

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Complaints:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred to:

RHU: Hospitalization:

Hospital: Physical Examination:

Private Practitioner: X-ray (Specify):

Others: 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:­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

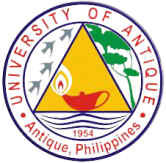
­Remarks: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:

Designation:

Office:

HS-FM-011 REV.1 / 03-05-20

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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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

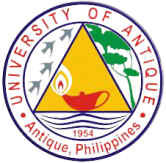
Signature

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.**

HS-FM-012 REV.1 / 03-05-20



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**Refusal of Care Against Medical Advice**

1. **Acknowledgement 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.

1. **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 acknowledgement of Information and Release of Liability.

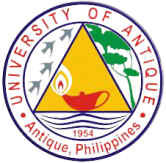
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Witness

(Signature over Printed Name) (Signature over Printed Name)

Date: Date:

HS-FM-019 REV.1 / 09-24-20



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**MEDICAL CLEARANCE**

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

Date

TO WHOM IT MAY CONCERN:

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

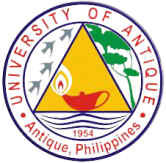
Others (please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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**CONSULTATION FORM**

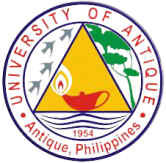
Name of Patient: \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_

(Last Name) (First Name) (Middle Name)

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

|  |  |  |
| --- | --- | --- |
| Date/Time | Complaints | Management |
|  |  |  |
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HS-FM-016 REV.1 / 03-16-20

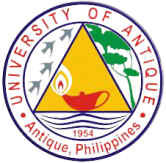


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**OVER-THE-COUNTER MEDICINE AND TREATMENT FORM**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date** | **Name** | **Age** | **Sex** | **Course & year** | **Complaint/sickness** | **Medicine/Treatment** | **remarks** | **Time in** | **Time Out** | **Signature** |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
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HS-FM-003 REV.1 / 03-16-20



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**Laboratory and Diagnostic Form**

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

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_ Sex: \_\_\_\_\_\_

Requested by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CBC FBS X-ray: \_\_\_\_\_\_\_\_\_\_\_

Platelet Count Cholesterol UTZ:\_\_\_\_\_\_\_\_\_\_\_\_

Blood Typing Triglycerides ECG:\_\_\_\_\_\_\_\_\_\_\_\_

Urinalysis Bilirubin CT Scan: \_\_\_\_\_\_\_\_\_

Fecalysis Lipid Profile Others:\_\_\_\_\_\_\_\_\_

HBsAg SGPT/ALT

SGOT/AST

Audiometry Creatinine

Ishihara BUN

Uric Acid

Serum Pregnancy Test HBA 1C

Sputum Exam TSH, T3, T4

HS-FM-014 REV.1 / 03-05-20