UNIVERSITY HEALTH SERVICE
UNIVERSITY OF THE PHILIPPINES
DILIMAN, QUEZON CITY

ALLERGIC TO _____ Student No. _____

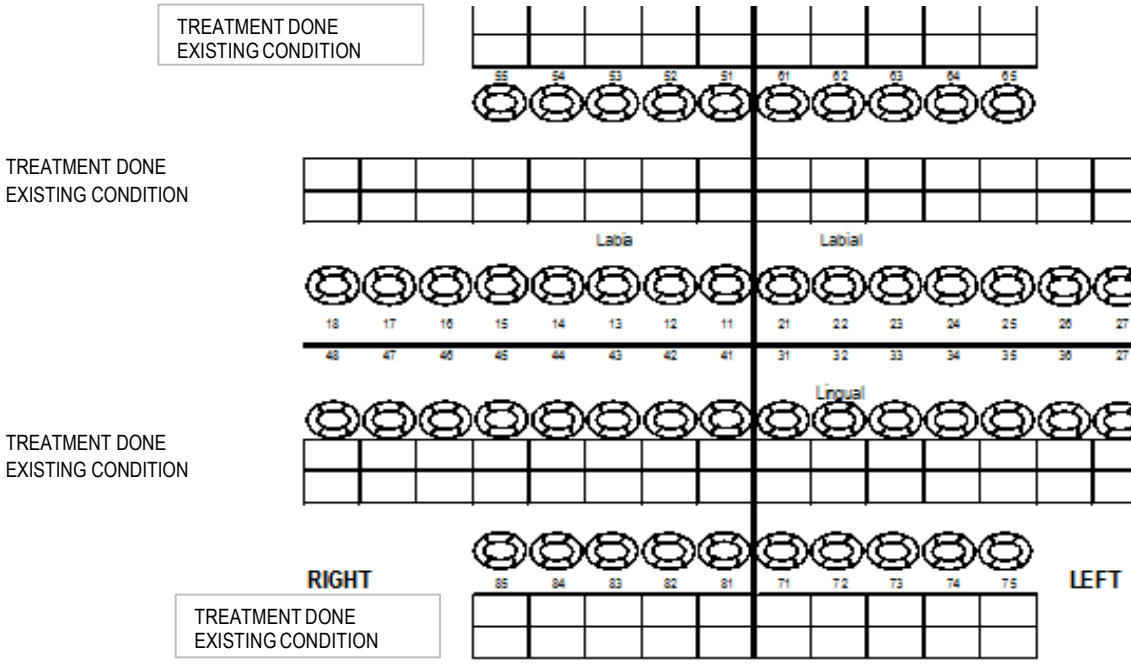
Date of Examination _____

DENTAL CLINIC

OUT PATIENT RECORD

PRINT NAME : _____ AGE _____ SEX _____ REL _____ CS _____
(LAST) (FIRST) (MIDDLE) SCHOOL/COLLEGE _____
DATE OF BIRTH : _____ OFFICE/DEPARTMENT _____
ADDRESS : _____ OCCUPATION _____
PARENT/GUARDIAN : _____ RELATION _____
ADDRESS : _____ TEL. NO. _____ OFFICE/DEPT _____

MARKINGS ON BLOCKS FOR CONDITION OPERATION



LEGEND:

C	-	DENTAL CARIES	CO	-	COMPOSITE	GJC	-	GOLD JACKET CROWN
RF	-	ROOT FRAGMENT	S	-	SEALANTS	AJC	-	ACRYLIC JACKET CROWN
I	-	IMPACTED	MO	-	METAL ONLAY	PJC	-	PORCELAIN JACKET CROWN
A	-	ABRASIONS (CERVICAL)	CEO	-	CERAMIC ONLAY	MJC	-	METAL JACKET CROWN
X	-	MISSING / EXTRACTED	MI	-	METAL INLAY	CD	-	COMPLETE DENTURES
AM	-	AMALGAM	CEI	-	CERAMIC INLAY	RPD	-	REMOVABLE PARTIAL DENTURE

GINGIVITIS	O MILD	O MODERATE	O SEVERE			
PERIODONTAL CONDITION	O LOCALIZED	O GENERALIZED				
OCCLUSION	O N	O DISTO	O MESIO	O CROWDING	O OPEN BITE	O DEEP BITE
HABITS :						
PRESENCE OF DENTO FACIAL ANOMALY :						

DR. _____ DMD
EXAMINER

UPHS FORM NO. 2-C

Print

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

(Last) (First) (Middle)

(Do not write on this side. To be filled out by your 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 : _____

_____ Under (< 18.5)
_____ Good (18.5 - 24.9)
_____ Over (25 - 29.9)
_____ Obese I (30 - 39.9)
_____ Obese II (≥ 40)

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

Visual Acuity:

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

Color vision : _____

Please check apporpriate 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-reactal			
Neurologic			

Chest x-ray findings: _____

Activity: I Unlimited II Unlimited with observation III Resticted and corrective IV Reconstructive V Activity

ASSESSMENT

RECOMMENDATIONS

Examined by: _____

PRC Licence number: _____

Date examined: _____