UNIVERSITY HEALTH SERVICE
UNIVERSITY OF THE PHILIPPINES
DILIMAN, QUEZON CITY

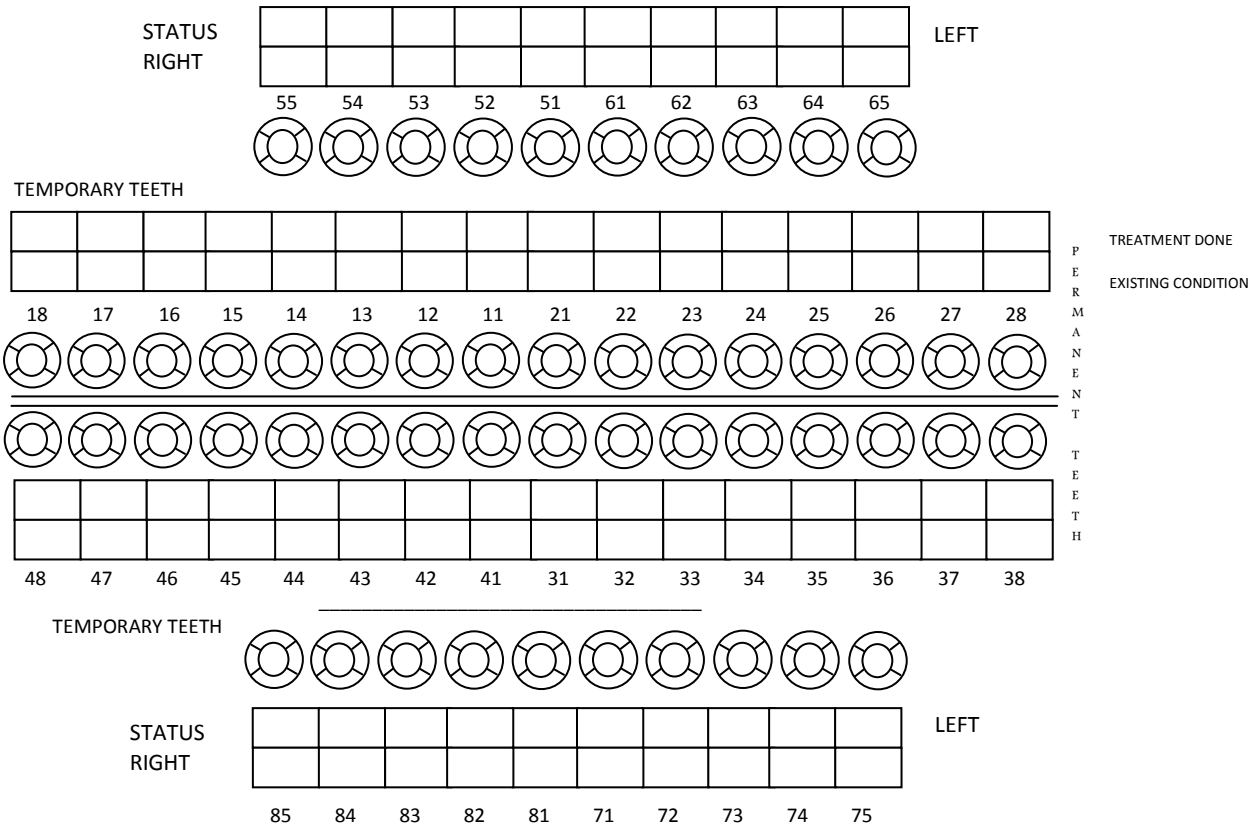
Student /OPD Number: _____
☐ Student ☐ Retired
☐ Faculty ☐ Dependent
☐ Employee ☐ Outsider

ALLERGIC TO _____

DENTAL CLINIC
OUT PATIENT RECORD

LASTNAME_____ Date of Birth _____Age _____Sex _____
FIRSTNAME_____ Contact No:_____Religion _____Civil Status_____
MIDDLENAME_____ School/College/Office/Department_____
PresentAddress _____
PARENT/GUARDIAN_____ RELATIONSHIP_____OCCUPATION_____
PERMANENT ADDRESS _____ CONTACT NO _____

INTRAORAL EXAMINATION



LEGEND:

C –Caries
Am – Amalgam Filling
G – Goldfilling
Im – Impacted Tooth
PFS – Pit & Fissure Sealant
JC – Jacket Crown (P-Porcelain, M-Metal, G-Gold, A-Acrylic, C-Ceramic)
Co – Composite
In – Inlay/On- Inlay (G: Gold; M: Metal; C: Ceramic)
Frac – Fractured (Co, AM, Tooth)
TF – Temporary Filling
X – Extraction due to Caries
Sp – Supermumerary

Gingivitis
☐ Mild
☐ Moderate
☐ Severe

Periodontal Condition
☐ calized
☐ Generalized
☐ Chronic
☐ Acute

Occlusion
☐ ss 1
☐ Class 2
☐ Class 3
☐ Midline Deviation
○ acial ○ ental
☐ Crowding
☐ TMD

Appliances
☐ thodontic
☐ Stayplate
☐ RPD
○ Upper ○ Lower
☐ Complete
○ Upper ○ Lower

Other Clinical Findings
_____
_____

_____
Dentist / Date

PATIENT INFORMATION RECORD

Name: _____
Last First Middle

DENTAL HISTORY

Previous Dentist: _____
Last Dentist visit: _____

MEDICAL HISTORY

Name of Physician: Dr. _____Specialty, if applicable: _____
Office Address: _____ Office Number: _____

1. Are you in good health? Yes No
2. Are you under medical treatment now? Yes No
   If so, what is the condition being treated? _____
3. Have you ever had serious illness or surgical operation? Yes No
   If so, what illness or operation? _____
4. Have you ever been hospitalized? Yes No
   If so, when and why? _____
5. Are you taking any prescription/non-prescription medication? Yes No
   If so, please specify _____
6. Do you use tobacco products? Yes No
7. Do you use alcohol, cocaine or other dangerous drugs? Yes No
8. Are you allergic to any of the following: Yes No
   ( ) Local Anesthetic (ex. Lidocaine) ( ) Penicillin, Antibiotics
   ( ) Sulfa drugs ( ) Aspirin ( ) Latex ( ) Other _____
9. Bleeding Time _____
10. For women only: Are you Pregnant? Yes No
    Are you nursing?
    Are you taking birth control pills?
11. Blood Type _____
12. Blood Pressure _____
13. Do you have or have you had any of the following? Check which apply Yes No

( ) High Blood Pressure
( ) Low Blood Pressure
( ) Epilepsy / Convulsions
( ) AIDS or HIV Infection
( ) Sexually Transmitted disease
( ) Stomach Troubles / Ulcers
( ) Fainting Seizure
( ) Rapid Weight Loss
( ) Radiation Therapy
( ) Joint Replacement / Implant
( ) Heart Surgery
( ) Heart Attack
( ) Thyroid Problem
( ) Heart Disease
( ) Heart Murmur
( ) Hepatitis / Liver Disease
( ) Rheumatic Fever
( ) Hay Fever / Allergies
( ) Respiratory Problems
( ) Hepatitis / Jaundice
( ) Tuberculosis
( ) Swollen ankles
( ) Kidney disease
( ) Diabetes
( ) Chest pain
( ) Stroke
( ) Cancer / Tumors
( ) Anemia
( ) Angina
( ) Asthma
( ) Emphysema
( ) Bleeding Problems
( ) Blood Diseases
( ) Head injuries
( ) Arthritis / Rheumatism
( ) Others

_____
Signature / Date