UNIVERSITY HEALTH SERVICE
UNIVERSITY OF THE PHILIPPINES
Diliman, Quezon City

CONSENT FOR PHYSICAL EXAMINATION

PLEASE CHECK ONE (1):

☐ **For Minors (below 18 years of age):**

I hereby grant consent to any of the staff physicians of the U.P. Health Service, Diliman, Quezon City to conduct a thorough physical/medical examination of my son/ daughter/ charge _____ as a pre-requisite for admission to U.P. Diliman.

☐ **For those of legal age (18 years old & above):**

I grant my consent to any of the staff physicians of the U.P. Health Service, Diliman, Quezon City to conduct a thorough physical/medical examination on myself as a pre-requisite for admission to U.P. Diliman.

_____ _____

Signature over Printed Name *Relationship (in the case of minors)*

Date: _____

freshmenpe_consent/purl/11aug2016

UNIVERSITY HEALTH SERVICE
UNIVERSITY OF THE PHILIPPINES
Diliman, Quezon City

CONSENT FOR MINORS

Name of Patient _____ Age _____

☐ Student ☐ Employee-/Faculty-Dependent ☐ Non-UP

I, _____, _____ years old resident of _____ in my capacity as his/her parent/legal guardian, give my consent to the UNIVERSITY HEALTH SERVICE and its staff to perform whatever diagnostic procedures/treatments, as may be deemed necessary in the OPD, in the management of his/her case. (For minor ailments only).

In reservation, I _____
_____

I, therefore, hereunder set my hand on this _____ of _____ 20____.

_____ _____

Signature of Parent/Guardian *Signature of Witness*

UNIVERSITY HEALTH SERVICE
UNIVERSITY OF THE PHILIPPINES
DILIMAN, QUEZON CITY

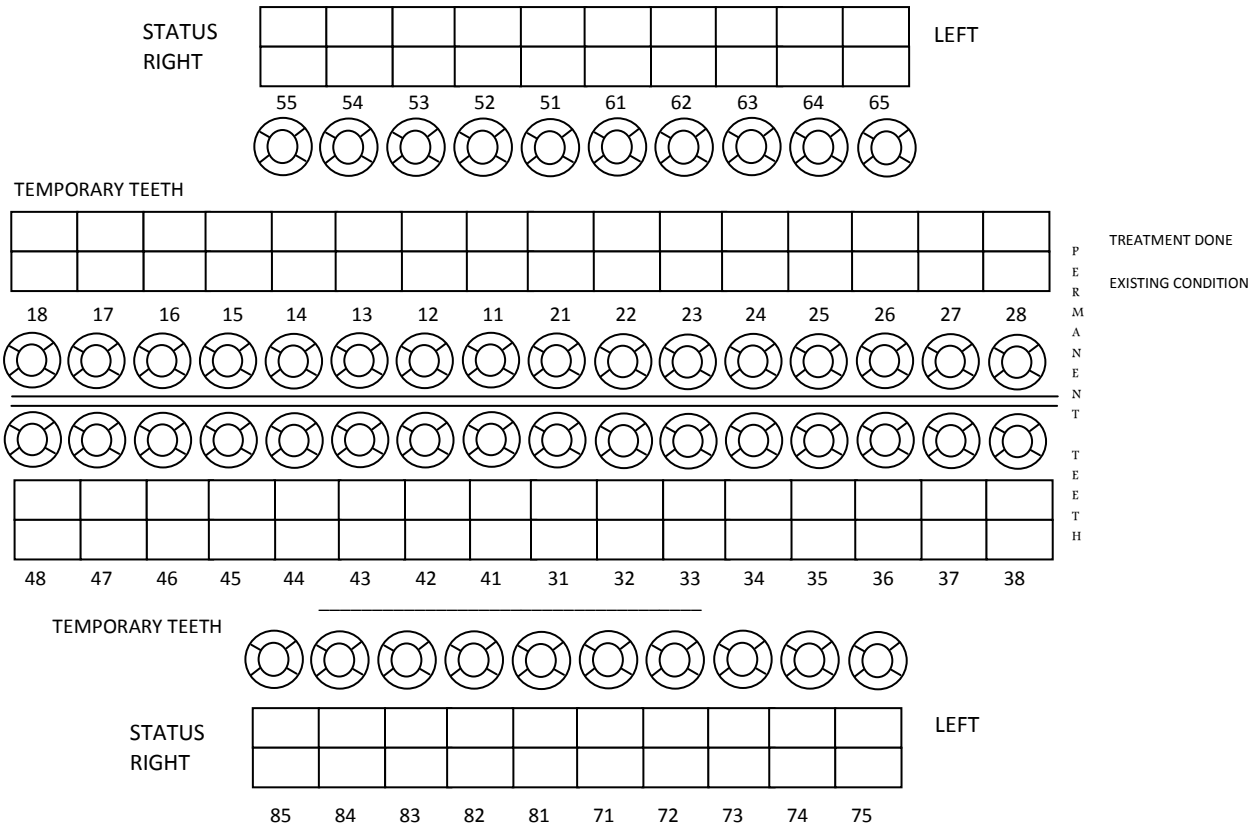
Student /OPD Number: _____
☐ Student ☐ Retired
☐ Faculty ☐ Dependent
☐ Employee ☐ Outsider

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

PROCEDURES FOR PRE-ENROLMENT PHYSICAL EXAMINATION

The Office of the University Registrar requires incoming freshmen and all other new students (post-graduate students, transferees, cross-registrants, etc.) to secure a **medical clearance** from the **University Health Service** (UHS) prior to enrolment. This certificate is issued after the student has undergone a **complete physical-medical and dental examination either at the UHS or any reputable hospital/clinic of choice**. The steps to follow are:

A. **For Physical-Medical Examination at the University Health Service**

1. The schedule of physical examination for 1st semester school year 2017-2018 is from March 1 to June 30, 2017, Mondays thru Fridays except holidays, 8:00am-11:30am and 1:00pm-4:30 pm. Freshmen and other students may report to the UHS for their physical examination as soon as they receive their NOTICE OF ADMISSION into UP Diliman.

2. Students must present the following documents at the UHS Public Health Unit Office:

   a. **Notice of Admission**
   b. **Consent** for Physical Examination duly signed by parent or legal guardian if the student is less than 18 years old, or by the student if he/she is already 18 years of age or older. **NO CONSENT, NO EXAMINATION.**
   c. **UPHS Form No. 2** – duly accomplished with a 2 x 2 or passport-size ID photo attached.
   d. **UPHS Form No. 2C**
      (The UPHS forms and Consent for Physical Examination are all enclosed with the Notice of Admission and can also be downloaded at **www.upd.edu.ph**.)
   e. For all students 19 years old and below, GAPS (Guidelines for Adolescent Preventive Services) form personally accomplished by the enrolee, unaided by the parent or guardian. The form will be issued at the frontline desk during the physical examination period.
   f. Students have the option to undergo their chest X-ray examination at the UHS for free, but must give a lead time of two to three working days to get the official result (reading). Alternatively, they may also have their Chest X-ray done at other reputable hospitals/facilities before undergoing the physical examination proper at the UHS.
      Chest X-ray done outside the UHS must not be more than 6 months old, and the student must bring the X-ray film or CD and the original copy of the official reading plus 2 photocopies thereof.

3. After presenting the above documents, you will be directed to any of the following areas:

   a. **X-ray Section -** Students (male and female) who will opt to undergo chest X-ray at the UHS are advised to wear T-shirts without buttons or zippers. **Results may be claimed after two (2) working days from the X-ray Section.**
   b. **Public Health Unit –** for height, weight, BP measurement, temperature, visual acuity testing, and BMI determination.
   c. **Dental Section**

d. **Triage –** for assignment to a same-sex physician who will perform the final physical examination.

4. After completing all the stages of the physical exam (3a to d above), submit the accomplished forms and chest X-ray results to the Public Health Unit to claim your medical certificate.

   NOTE: Do not submit unfinished forms. Keep the unfinished forms with you until you have completed Steps 3a to d above.

B. **For Physical-Medical Examination in facilities other than the UHS**

1. Have a chest X-ray at any hospital or diagnostic center of your choice.

2. Undergo your medical and dental examination and ask your attending physician and dentist to fully accomplish and sign your Form 2C. The physician must indicate whether the student is physically fit or unfit for schooling, and he/she must also affix his/her signature over printed name, license number, and date in the appropriate spaces. Forms without such information will be considered invalid.

3. Present at the Public Health Unit the following documents:

   a. **Notice of Admission**
   b. **Chest X-ray film or CD not older than 6 months and the original copy of the official reading plus two photocopies thereof.**
   c. Duly accomplished **UPHS Forms No. 2 and No. 2c**
   d. For all students19 years old and below, GAPS (Guidelines for Adolescent Preventive Services) form personally accomplished by the enrolee unaided by the parent or guardian. The form will be issued by the Public Health Unit during the physical examination period.

IMPORTANT REMINDERS:

1. **Bring your own blue or black ball pen.**
2. **Students who will undergo their physical examination at the UHS are advised to wear footwear that can easily be slipped on and off when their height and weight are to be taken.**

Prepared by:

Committee on Pre-enrolment Physical Examination
January 25, 2017

Noted and approved by:

Dr. Jesusa T. Catabui
Acting Director, UHS

Name of Student: _____
UP Student No.:_____

Dear Parent/Guardian:

Please request the examining physician and dentist to fill out this form as a summary of their recommendations. The student has the option to come to the University Health Service for any of the services and dental procedures mentioned below, most of which may be availed of at discounted rates.

Committee on Pre-enrolment Physical Examination

A. Medical Recommendations

- ☐ Consult an Ophthalmologist (Eye)
- ☐ Consult a Dermatologist
- ☐ Consult an ENT doctor
- ☐ Consult an Orthopedic Surgeon
- ☐ Consult at Nutrition Clinic ☐ Underweight Overweight ☐ Obese ☐
- ☐ Others:_____
- ☐ None

_____
Examining Physician
Date:

B. Dental Recommendations

- ☐ Oral prophylaxis
- ☐ Filling, tooth # _____
- ☐ Extraction, tooth # _____
- ☐ Pit and fissure sealant _____
- ☐ Fluoride treatment _____
- ☐ See specialist for consultation:
  - ☐ Pedodontist
  - ☐ Endodontist
  - ☐ Orthodontist
  - ☐ Periodontist
  - ☐ TMJ Specialist
  - ☐ Prosthodontist
  - ☐ Oral Surgeon
  - ☐ Implantologist
- ☐ Others: _____
- ☐ None

_____
Examining Dentist
Date:

UNIVERSITY OF THE PHILIPPINES
HEALTH SERVICE

ENTRANCE HEALTH EXAMINATIONS

A complete Medical History and Physical Examination is compulsory to complete your admission to the University of the Philippines and must be on file on or before your registration. This is the **responsibility of the applicant** and not your physician. Please type or complete in Ink. This record will be treated with confidentiality.

Important: Please bring accomplished form with you to the U.P. Health Service when you come for physical examination

PLEASE KEEP THIS FORM NEAT AND CLEAN

A. Complete this form if you are enrolling during a regular semester and if you are:

1. A beginning undergraduate or a beginning graduate student
2. A transfer student from a regional campus or another school or university
3. A re-entry student (undergraduate or graduate) who has been out of the University of the Philippines for at least one semester
4. A graduate student employed under the classification of "Graduate Assistant" or "Graduate Instructor"

B. Completion of this form is not required if:

1. You are a foreign student sponsored by a government agency whose files provides a complete health record signed by a physician. A copy of the health record should be submitted in lieu of this form.
2. Enrolling for a Summer Session only.

2x2 or passport-size ID photo taken within the last 3 months

☐ Allergic to: _____ Entrance Date to U.P. _____

☐ No known allergies

Please print

Last Name	First Name	Middle	Sex	Age

☐ Single ☐ Married ☐ Widowed ☐ Divorced

Date of Birth: _____ Place : _____

College/ School of Registration in the University of the Philippines : _____

☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior ☐ Graduate ☐ Special

Home Address : _____ Contact No. _____

No Street City Province Country

Address while in School: _____ Contact No. _____

Name of Parent/Guardian/Spouse: _____

Address: _____ Contact No. _____

Family History

Mother Living _____ (Age) If deceased, _____ (Age at death) Cause of death _____

Father Living _____ (Age) If deceased, _____ (Age at death) Cause of death _____

Among your blood relatives, is there a history of any of the following:

	Yes	No	Relationship		Yes	No	Relationship
Cancer				Diabetes			
Heart Disease				Mental Disorder/Problem			
High Blood Pressure				Asthma or Hay Fever			
Stroke				Convulsions/Neurologic Problems			
Tuberculosis				Bleeding Problems/Blood Disorders			
Kidney Disease				Digestive disturbances			
Arthritis/Rheumatism				Skin Disease			

Personal History. Give the appropriate age to which you had the following:

	AGE		AGE		AGE
Anemia/Blood Disorder		Hernia		Poliomyelitis	
Asthma		High Blood Pressure		Rheumatic Fever	
Cancer		Influenza A (H1N1) (indicate date)		Skin Disease	
Chickenpox		Joint Pains/Arthritis		Smallpox	
Convulsions		Kidney disease		Syphillis	
Dengue		Malaria		Thyroid Disease	
Diabetes		Measles		Tonsilitis	
Diphtheria		Mental Problem/Disorder		Tuberculosis/Primary Complex	
Ear disease/defect		Mumps		Typhoid	
Eye disease/defect		Neurologic Problem/Disorder		Ulcer (peptic)	
Gonorrhea		Pertussis (Whooping cough)		Ulcer (skin)	
Heart disease		Pleurlsy		Other conditions (please list)	
Hepatitis (indicate type)		Pneumonia			

Have you ever had or do you have any of the folowing. Check each item Yes or No.

	YES	NO		YES	NO		YES	NO
Headaches (frequent)			Sore throat (frequent)			Diarrhea/Constipation (specify)		
Dizziness (frequent)			Chest pain			Joint pains		
Fainting/Loss of consciousness			Back pain			Muscle pain (frequent)		
Insomnia			Easily gets tired			Frequent urination		
Depressed mood (> 2 weeks)			Difficulty of breathing			Eczema/Skin problems		
Eye/Visual problems			Palpitations			Fracture		
Hearing problems			Swelling of feet			Accident/Injuries		
Cough (> 2 weeks)			Nausea (frequent)			Hospitalization (reason)		
Colds/Nasal Congestion			Vomiting			Operation (specify)		
Fever (frequent/recurrent)			Abdominal pain/discomfort			Others, specify		
Frequent early morning sneezing			Loss of appetite					
Nosebleed (frequent)			Weight loss/gain (specify)					

If answer is Yes, give details _____

Do you worry too much? _____ Does your self-consciousness interfere with your getting along with others easily? _____
Are you bothered by a feeling that people are watching you or talking about you? _____ Are you concerned about alternating period of gloom and cheerfulness? _____ Is it difficult for you to pull out of a depressed mood? _____
Are you inclined to be secretive or seclusive? _____

Date of last dental check up _____ Date of last eye refraction _____

Do you consider yourself in good health? Yes ____ No ____ If not, give details_____

Do you wish to discuss any question with regards to your health, family history, sex or personal habit with a physician. Yes _____ No _____ Are you taking any medicines regularly? Yes ____ No ____ If so, what are these medicines?_____

Do you have any physical condition or handicap which requires special treatment, diet or other special consideration? Yes _____ No _____

FOR FEMALE STUDENTS:

Menstruation: Have not begun _____ or Age at onset _____ Periods occur every ____ to ____ days

Duration ____ days Flow: ____ Moderate ____ Excessive ____ Scanty Painful: _____ Incapacitating: _____

Bleeding between periods: Yes _____ No _____

Have you had any trouble with your breasts, such as lumps, tumor, surgery? No ____ Yes _____. If so, give details _____

_____

I certify that the above history is true to the best of my knowledge.

_____
Signature and Date

Print

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

(Last) (First) (Middle)

(Do not write below this line. To be filled out by the 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 : _____

[wt. in kg./(ht. in m.)^2]

Asia-Pacific BMI Cut-Offs

Underweight
___ Severe Thinness <16.00
___ Moderate Thinness 16.00-16.99
___ Mild Thinness 17.00-18.49

___ **Normal** 18.50-22.99
___ **Overweight** 23.00-24.90

Obese
___ Obese 1 25.00-29.90
___ Obese 2 >30.00

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

Visual Acuity:

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

Color vision : _____

Please check appropriate 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-rectal			
Neurologic			

Chest x-ray findings: _____

Activity: I Unlimited II Unlimited with observation III Restricted and corrective IV Reconstructive V No Activity

ASSESSMENT

RECOMMENDATIONS

Examined by: _____

PRC license number: _____

Date examined: _____