WEST VISAYAS STATE UNIVERSITY
(Permanent Dental Record)

Name: _____ Age: _____
(Surname) (Given Name)

Address: _____ Tel. No. _____

Course Taken _____ Date of Birth: _____

Sex: _____ Civil Status: _____ Allergy to Medicines/Food: _____

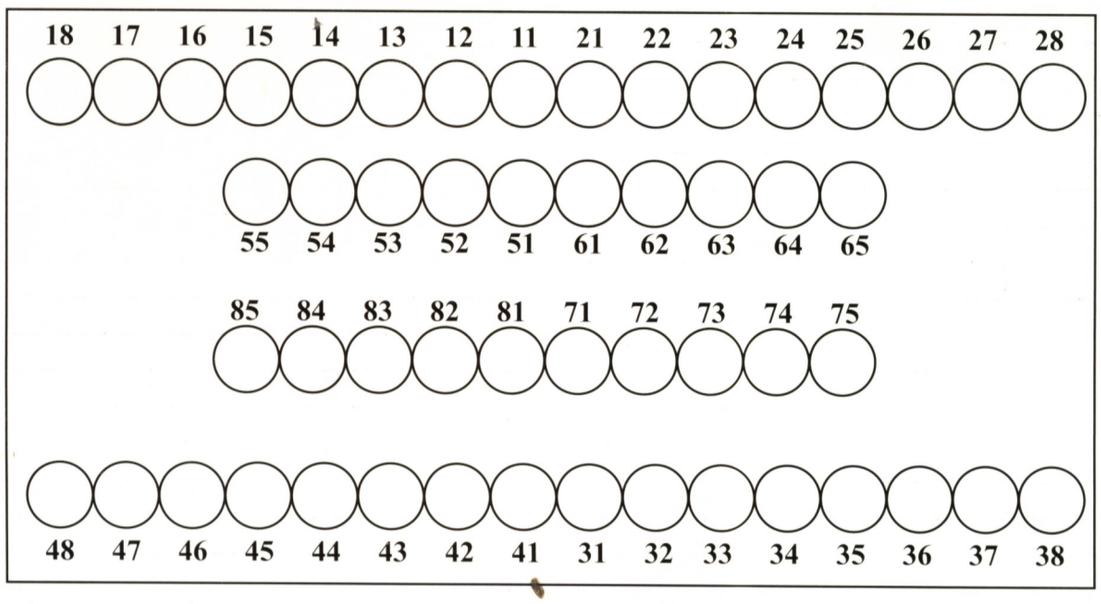
HISTORY

(Encircle the correct answer)

1. Are you under current medical treatment? ..... **Yes No**
2. Has a physician informed you that you have or had:
   a) Heart ailment ..... **Yes No**
   b) High blood pressure ..... **Yes No**
   c) Diabetes ..... **Yes No**
   d) Rheumatic Fever ..... **Yes No**
   c) Lung Disease ..... **Yes No**
   f) Any Liver Disease ..... **Yes No**
3. Have you had any major operation? If so what? ..... **Yes No**
4. Do you have night sweats, cough and weight loss? ..... **Yes No**
5. Are you allergic to any food or medicine resulting in hives, asthma, eczema, etc. ..... **Yes No**
6. Are you taking any drugs or medication? ..... **Yes No**
7. Are you on any kind of special diet? ..... **Yes No**
8. Do you experience shortness of breath when climbing up stairs ..... **Yes No**
9. Have you experienced any complication with healing? ..... **Yes No**
10. Are you in good general health at this time? ..... **Yes No**
11. Are you pregnant? If so, how many months ..... **Yes No**
12. Have experienced profuse bleeding after tooth extraction? ..... **Yes No**

_____
Signature of patient/parent/guardian

MOUTH EXAMINATION



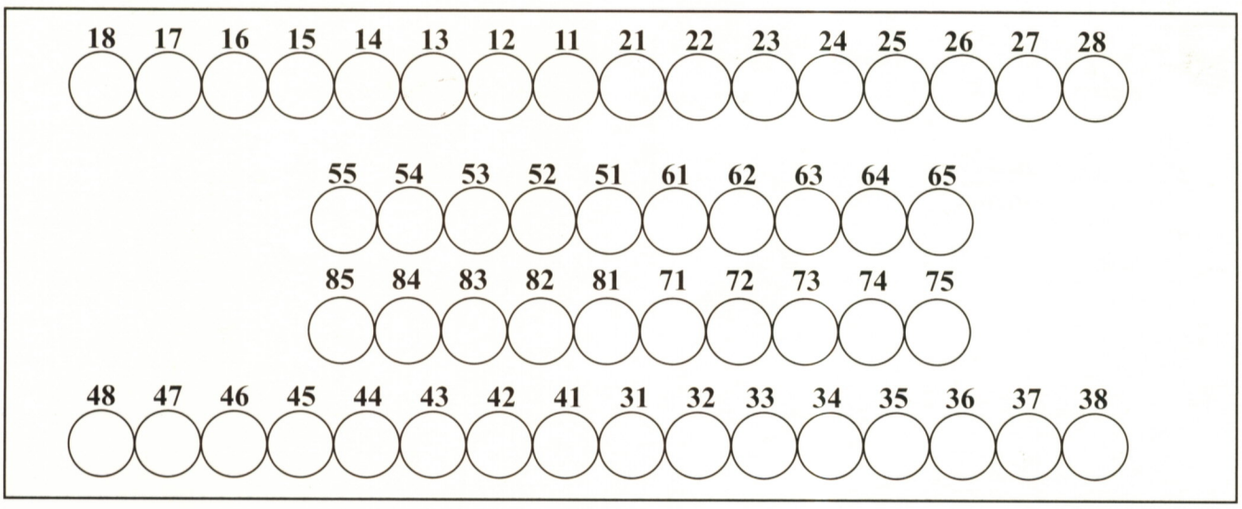
✓	- sound	**RF**	- root fragment
×	- for extraction	**P**	- pontic
C	- caries	**EXO**	- extracted
Am	- amalgam filling	**LC**	- light cure filling
TF	- temporary filling	**Un**	- unerupted
JC	- Jacket Crown		
M	- missing		

Examined by:

GEORGE N. SIBONGA, D.MD.
Dentist III

Date of Oral Examination: _____

School Year: 201 _____ 201 _____



DATE	DIAGNOSIS	TREATMENT GIVEN	REMARKS