

AUM NURSING CARE CENTER

ADOLESCENT/ADULT HEALTH HISTORY

Date 2/21/2015Name Brenda Dauburly

1. What is the reason for your visit today? TB Skin Test
2. Is there anything about you and your health that we need to know? NO

- *3. List medicine, drugs, or food you are allergic to: morphine + Singulair
- *4. List any medicines or drugs you take: _____

5. Have YOU or anyone in your family had any of the following: (circle)

heart disease
high blood pressure
 stroke

diabetes/sugar
 blood problem or disease
 cancer

tuberculosis
 birth defects
 mental retardation

nerve or mental problems
asthma
 died before age 50
 other "family" disease

6. Have you ever been in the hospital? yes Why? surgery
7. Have you ever had surgery? yes Why? _____
8. Have you ever had a serious accident? NO
9. Have you had serious or recent problems with:

ears or throat	<u>NO</u> YES	cough	<u>NO</u> YES	kidneys	<u>NO</u> YES	gallbladder	<u>NO</u> YES
allergies	<u>NO</u> YES	thyroid	<u>NO</u> YES	weight loss	<u>NO</u> YES	liver	<u>NO</u> YES
lung infections	<u>NO</u> YES	skin problems	<u>NO</u> YES	ulcers	<u>NO</u> YES	depression	<u>NO</u> YES
						headaches	<u>NO</u> YES

10. Have you ever had a seizure, convulsion, or "falling out" spell? NO YES
11. Have you ever had a blood clot in your lungs, legs or anywhere? NO YES
- *12. Have you ever smoked cigarettes or used smokeless tobacco? NO YES
- If yes, are you an: Ex-smoker? Smoking now? Do you smoke (less) (more) than a pack a day?
- How much smokeless tobacco do you use a day? _____
- *13. How often do you drink beer, wine, wine coolers, or liquor?
- Never Rarely 1-2 times a week 3-4 times a week 5 or more times a week
- If you drink beer, wine, wine coolers, or liquor, do you have:
- (less) (more) than 5 drinks a day?

- *14. Have you ever used marijuana, cocaine, crack or other drugs? NO YES
- *15. Have you ever used I.V. drugs? NO YES
16. Have you ever had a blood transfusion? NO YES
17. Do you have any tattoos? NO YES
18. Have you ever been treated for a venereal disease? NO YES
19. Have you had more than one sex partner in the past 5 years? NO YES
20. Have you ever had sex with a member of your own sex? NO YES
21. Have you had or been around anyone with hepatitis? NO YES
22. Would your sex partner(s) answer Yes to any of the questions 14-22? NO YES

FOR FEMALES ONLY

- A. How old were you when you started your periods? 15 Date of your last period? N/A
- How often do you have your periods? _____ Are they regular? _____
- How many days do they last? _____
- Do you have: (circle) bad cramps bleeding or spotting between periods unusual discharge
- B. Do you have any problems with your breasts (lumps, discharge, or other)? NO YES
- Do you check them regularly? _____ YES NO
- *C. How many times have you ever been pregnant? 4 How many children are living? 4
- Have you ever had any children born dead; any stillbirths, miscarriages, or abortions? NO YES
- Were any of your children premature? NO YES
- How old were you when your first child was born? _____
- D. Have you ever used: (circle NO/YES) birth control pills? NO YES; foam? NO YES; condoms? NO YES; IUD? NO YES; diaphragm? NO YES
- E. Did you have problems with any of these methods? NO YES
- F. Have you ever had an abnormal PAP smear? NO YES

AUM STUDENT HEALTH CENTER**PATIENT INFORMATION (PLEASE PRINT)**Date: 2/17/15 Are you an AUM student? YES NO Student ID # _____Name: Brenda DouberlySocial Security Number: _____ Birth Date: 4/25/1962Local Phone Number: 334-430-1791 Alternate Number: 334-262-5744Local Address: 1906 Dunder Drive Box Number _____City: Prattville State: AL Zip Code: 36066Permanent Address: SAM

City: _____ State: _____ Zip Code: _____

Marital Status (Please Circle): Single Married Divorced Widowed Other _____Sex (Please Circle): Male Female

Primary Physician: _____ City: _____ Phone #: _____

Patient's Employer: CCAD Work #: 262-5744Parent's or Spouse's Name (Circle which) John Douberly Phone #: 334-430-1792Parent's or Spouse's Employer: Fanco Pto Work #: _____Emergency Contact: John Douberly Relationship: Husband Phone #: 430-1792How did you hear about the Clinic? Friend ☐ Faculty/Staff ☐ Orientation ☒ Other _____**INSURANCE INFORMATION**

Do you have health insurance? YES NO

If yes, please give your card to the receptionist in order for a copy to be made for your chart.

~~Insurance Company _____ Name on Card _____~~~~Policy Number _____ Group Number _____~~~~Insurance Company Address _____~~

Patient Bill of Rights

AUM Nursing Care Center (AUM NCC) exists primarily for the purpose of providing high quality care that meets or exceeds accepted standards for care. AUM NCC believes that each client is worthy of respect and understanding and has certain rights and responsibilities related to the care he/she receives. In accordance with this philosophy, AUM NCC wishes to advise you of the following rights and responsibilities and to assist you in understanding and exercising these rights.

As a client of AUM NCC, you have the right to:

1. Be treated with dignity, courtesy, and respect.
2. Obtain from caregivers relevant, current, and understandable information concerning diagnosis, treatment, and prognosis.
3. Know the identity of all caregivers involved in their care, as well as when those involved are students or trainees.
4. Know the immediate and long-term financial implications of treatment choices, insofar as they are known.
5. Make decisions about the plan of care prior to and during the course of treatment and to refuse a recommended treatment or plan of care to the extent permitted by law and AUM NCC policy and to be informed of the medical consequences of the action. In case of refusal, the patient is entitled to other appropriate care and services or to be referred to another health care facility.
6. Receive competent, individualized quality services from AUM NCC regardless of age, race, color, national origin, religion, sex, disability, being a qualified disabled veteran, or any other category protected by law.
7. Expect confidentiality of all clinical records and access to your records on request. Information will not be released to anyone without your written consent or unless required by law.
8. Have family or guardian exercise these rights on your behalf if you are unable to do so yourself.
9. Voice grievances about care which is or is not provided, recommend policy/service changes, and make complaints without fear of reprisal or unreasonable interruption of care.

I also understand I have a responsibility to:

1. Provide accurate and complete information to AUM NCC regarding medical history and current condition and medications, and to promptly inform AUM NCC of any changes in this information.
2. Agree to accept all caregivers regardless of age, race, color, national origin, religion, sex, disability, being a qualified disabled veteran, being a qualified veteran of the Vietnam era, or any other category protected by law.
3. Participate in planning, evaluation and revising my plan of care to the degree that I am able to do so and to take responsibility for my actions and for the impact that those actions have on my health and recovery.
4. Adhere to the plan of care which I have participated in developing.
5. Treat AUM NCC staff with respect, courtesy, and consideration.

I have read and understand the above Patient Bill of Rights and agree to the contents thereof.

Patient Signature: Brenda D. Doherty

Date: 2/17/2015

AUM STUDENT HEALTH CENTER
CONSENT FOR SERVICES FORM

Patient Name Brenda Douberly Date of Birth 4/25/62

General Consent for Treatment

I request and authorize health care services by my provider and his/her designees(s) as my provider may deem advisable and in my best interest. This may include routine diagnostic, laboratory procedures and medication administration.

I understand that excluding emergency or extraordinary circumstances, no substantial procedure will be performed without providing me an opportunity to give me informed consent for that procedure. Informed consent means that the medical provider must disclose information to me including benefits and risks of a particular procedure and/or treatment.

Payment

I am responsible for all bills incurred at the Student Health Center. Payment is due at the time that services are rendered unless prior arrangements have been made.

I have read the consent form, or it has been read to me, and I am satisfied that I understand its contents. My questions have been answered to my satisfaction.

Brenda Douberly
Signature of Patient

6/1/2016
Date of Signature

Signature of Legal Representative (if patient unable to sign)

Relationship to Patient

SERVICES CONSENT FORM

NAME: Brenda Doubery
DATE OF BIRTH: 4/25/1962

I AM REQUESTING CARE FOR MYSELF OR MY ABOVE NAMED DEPENDENT AND
GIVE MY CONSENT FOR TREATMENT. I AM RESPONSIBLE FOR ALL BILLS
INCURRED AT THE NURSING CARE CENTER.

SIGNATURE: Brenda Doubery
DATE: 2/19/2015

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AUM Student Health Services PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your *Summary of the HIPAA Privacy Rule*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this 17 day of 2 2015.

Print Patient Name Brenda Deubery

Signature Brenda Deubery

Relationship to Patient _____

**AUM Student Health Services
Medical Information Release Form
(HIPAA Release Form)**

Name: Brenda Dauberly Date of Birth: 4/25/62

Release of Information

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

☒ Spouse John Dauberly

☐ Child(ren) _____

☐ Other _____

☐ Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages

Please call ☐ my home ☐ my work ☐ my cell Number: 430-1791

If unable to reach me:

☒ you may leave a detailed message

☐ please leave a message asking me to return your call

☐ _____

The best time to reach me is (day) Any between (time) _____

Signed: Brenda Dauberly Date: 02/02/2015