

FAUM STUDENT HEALTH CENTER  
TRAVEL HEALTH HISTORY

Date 6/13/11 Name Ruby Henley

1. What is the reason for your visit today Typhoid + Malaria pills for travel
2. List allergies you have to medicines, foods or iodine: \_\_\_\_\_
3. List any medications or drugs you are currently taking (this would include herbal and over-the-counter as well as prescription drugs): Trazadone 50mg qHS
4. Have you had any of the following: (circle if this applies to you);  
Heart disease \_\_\_\_\_  
Kidney disease \_\_\_\_\_  
Stomach/Gastrointestinal disease \_\_\_\_\_  
Diabetes/sugar \_\_\_\_\_
5. Are you immunocompromised? (Is there a problem with your immune system) Yes \_\_\_\_\_ No ☒  
Thymus disorder ( Myasthenia gravis, thymoma, thymectomy) \_\_\_\_\_  
Spleen removed \_\_\_\_\_  
Transplant recipient \_\_\_\_\_  
Cirrhosis of the liver \_\_\_\_\_  
Cancer \_\_\_\_\_  
HIV \_\_\_\_\_
6. How often do you drink beer, wine, wine cooler, or liquor? (Please circle)  
Never / Rarely / 1-2 times a week / 3-4 times a week / 5 or more times a week
7. Where are you going on your trip? Malawi Botswana Zimbabwe
8. How long is your trip? Months \_\_\_\_\_ Days 14
9. When are you leaving on your trip? July 31

FOR FEMALES ONLY

- A. Date of your last period? \_\_\_\_\_ Have you had a hysterectomy? YES ☒ NO \_\_\_\_\_
- B. Are you currently pregnant? YES \_\_\_\_\_ NO \_\_\_\_\_  
What is your due date? \_\_\_\_\_
- C. Do you plan to become pregnant in the next 3 months? YES \_\_\_\_\_ NO \_\_\_\_\_
- D. Are you breastfeeding? YES \_\_\_\_\_ NO \_\_\_\_\_

# AUM STUDENT HEALTH CENTER

## PATIENT INFORMATION (PLEASE PRINT)

Date: 6/13/2011 Are you an AUM student? YES ☐ NO ☒ Alum  
Name: Rubyanne Sachar Henley  
Social Security Number: 418968268 Birth Date: 11-29-1959  
Local Phone Number: 272 8719 Alternate Number: 328-9248  
Local Address: 6202 Henley Way Box Number: \_\_\_\_\_  
City: Monty State: AL Zip Code: 36117  
Permanent Address: Same  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Please Circle Your Marital Status: Single ☐ Married ☒ Divorced ☐ Widowed ☐ Other \_\_\_\_\_  
Sex: Male ☐ Female ☒ (Please Circle)  
Primary Physician: John Dailey City: Monty Phone #: \_\_\_\_\_  
Patient's Employer: Blue Cross Work #: \_\_\_\_\_  
Parent's or Spouse's Name (Circle which): Holt Henley Phone #: 312-4445  
Parent's or Spouse's Employer: Holley Henley Builders Work #: 272-2988  
Emergency Contact: Rob Sachar Relationship: bro Phone #: 314-1500  
How did you hear about the Clinic? (Please Circle) 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.

## CONSENT FOR TREATMENT

I am requesting care for myself or my above named dependent and give my consent for treatment. I am responsible for all fees for services incurred at the Student Health Center (Nursing Care Center).

Signature X \_\_\_\_\_  
Signature of patient or parent/guardian, if patient is a minor.

## 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: \_\_\_\_\_

Date: \_\_\_\_\_

## SERVICES CONSENT FORM

NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

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.

o SIGNATURE: Ruby Hernandez  
DATE: 6/30/11

SIGNATURE: \_\_\_\_\_  
DATE: \_\_\_\_\_

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