

Name Amanda ReedDate of Birth 8-7-80PAST/CURRENT PERSONAL MEDICAL HISTORY: Have YOU EVER had any of the following?

Heart/Lungs ☐ Asthma ☐ Heart Disease (<i>valve, vessel, rheumatic, etc.</i>) ☐ Heart Murmur ☒ High Blood Pressure ☒ High Cholesterol ☐ Pneumonia	Stomach/Bowel ☒ Celiac Disease ☐ Irritable Bowel Syndrome ☐ Stomach/Duodenal Ulcers ☐ Ulcerative Colitis/Crohn's ☐ Other Liver, Stomach, or Bowel Disease	Hematology/Oncology ☐ Anemia ☒ Bleeding Disorders ☐ Blood Clots/Clotting Disorders ☐ Cancer ☐ Radiation Therapy	Anesthesia History ☐ Difficult intubation ☐ Malignant hyperthermia ☐ PostOp Nausea or Vomiting (PONV) ☐ Pseudocholinesterase Deficiency	STDs ☐ Chlamydia ☐ Genital Herpes ☐ Genital Warts ☐ Gonorrhea ☐ HPV ☐ Other STD
Endocrine ☐ Adrenal Disorders ☐ Diabetes ☐ Polycystic Ovary Syndrome (PCOS) ☐ Thyroid Disorder	Neurological ☐ Concussions ☐ Convulsions/Seizures ☒ Migraines/Severe Headaches ☐ Multiple Sclerosis ☐ Muscular Dystrophy ☐ Stroke/TIA	Orthopedics ☐ Arthritis ☐ Fractures/Broken Bones	Surgical History ☐ Appendectomy ☐ Adenoidectomy ☐ Ear Tubes ☐ Gallbladder Removal ☐ Knee ACL Repair ☐ Knee Arthroscopy ☐ Organ Transplant	OB/GYN History ☐ Endometriosis ☐ Pregnancies #:
Kidney ☐ Chronic Kidney or Bladder Disease ☐ Kidney Stones	Mental Health ☒ ADHD - ADD ☐ Alcohol Abuse ☐ Anorexia (<i>Eating Disorder</i>) ☐ Anxiety Disorder ☐ Bulimia (<i>Eating Disorder</i>) ☐ Depression ☐ Drug Dependency ☐ Other Mental Health Problems	Infectious Diseases ☐ Chickenpox/Varicella ☐ Hepatitis Type: ☐ HIV Infection ☐ Infectious Mononucleosis ☐ Malaria ☐ Mumps ☐ Tuberculosis ☐ Typhoid Fever	☐ Ovarian Cyst Removal ☐ Splenectomy ☐ Tonsillectomy ☐ Weight Loss Surgery ☐ Other Prior Surgeries	Exercise History ☐ Lack of exercise ☐ Exercising regularly Moderate Exercising <i>Walking briskly, water aerobics, etc.</i> ☐ Less than 3 times per week ☐ 3 or more times per week Strenuous Exercising <i>Running, swimming laps, etc.</i> ☐ Less than 3 times per week ☐ 3 or more times per week
Ears/Eyes/Nose/Throat ☐ Chronic Sinus Infections ☐ Eye Disorders (<i>other than glasses or contacts</i>) ☐ Hearing Loss ☐ Nasal Allergies/Hayfever		Skin ☐ Eczema ☐ Psoriasis ☐ Hives		

☒ NO Significant Health Problems

☐ List Medications
Allergies clindamycinHave you ever had an allergic reaction? ☒ Yes ☐ NoMedication Allergies: clindamycinFood Allergies: Bell Peppers / Dairy / Gluten

Other Allergies (latex, bee stings, etc.):

Other History

☐ Previous Hospitalizations☐ OTHER Health ProblemsDoes YOUR IMMEDIATE FAMILY have any of the following?☐ Adopted (Family history unknown)

	Mother	Father	Siblings	Grandparents
Alcoholism				
Blood Clots/Clotting Disorders	☒			
Cancer				
Breast				
Colon				
Melanoma				
Other Cancers (List type)				
Diabetes				
Drug Dependency				
Heart Disease				
High Blood Pressure	☒	☒		☒
High Cholesterol				
Mental Illness		☒		☒
Stroke				
Sudden Cardiac Arrest (under age 50)				
Other (Please explain)				
Parent Deceased				

1. What is the reason for your visit today? Physical and Titer check
2. Is there anything about you and your health that we need to know? _____
3. List medicine, drugs, or food you are allergic to: Clindamycin / Bell peppers
4. List any medicines or drugs you take: Crestor, orthotricydin, welbutrin, Nexium

5. Have YOU or anyone in your family had any of the following: (circle)
- | | | | |
|---------------------|--------------------------|--------------------|--------------------------|
| heart disease | diabetes/sugar | tuberculosis | nerve or mental problems |
| high blood pressure | blood problem or disease | birth defects | asthma |
| stroke | cancer | mental retardation | died before age 50 |
| | | | other "family" disease |

6. Have you ever been in the hospital? Yes Why? Maxillofacial surgery
7. Have you ever had surgery? Yes Why? Maxillofacial Surgery / Tumor removed
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? 5

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? 11 yrs Date of your last period? 10-12-12
How often do you have your periods? monthly Are they regular? Yes
How many days do they last? 5
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? 0 How many children are living? 0
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

Name: REED, AMANDA L
Active Emp.:
Status: PART TIME

Emp. No.: 21363
DOB: 8/7/1980 Sex: F
Hire Date: 12/18/2006 Term. Date:

Job Title: PATIENT CARE TECH II
Cost Center:
Department: EMERGENCY ROOM
Work Location:
Hospital: BAPTIST MEDICAL CENTER SOUTH

Address: 6736 JAKEFIELD DR
MONTGOMERY, AL 36117
Phone: (334) 318-1406

===== MEDICAL INFORMATION =====

Immunizations:

Immunization	Date	Follow-Up Action	Follow-Up Date
FLU SHOT	10/12/2013		
Administered By :		Manufacturer :	
Route:		Lot No:	
Site:		Expiration Date:	
Comments:			
FLU SHOT	10/10/2012		
Administered By :		Manufacturer :	
Route:		Lot No:	
Site:		Expiration Date:	
Comments:			
FLU SHOT	10/7/2011		
Administered By :		Manufacturer :	
Route:		Lot No:	
Site:		Expiration Date:	
Comments:			
FLU SHOT	10/8/2010		
Administered By :		Manufacturer :	
Route:		Lot No:	
Site:		Expiration Date:	
Comments:			
H1N1 VACCINATION	12/22/2009		
Administered By :		Manufacturer :	
Route:		Lot No:	
Site:		Expiration Date:	
Comments:			

Carol Stewart, C.R.N.P.
Lic. #1-045437
Rx: 1178

AUBURN MONTGOMERY
STUDENT HEALTH CENTER
P. O. Box 244023
Montgomery, AL 36124-4023
(334) 244-3281

Ramona Lazenby, C.R.N.P.
Lic. #1-039092
Rx: 0703

Maryluz Fuentes, M.D.
(334) 286-2390
DEA #BF 6451520
AL #24127

Name

Amanda Reed

Date

8-29-14

Address

Rx

Lazex 20mg
dispo: 30
sig: + po qd
Stewart

Label: all prescriptions

Refill: 1 2 3 5 PRN NR

Product Selection Permitted

Dispense As Written

M.D. or C.R.N.P.

M.D. or C.R.N.P.

altreed2012@gmail.com

**AUM NURSING CARE CENTER
PROBLEM VISIT RECORD**

DATE: 8/29/14 TIME: 1455 PT. HISTORY REVIEWED / UPDATED:

PATIENT NAME: Amanda Reed DOB: AGE: 34

PRESENT COMPLAINT: Difficulty w concentration & focusing, Difficulty being still, Preoccupied w food.

MEDICATIONS: Wellbutrin SR 150 BID, Symvastatin 20mg, vitamins LMP:

Temp	Pulse	Resp	BP	HT	WT	Allergies
	90		133/85	64.7	264.9	clindamycin

INITIAL VISIT 44.7

Skin	RETURN VISIT
<u>Diaper area more than</u>	<u>9-22-14 12:13</u>
<u>Sinuses Very anxious, depressed</u>	<u>wt. 261.8</u>
<u>Ears 1 lined easily</u>	<u>stated see</u>
<u>Eyes Wellbutrin SR 150. W-10</u>	<u>more than</u>
<u>Nose on Nasex-ant stopped</u>	<u>fasting</u>
<u>Throat tearing. Hoes up at</u>	<u>later</u>
<u>Neck/Back of family? Seemed</u>	<u>wellbutrin</u>
<u>Heart pressures.</u>	<u>on RX.</u>
<u>Lungs</u>	<u>Doing well</u>
<u>Abdomen</u>	<u>on med</u>
<u>GU/GI</u>	<u>will maintain</u>
<u>Extremities</u>	<u>current.</u>
	<u>dosage</u>
	<u>1/2 hr 2 in</u>
	<u>2 mo.</u>
	<u>later, up</u>

DIAGNOSIS:	TESTS	RESULTS
<u>1) Anxiety / Depression</u>		
<u>unintended</u>		

PLAN: Cont. Wellbutrin
SR 150
Statop 20mg q.o.d

PRACTITIONER SIGNATURE: STAFF SIGNATURE:

AUDIT DATE: COMMENTS:

PHYSICIAN SIGNATURE:

Faxing completed TB skin Test form is acceptable; however the original form must be returned to Employee Health .

Fax: 286-2494

BAPTIST MEDICAL CENTER SOUTH
TB SKIN TEST FORM

Employee's Name Reed, Amanda

Employee # 21363 Date Skin Test Administered 12-19-13

Administered By R. Pector

Administered In: Right Arm ☒ Left Arm ☒

Read By Meef Pector

Result 0 mm Date Read 12/21/13

☐ First Step ☐ Second Step ☒ Annual

☐ 6 Month ☐ Post TB Exposure ☐ Credentials

Your skin test **MUST BE READ** within 48-72 hours and must be read by one of the following designated readers:

☒ 1) Employee Health M-F 8a-4p

☐ 2) Hospital Laboratory First Floor Everyday **3:00p-7:00a**

DO NOT REPORT TO LABORATORY BEFORE 3pm or After 7am

☐ 3) Infection Control M-F 8:30-3:00pm

☐ 4) Nursing Services Supervisors M-F 3:30p-7a & Sat & Sun 24 hours

FAILURE TO RETURN FOR SKIN TEST READING WILL RESULT IN ADDITIONAL SKIN TESTING.

SANOFI PASTEUR-Tubersol ☐ Other Boehr

Lot # 3000 434A Expiration Date 06/2015

YOU MUST HAVE THIS FORM WITH YOU WHEN THE SKIN TEST IS READ ON:

Sat. 12/21 OR Sun. 12/22

THIS DOCUMENT CONTAINS NO INFORMATION THAT IS UNLAWFUL TO REPRODUCE OR TRANSMIT IN ANY MANNER

Carol Stewart, C.R.N.P.
Lic. #1-045437
Rx: 1178

AUBURN MONTGOMERY
STUDENT HEALTH CENTER
P. O. Box 244023
Montgomery, AL 36124-4023
(334) 244-3281

Ramona Lazenby, C.R.N.P.
Lic. #1-039092
Rx: 0703

Darlene Pierce, C.R.N.P.
Lic. #1-134315
RX: 3692

Maryluz Fuentes, M.D.
(334) 286-3444
DEA #BF 6451520
AL #24127

Name Omanda Reed Date 4-23-13

Address _____

R Levexa 20mg
30
sig: + q. o. d.
L. Fuentes
M.D. or C.R.N.P.

Product Selection Permitted

Label all prescriptions

Refill: 2 3 5 PRN NR

Dispense As Written

M.D. or C.R.N.P.

C. Stewart, C.R.N.P.
Lic. #1-045437
Rx: 1178

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Lic. #1-134315
RX: 3692

Maryluz Fuentes, M.D.
(334) 286-3444
DEA #BF 6451520
AL #24127

Name

Omaria Reed

Date

3-27-13

Address

Rx

Went to 40 mg
Dose: 30
Sig: Take 1 tablet
45 min before bedtime
M.D. or C.R.N.P.

Product Selection Permitted

Label all prescriptions

Refill: 1 2 3 5 PRN NR

Dispense As Written

M.D. or C.R.N.P.

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Lic. #1-134315
RX: 3692

Maryluz Fuentes, M.D.
(334) 286-3444
DEA #BF 6451520
AL #24127

Name

Omaria Reed

Date

3-27-13

Address

Rx

Went to 20 mg
Dose: 30
Sig: Take 1 tablet
45 min before bedtime
M.D. or C.R.N.P.

Product Selection Permitted

Label all prescriptions

Refill: 1 2 3 5 PRN NR

Dispense As Written

M.D. or C.R.N.P.

**AUM NURSING CARE CENTER
PROBLEM VISIT RECORD**

DATE: 3/27/13 TIME: 1050 PT. HISTORY REVIEWED/UPDATED: 1 / 1
 PATIENT NAME: Amanda Reed DOB: _____ AGE: _____

PRESENT COMPLAINT: Wants to add or D antidepressant. Ad And needs something for anxiety; yesterday felt like she may pass out while validating 4345

MEDICATIONS: Wellbutrin SR 150 BID & Dr. May LMP: 4 days ago

Temp	Pulse	Resp	BP	HT	WT	Allergies
	<u>73</u>		<u>115/74</u>	<u>650</u>	<u>248.0</u>	<u>Clindamycin</u>

INITIAL VISIT 41.3

INITIAL VISIT	RETURN VISIT
Skin <u>stated 2nd and 3rd</u>	
Sinuses <u>laying not lately</u>	<u>4-23-13</u>
Ears <u>very not lately</u>	<u>102/71 HR 69</u>
Eyes <u>weakened at 2nd visit</u>	<u>Dairy was 2</u>
Nose <u>very Becomes very</u>	<u>Loose</u>
Throat <u>in 1st visit during</u>	<u>Dated was</u>
Neck/Back <u>of 1st visit</u>	<u>ag 2nd visit</u>
Heart <u>performed evaluation</u>	<u>prior to</u>
Lungs	<u>"Loose - 2nd</u>
Abdomen	<u>and 2nd</u>
GU/GI	<u>of 1st visit</u>
Extremities	<u>happened</u>
	<u>was cont.</u>
	<u>meds</u>
	<u>re-evaluated</u>
	<u>in 2 mo.</u>

DIAGNOSIS:	TESTS	RESULTS
<u>Depression</u>		
<u>Anxiety (performed)</u>		

PLAN:
 1) Cont. Wellbutrin
 2) Loose 2nd visit
 3) Loose 4th visit
45 min prior to
event

PRACTITIONER SIGNATURE: Least report, m STAFF SIGNATURE: Byon

AUDIT DATE: _____ COMMENTS: _____

PHYSICIAN SIGNATURE: _____



BlueCross BlueShield
of Alabama

BLUE CROSS
PREFERRED
CARE

Subscriber Name
AMANDA L REED
Contract Number
PPA863421182

BAPTIST HEALTH

Group Number 77496
Effective Date 01-01-2013
Rx BIN Number 004915

HEALTH

PAC

PPO Rx

Medical providers file claims
and direct questions about claim
payments to the local Blue Cross
and/or Blue Shield Plan.

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number for prescription drugs
and file the claim to Blue Cross
and Blue Shield of Alabama.

Blue Cross and Blue Shield of
Alabama provides administrative
services only and does not
assume any financial risk for
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www.bcbsal.com

Member Customer Service: 1 800 292-8868
PPO Provider Locator: 1 800 810-2583
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Provider Benefits/Eligibility: 1 800 517-6425
Pharmacist: 1 800 216-9920

Blue Cross and Blue Shield of Alabama
450 Riverchase Parkway East
Birmingham, Alabama 35244
An Independent Licensee of the
Blue Cross and Blue Shield Association.

10C003-032

Healthcare Provider



Amanda Reed

This card certifies that the above individual has successfully completed the cognitive and skills evaluations in accordance with the curriculum of the American Heart Association BLS for Healthcare Providers (CPR and AED) Program.

11-16-2012

Issue Date

11-2014

Recommended Renewal Date

↑
PEEL
HERE
↑

Training Center Name Empact Southeast Alabama TC ID # AL04282

TC Info 2323 West Main Street, Suite 223 Dothan, AL 36301 ZIP (334) 793-7789

Course Location Montgomery, AL

Instructor Name Arlene Morris Inst ID # (03112315476)

Holder's Signature

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This card contains unique security features to protect against forgery.



AUBURN

MONTGOMERY

Auburn Montgomery Student Health Services

F A C S I M I L E

TO:

FROM:

COMPANY:

DATE:

FAX NUMBER:

TOTAL NO. PAGES, INCLUDING COVER:

PHONE NUMBER:

SENDER'S REFERENCE NUMBER:

RE:

CC:

☐ URGENT

☐ FOR REVIEW

☐ PLEASE COMMENT

☐ PLEASE REPLY

☐ PLEASE RECYCLE

NOTES/COMMENTS:

Auburn University Montgomery
P. O. Box 244023
7461 East Drive
Montgomery, AL 36124
(334) 244-3281

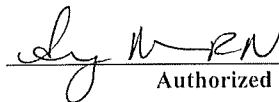
Immunization Record

Reed, Amanda

Printed On: 12/13/2012

Student No.:	S00198008	Student Status:		School:	04
Gender:	Female	Class:		Enrollment:	8/10/2012
Date of Birth:	8/7/1980	Standing:			

CPT	Description	Imm Date	Results	Measurement	Waiver
	Hepatitis B Dose #1	12/22/2006			
	Hepatitis B Dose #2	01/18/2007			
	Hepatitis B Dose #3	06/28/2007			
	Hepatitis B Surface Antibody Titer	08/20/2007	Positive		
	Mantoux Test	06/13/2012	Negative	0mm	
	Mantoux Test	11/14/2012	Negative	0mm	
	Mantoux Test	11/16/2012	Negative	0mm	
	MMR Dose #1	02/10/1982			
	MMR Dose #2	04/29/1991			
	Tetanus, Diphtheria, Pertussis (TDaP)	03/10/2009			
	Varicella IgG Titer	11/07/2012	Positive	154.9 Immune	


Authorized Signature

12/13/12
Date

AUBURN UNIVERSITY MONTGOMERY
STUDENT HEALTH CENTER
IRMA B. MOORE HALL RM. 102
P.O. BOX 244023
MONTGOMERY, AL 36124-4023

AUBURN UNIVERSITY MONTGOMERY

STUDENT HEALTH CENTER

P.O. Box 244023

Montgomery AL 36124

7461 East Drive 36117

Office (334) 244-3281 Fax (334) 244-3396

This is to verify that a copy of the following records and/pr lab results were given to

X Amanda L. Reed on 12-13-12

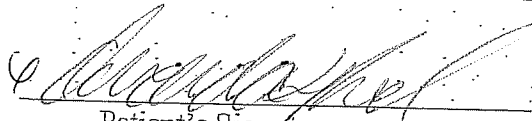
Print Patient's Name

Date

(Description of records(s) copied: TB skin test results

copied and faxed to Baptist Employee Health

Fax # 334-286-2494 Phone # 286-2739



Patient's Signature

4 12-13-12

Date

**AUM NURSING CARE CENTER
PHYSICAL EXAMINATION RECORD**

DATE: 11/7/12 TIME: 13/40

PATIENT NAME: Amanda Reed DOB: 8/7/80 AGE: 32

PRESENTATION: PE for SON -> Facial reconstructive surgery / genetic deformation. Last Pap - Feb 2012 Normal
S- deficiency

MEDICATIONS: Crestor, BCP, wellbutrin, nexium LMP: 10/12/12

Temp	Pulse	Resp	B/P	HT	WT	VISION SCREENING	Allergies
98.7	70		134/86	5'4"	253	OD: 20/20 OS: 20/20	clindamycin -

PHYSICAL EXAMINATION: 5'4" wears contacts Bell peppers

SYSTEM	NORMAL	SIGNIFICANT FINDINGS	INTERVENTIONS
Sinuses	✓		<u>CONTRACEPTIVE COUNSELING</u>
Eyes	✓		
Ears	✓		
Nose	✓		
Throat	✓		
Neck/Back	✓		
Heart	✓	<u>5'5" 3cm</u>	
Lungs	✓		
Abdomen	✓		
GU/GI			
Extremities	✓		

	NORMAL	FEMALE		NORMAL	MALE
Ext. Genitalia			Ext. Genitalia		
Vagina			Prostate		
Cervix			Testicles		
Bi-manual			Rectum		
Rectum			Breasts		
Breasts		Self Breast Exam taught: Yes No	Self Testicular Exam taught: Yes No		

TB(PPD-Mantoux) 0.1ml ID STEP 1 Lot # <u>C8994AA</u> MFR: <u>50</u> Date: <u>11/7/12</u> Results: <u>0</u> STEP 2 Lot # <u>C4175AA</u> MFR: <u>50</u> Date: <u>11/14/12</u> Results: <u>0</u>		URINALYSIS: Sp. Gr. <u>1.020</u> Nitrite <u>0</u> pH <u>5</u> Protein <u>0</u> Leuk <u>+1</u> Glucose <u>0</u>		Ketones <u>0</u> Urobil. <u>0</u> Bili. <u>0</u> Blood <u>trace</u>	LAB TESTS: Hgb/Hct Rubella VDRL	PAP GC Chlamydia Wet Prep	KOH UCG FSBS <u>Varicella</u>
--	--	--	--	--	---	------------------------------------	--

ASSESSMENT / PLAN: A: 2nd trimester normal exam
except for ut. Resuscitated
need to cont. diet: splenic

SIGNATURE: [Signature] PRACTITIONER SIGNATURE: [Signature] STAFF