

# AUM STUDENT HEALTH CENTER

## PATIENT INFORMATION (PLEASE PRINT)

Date: 3/23/17 Are you an AUM student? ☒ YES ☐ NO Student ID # 00325473

Name: Daniel Oran Burton

Social Security Number: 421-49-7910 Birth Date: 4/2/1999

Local Phone Number: 334-313-7688 Alternate Number: 334-538-5404

Local Address: 373 Wetumpka St. Box Number: \_\_\_\_\_

City: Prattville State: AL Zip Code: 36067

Permanent Address: Same as above

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: N/A Work #: \_\_\_\_\_

☒ Parent's or Spouse's Name (Circle which) ROBERT BURTON Phone #: 334-538-5404

Parent's or Spouse's Employer: self-employed Work #: 334-365-2686

Emergency Contact: Sharon Burton Relationship: Mother Phone #: 334-546-9011

How 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 Medi-Share Name on Card DANIEL BURTON

Policy Number 12603843527 Group Number \_\_\_\_\_

Insurance Company Address P.O. Box 981652, El Paso, TX 79998

AUM STUDENT HEALTH CENTER  
CONSENT FOR SERVICES FORM

Patient Name Daniel Burton

Date of Birth 4/2/1999

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.

Daniel O. Burton  
Signature of Patient

3/23/17  
Date of Signature

\_\_\_\_\_  
Signature of Legal Representative (if patient unable to sign)

\_\_\_\_\_  
Relationship to Patient

## 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 HIPPA 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 23 day of March 2017

Print Patient Name Daniel Burton

Signature Daniel Burton

Relationship to Patient \_\_\_\_\_

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

Name: Daniel Burton Date of Birth: 3 / 23 / 17

**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 \_\_\_\_\_

☐ Child(ren) \_\_\_\_\_

☒ Other Parents Bob + Sharon Burton

☐ 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: \_\_\_\_\_

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) anytime between (time) \_\_\_\_\_

Signed: Daniel Burton Date: 3 / 23 / 17

# AUM Student Health Services

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

PAST/CURRENT PERSONAL MEDICAL HISTORY: Have YOU EVER had any of the following?

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

☐ NO Significant Health Problems

List Medications: \_\_\_\_\_

## Allergies

Have you ever had an allergic reaction? ☐ Yes ☒ No

Medication Allergies: N/A

Food Allergies: N/A

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

## Other History

☐ Previous Hospitalizations \_\_\_\_\_

☐ OTHER Health Problems \_\_\_\_\_

Does 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)            |        |        |          | Prostate     |
| Diabetes                             |        |        |          |              |
| Drug Dependency                      |        |        |          |              |
| Heart Disease                        |        |        |          |              |
| High Blood Pressure                  |        |        |          |              |
| High Cholesterol                     |        |        |          |              |
| Mental Illness                       |        |        |          |              |
| Stroke                               |        |        |          |              |
| Sudden Cardiac Arrest (under age 50) |        |        |          |              |
| Other (Please explain)               |        |        |          |              |
| Parent Deceased                      |        |        |          |              |

### What is your gender?

- ☐ Female  
☒ Male  
☐ Transgender  
☐ Other

### What is your sexual orientation?

- ☒ Heterosexual (Straight)  
☐ Gay or Lesbian  
☐ Bisexual  
☐ Other

### Abuse History

As violence is a problem in many families, we ask these questions to ALL patients.

- Verbal Abuse ☐ Yes ☒ No  
Physical Abuse ☐ Yes ☒ No  
Sexual Abuse ☐ Yes ☒ No

### Drug History

Do you take recreational drugs?

- ☐ Yes ☒ No

How much? \_\_\_\_\_ How often? \_\_\_\_\_ What type? Marijuana Cocaine Meth Heroin Spice Other \_\_\_\_\_

### Sexual History

Sexually active? ☐ Yes ☒ No ☐ Not currently

Partners ☐ Male ☐ Female ☐ Both

Birth Control/Protection - Please circle:

Abstinence Birth Control Pills Cervical Cap Condom Diaphragm Implant Injection IUD Patch

Post-menopausal Rhythm Spermicide Sponge Surgical Vaginal Condom Withdrawal Other see comments None

Last Menstrual Cycle \_\_\_\_\_ Last PAP \_\_\_\_\_ Normal Abnormal (Circle)

Comments:

### Tobacco Use History

- ☐ Current every day  
☐ Current some days  
☐ Former smoker  
☐ Heavy tobacco smoker  
☐ Light tobacco smoker  
☒ Never smoker  
☐ Passive smoker - never smoked

Please circle:

Type used: Cigarettes Pipe Cigars Hookah E-cigs Chew

Packs/day: 0.25 0.5 1 1.5 2 3

Years: 0.5 1 2 2 4 5 10

### Alcohol Use History

- ☐ Current every day  
☐ Current some days  
☐ Former drinker  
☐ Heavy drinker  
☐ Social drinker  
☒ Never drinks

Please circle:

Type used: Beer Wine Liquor

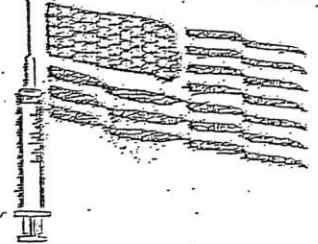
Drinks/day: 0.25 0.5 1 1.5 2 3 4 5

Years: 0.5 1 2 2 4 5 10

# ADOLESCENT & ADULT IMMUNIZATION RECORD

CLINIC:

Protect Our Future!



Name: Daniel Burton

Date of birth: 4/2/1999 Record # \_\_\_\_\_

Allergies: \_\_\_\_\_ Reactions: \_\_\_\_\_

History of Chickenpox? YES or NO If yes, date if known: \_\_\_\_\_

Immunize!

| Vaccine                   | Date Admin |     |    | Age at<br>the time | VIS Form Given |    |    | Manuf<br>Abbr* | Lot<br>Number | Dose  | Admin<br>Site** | Route | Provider Initials*** or<br>Outside Provider Name |
|---------------------------|------------|-----|----|--------------------|----------------|----|----|----------------|---------------|-------|-----------------|-------|--------------------------------------------------|
|                           | Mo         | Day | Yr |                    | Type           | Mo | Yr |                |               |       |                 |       |                                                  |
| Td                        |            |     |    |                    | Td             |    |    |                |               | 0.5cc |                 | IM    |                                                  |
| Td                        |            |     |    |                    | Td             |    |    |                |               | 0.5cc |                 | IM    |                                                  |
| Td                        |            |     |    |                    | Td             |    |    |                |               | 0.5cc |                 | IM    |                                                  |
| Td                        |            |     |    |                    | Td             |    |    |                |               | 0.5cc |                 | IM    |                                                  |
| Tdap                      |            |     |    |                    | Tdap           |    |    |                |               | 0.5cc |                 | IM    |                                                  |
| Hep B                     |            |     |    |                    | Hep B          |    |    |                |               |       |                 | IM    |                                                  |
| Hep B                     |            |     |    |                    | Hep B          |    |    |                |               |       |                 | IM    |                                                  |
| Hep B                     |            |     |    |                    | Hep B          |    |    |                |               |       |                 | IM    |                                                  |
| Hep B (booster if needed) |            |     |    |                    | Hep B          |    |    |                |               |       |                 | IM    |                                                  |
| MMR Rubella Rubeola       |            |     |    |                    | MMR            |    |    |                |               | 0.5cc |                 | SQ    |                                                  |
| MMR Rubella Rubeola       |            |     |    |                    | MMR            |    |    |                |               | 0.5cc |                 | SQ    |                                                  |
| Varicella                 |            |     |    |                    | Var            |    |    |                |               | 0.5cc |                 | SQ    |                                                  |
| Varicella                 |            |     |    |                    | Var            |    |    |                |               | 0.5cc |                 | SQ    |                                                  |
| IPV                       |            |     |    |                    | Polio          |    |    |                |               | 0.5cc |                 | SQ    |                                                  |
| IPV                       |            |     |    |                    | Polio          |    |    |                |               | 0.5cc |                 | SQ    |                                                  |
| IPV                       |            |     |    |                    | Polio          |    |    |                |               | 0.5cc |                 | SQ    |                                                  |
| IPV                       |            |     |    |                    | Polio          |    |    |                |               | 0.5cc |                 | SQ    |                                                  |
| PPV23                     |            |     |    |                    | PPV            |    |    |                |               | 0.5cc |                 | IM    |                                                  |
| PPV23                     |            |     |    |                    | PPV            |    |    |                |               | 0.5cc |                 | IM    |                                                  |
| Hepatitis A               | 4          | 25  | 17 | 18                 | Hep A          | 7  | 16 | ESK N2D79      |               | 0.5   | LD              | IM    | AM                                               |
| Hepatitis A               |            |     |    |                    | Hep A          |    |    |                |               |       |                 | IM    |                                                  |
| HPV                       |            |     |    |                    | HPV            |    |    |                |               | 0.5cc |                 | IM    |                                                  |
| HPV                       |            |     |    |                    | HPV            |    |    |                |               | 0.5cc |                 | IM    |                                                  |
| HPV                       |            |     |    |                    | HPV            |    |    |                |               | 0.5cc |                 | IM    |                                                  |
| Influenza                 |            |     |    |                    | Flu            |    |    |                |               | 0.5cc |                 | IM    |                                                  |
| Influenza                 |            |     |    |                    | Flu            |    |    |                |               | 0.5cc |                 | IM    |                                                  |
| Influenza                 |            |     |    |                    | Flu            |    |    |                |               | 0.5cc |                 | IM    |                                                  |
| MCV4                      |            |     |    |                    | Mening         |    |    |                |               |       |                 | IM    |                                                  |
| MPSV4                     |            |     |    |                    | Mening         |    |    |                |               |       |                 | SQ    |                                                  |

\* Manufacturers: M=Merck; S=Sanofi Pasteur; W=Wyeth; G=GlaxoSmithKline

\*\*Sites: LT=Left Thigh, RT=Right Thigh, LA=Left Arm, RA=Right Arm, LD=Left Deltoid, RD=Right Deltoid

\*\*\*VIS Language given, if not English: \_\_\_\_\_

### \*\*\*Provider Information

[illegible]

## Tuberculin Test

[illegible]

### Titer Test Results for Non Susceptibility (IgM)

[illegible][illegible]

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) 286-3444  
DEA #BF 6451520  
AL #24127

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

Date 4/25/17

Name

Daniel Burton

Address

R

Vivotif

Disp: 4

Sig: Take as directed.

Product Selection Permitted

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

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

Label all prescriptions

Refill: 1 2 3 5 PRN

Dispense As Written

Salmonella Typhi (S Typhi), the bacterium that causes typhoid fever; only people who work in a laboratory with S Typhi.

Not everyone who takes Vivotif will be fully protected against typhoid fever. Therefore, you should continue to take precautions against typhoid fever exposure. Vivotif does not protect against other *Salmonella* species or other bacteria that cause disease of the gastrointestinal tract. Vivotif should not be used to treat infections with S Typhi.

#### Important Safety Information

Do not take Vivotif if:

- You are allergic (hypersensitive) to any of the ingredients contained in Vivotif
- You have a poor immune system for any reason
- You have an infection with a high temperature
- You have an acute gastrointestinal illness

Tell your health care professional if you are taking or have recently taken any other medicines. This is because Vivotif can affect the way some medicines work and some medicines can affect the way Vivotif works. In particular, tell your health care professional if you are taking antibiotics or medicines to prevent malaria. Postpone taking Vivotif if persistent diarrhea or vomiting is occurring. It is essential that all 4 doses of vaccine be taken at the prescribed alternate day interval to obtain a maximal protective immune response. In clinical trials, the most common side effects observed were abdominal pain, nausea, headache, fever, diarrhea, vomiting, and skin rash.

Report any serious adverse reactions to your health care professional. You may also report an adverse reaction directly to the Vaccine Adverse Event Reporting System at 1-800-822-7967 or <http://vaers.hhs.gov>.

For more information about Vivotif, please see accompanying full Prescribing Information.

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PAX-US-0035 | FEB 2016

PaxVax

reaction to this drug is rare. However, seek immediate medical attention if you notice any symptoms of a serious allergic reaction, including: rash, itching/swelling (especially of the face/tongue/throat), severe dizziness, trouble breathing. This is not a complete list of possible side effects. If you notice other effects not listed above, contact your doctor or pharmacist. Contact your doctor for medical advice about side effects. The following numbers do not provide medical advice, but in the US, you may report side effects to the Vaccine Adverse Event Reporting System (VAERS) at 1-800-822-7967. In Canada, you may call Health Canada at 1-866-234-2345.

**OVERDOSE:** If overdose is suspected, contact a poison control center or emergency room immediately. US residents can call the US National Poison Hotline at 1-800-222-1222. Canada residents can call a provincial poison control center.

SULE - ORAL (TIE-foyd)

used by a certain bacteria  
and or drinking contaminated  
traveling to areas where  
Africa, Asia), who are exposed  
in a laboratory. Typhoid  
the body to produce its own

from your health care provider before  
tions, consult your health care provider. Before taking each  
sure it is completely sealed. Carefully open the blister pack and  
damaged. Consult your pharmacist if the foil blister pack or  
on by mouth without food, usually every other day for 4 doses or  
capsule whole with cold or barely warm liquid about 1 hour before  
and swallow with the liquid immediately. Do not chew, crush, or  
the dosing schedule closely for the vaccine to be most effective.  
far to keep track of when to take your next dose. You should  
at least 1 week before possible exposure to typhoid fever. You may  
at risk for typhoid fever after 5 years. Ask your doctor or

is effect persists or worsens, tell your doctor or pharmacist  
is prescribed this medication because he or she has judged that  
of side effects. Many people using this medication do not have

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

Name Daniel Burton Date 4/25/17  
Address \_\_\_\_\_

R

Malarone 250/100mg

Disp: 17

Sig: Take one pill a day. Begin 2 days before  
departure, continue through stay and  
for 7 days after return.

L. Stewart, M.D. or C.R.N.P.

Product Selection Permitted

Dispense As Written

Label all prescriptions

Refill: 1 2 3 5 PRN NR