

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 Erin Rabbey Date 5-13-15  
Address \_\_\_\_\_

R Prochlorperazine 5 mg dose  
# 1  
30 x 1 per as directed

LaStewart M.D. or C.R.N.P.  
Product Selection Permitted

Label all prescriptions

Refill: 1 2 3 5 PRN NR

Dispense As Written

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Lic. #1-039092  
Rx: 0703

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

Name Erin Rabbey Date 5-13-15  
Address \_\_\_\_\_

R azithromycin 250 mg  
2 per  
30 x 1 per as directed

LaStewart 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: 5/13/15 TIME: 1500 PT. HISTORY REVIEWED / UPDATED: 1 / 1

PATIENT NAME: Erin Reilly DOB: \_\_\_\_\_ AGE: \_\_\_\_\_

PRESENT COMPLAINT: Symptoms began almost 2 wks ago. (+) congestion  
(+) drainage, fatigue, sinus HA. Drainage is beg. become  
green, thicker. No known fever. (+) cough, (+) night sweats

EDICATIONS: Sudafed, Mucinex, Dayquil, Saline LMP: Hyd

| Temp        | Pulse     | Resp | B/P           | HT          | WT           | Lavage | Allergies   |
|-------------|-----------|------|---------------|-------------|--------------|--------|-------------|
| <u>98.6</u> | <u>76</u> |      | <u>114/82</u> | <u>62.5</u> | <u>138.1</u> |        | <u>NKMA</u> |

Flonase, 2 dofs 100mg, wellbutrin XL 150mg, Ambien 5mg

| INITIAL VISIT                                                                                                                                                                                                                                                                                                                                                                                                                       | RETURN VISIT |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|
| <p>Skin <u>Difficultly sleeping (not unusual).</u></p> <p>Sinuses <u>(+) tenderness over</u></p> <p>Ears <u>(+) redness, (+) JTD</u></p> <p>Eyes <u>Clear Pink</u></p> <p>Nose <u>Longest</u></p> <p>Throat <u>(+) redness, (+) expector</u></p> <p>Neck/ Back <u>(+) aching - back</u></p> <p>Heart <u>5' 5" 50</u></p> <p>Lungs <u>Clear Pink, (+) cough</u></p> <p>Abdomen <u>non-tender</u></p> <p>GU/GI</p> <p>Extremities</p> |              |

| DIAGNOSIS:      | TESTS | RESULTS |
|-----------------|-------|---------|
| <u>Rhinitis</u> |       |         |
|                 |       |         |
|                 |       |         |

PLAN: 1) Azithromycin 250mg  
2) Prednisone 5mg  
do as pk. 6 days

CALL BACK: 5/18/15 @ 1145. Pt states she  
is beginning to feel better @  
this time. AM

PRACTITIONER SIGNATURE: Latane, CRNP STAFF SIGNATURE: Byron

AUDIT DATE: \_\_\_\_\_ COMMENTS: \_\_\_\_\_

PHYSICIAN SIGNATURE: \_\_\_\_\_

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

Name \_\_\_\_\_

Address

R

~~maazing~~ 25  
# 60



The image shows a document page that has been almost entirely redacted with large, thick black ink scribbles. Only fragments of text are visible, including what appears to be a header with the word "MEMORANDUM" and several lines of body text that are mostly illegible due to the heavy blacking out.

$\frac{1}{2} \cdot 0 + 2 \cdot 0 = 0$

Letter 27

**Label all prescriptions**

Refill: 1 2 3 5 PRIN NR

Product Selection Permitted

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

## Dispense As Written

\_\_\_\_\_, M.D. or C.R.N.P.

**AUM NURSING CARE CENTER  
PROBLEM VISIT RECORD**

DATE: 1-30-15 TIME: 11:30 AM PT. HISTORY REVIEWED / UPDATED

PATIENT NAME: Enin Reilly DOB: \_\_\_\_\_ AGE: \_\_\_\_\_

PRESENT COMPLAINT: yo dizzy & nausea particularly  
with movement / changing  
position. began past night

| MEDICATIONS: |       |      |               |    |    | LMP:        |
|--------------|-------|------|---------------|----|----|-------------|
| Temp         | Pulse | Resp | B/P           | HT | WT | Allergies   |
|              |       |      | <u>136/86</u> |    |    | <u>NKMA</u> |

| INITIAL VISIT |       | RETURN VISIT |
|---------------|-------|--------------|
| Skin          |       |              |
| Slituses      |       |              |
| Ears          |       |              |
| Eyes          |       |              |
| Nose          |       |              |
| Throat        |       |              |
| Neck/ Back    |       |              |
| Heart         |       |              |
| Lungs         |       |              |
| Abdomen       |       |              |
| GU/GI         |       |              |
| Extremities   |       |              |
|               |       |              |
|               |       |              |
|               |       |              |
| DIAGNOSIS:    | TESTS | RESULTS      |
| <u>BPPV</u>   |       |              |
|               |       |              |
|               |       |              |

PLAN: meclizine 25mg  
po tid prn  
educational material  
provided.

CALL BACK: 2/2/15. left message to call & Hx. @  
2/2/15. Ph returned call, state  
she is much better today. @

PRACTITIONER SIGNATURE: [Signature] STAFF SIGNATURE: \_\_\_\_\_

AUDIT DATE: \_\_\_\_\_ COMMENTS: \_\_\_\_\_

PHYSICIAN SIGNATURE: \_\_\_\_\_

# AUBURN MONTGOMERY

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

Stacey E. White, C.R.N.P.  
Lic. #1-077155  
RX: 1501

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

Name Enin R. Lopez Date 11-3-11

Address \_\_\_\_\_

Rx

*Augmentin 500mg*  
*#20*  
*sig: 1 po BID x 10 d*

*[Signature]* M.D. or C.R.N.P.

Label all prescriptions

Refill: 1 2 3 5 PRN NR

Product Selection Permitted

Dispense As Written \_\_\_\_\_ M.D. or C.R.N.P.

1/27/12 @ 12:00 - Pt called requesting refills of  
1) Wellbutrin XL 150mg ÷ po QD disp 30  
Refill 5x.  
2) Flonase  
168  
sig 11 5 sprays in each nostril QD. Refill 5x.  
called into Walgreens pharmacy on Atl Hwy  
@ 409 0611 AM

*[Signature]*, NP

AUM NURSING CARE CENTER  
PROBLEM VISIT RECORD

DATE: 11-3-11 TIME: 3:35 PT. HISTORY REVIEWED / UPDATED 1/1  
PATIENT NAME: Erin Raudy DOB:                      AGE:               
PRESENT COMPLAINT: c/o dizziness from 10/11

PRESENT COMPLAINT: 100% pain from K. Throat part right  
(throat) Began swelling  
throat and swelling

**INDICATIONS:** Cataract - L. cataract - R. cataract

| Temp | Pulse | Resp | B/P | HT | WT | Allergies |
|------|-------|------|-----|----|----|-----------|
|      |       |      |     |    |    | NKMA      |

## INITIAL VISIT

SKIN: Distal portion of (R) index

|         |          |
|---------|----------|
| Sinuses | Anterior |
|---------|----------|

Ears Heaven, Under, Warm

Eyes to touch, Two ~~small~~ small

Nose puncture & wounds noted

Throat

Neck/Back

Heart

|       |  |
|-------|--|
| Lungs |  |
|-------|--|

|         |  |
|---------|--|
| Abdomen |  |
|---------|--|

|       |  |
|-------|--|
| GU/GI |  |
|-------|--|

Extremities \* Stalled part Tetanus

was written 10 years

*[Faint, illegible text from bleed-through]*

|                                                                            |  |       |         |
|----------------------------------------------------------------------------|--|-------|---------|
| DIAGNOSIS:                                                                 |  | TESTS | RESULTS |
| <p>1. <u>Chronic</u></p> <p>2. <u>Chronic</u></p> <p>3. <u>Chronic</u></p> |  |       |         |

|  |  |  |
|--|--|--|
|  |  |  |
|--|--|--|

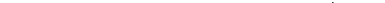
|                                  |  |  |
|----------------------------------|--|--|
| <p>           4. AL         </p> |  |  |
|----------------------------------|--|--|

CALL BACK: 50000 11/14/14 1:00 PM 1 of 1 stated line

BID X 10 days

ATC of not bearing

\_\_\_\_\_

ACTIONER  STAFF

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

DATE: \_\_\_\_\_ COMMENTS: \_\_\_\_\_

PHYSICIAN SIGNATURE \_\_\_\_\_

PREPARED BY AUC  
REVISED/ADOPTED 10/98

**AUM NURSING CARE CENTER  
PROBLEM VISIT RECORD**

DATE: 7/29/11 TIME: 1445 PT. HISTORY REVIEWED / UPDATED: 1 / 1

PATIENT NAME: Erin Reilly DOB: \_\_\_\_\_ AGE: \_\_\_\_\_

PRESENT COMPLAINT: Spot on (R) side of back, first noticed because of itching. ~ size of quarter. Noticed months ago. Has never resolved. Continues to itch. Has tried antiitch

EDICATIONS: Celebra, welbutrin, flonase LMP: \_\_\_\_\_

| Temp | Pulse | Resp | BP | HT | WT | Allergies   |
|------|-------|------|----|----|----|-------------|
|      |       |      |    |    |    | <u>OKMA</u> |

**INITIAL VISIT**

|                                                         |                     |
|---------------------------------------------------------|---------------------|
| Skin <u>creams 5 results. Has stayed same size. Not</u> | <b>RETURN VISIT</b> |
| sinuses <u>raised.</u>                                  |                     |
| Ears                                                    |                     |
| Eyes <u>Swim : ~ 1 1/2 cm</u>                           |                     |
| Nose <u>any intermittent pruritus</u>                   |                     |
| Throat <u>on (R) posterior shoulder</u>                 |                     |
| Neck/Back <u>of scapula, of lateral</u>                 |                     |
| Heart <u>beating, no other</u>                          |                     |
| Lungs <u>respiratory noted.</u>                         |                     |
| Abdomen                                                 |                     |
| GU/GI                                                   |                     |
| Extremities                                             |                     |

| DIAGNOSIS:        | TESTS | RESULTS |
|-------------------|-------|---------|
| <u>dermatitis</u> |       |         |
|                   |       |         |
|                   |       |         |

PLAN: Hydrocortisone cream  
2.5% tid  
RTC if not resolving

CALL BACK: \_\_\_\_\_

HYDROCORTISONE 2.1  
NDC# 51672-3003-2  
LOT# A1172  
01/31/2013  
30 GRAMS

PRACTITIONER SIGNATURE: [Signature]

STAFF SIGNATURE: [Signature]

AUDIT DATE: \_\_\_\_\_ COMMENTS: \_\_\_\_\_

PHYSICIAN SIGNATURE: \_\_\_\_\_

(45)

**AU Adult Screening and Immunization Documentation Form  
2009 H1N1 Influenza Monovalent Vaccination Program**

|                                         |                                                                     |
|-----------------------------------------|---------------------------------------------------------------------|
| <b>Patient Information:</b>             |                                                                     |
| Last Name: <u>Reilly</u>                | First Name: <u>Erin</u>                                             |
| Date of Birth: <u>2/4/64</u>            |                                                                     |
| AU Banner ID Number: <u>551 61 0512</u> | E-mail Address: <u>ereilly@auburn.edu</u> Phone #: <u>ext. 3586</u> |

| Please Carefully Read and Answer the Following Questions: (circle your answer) |                                                                                                                                                                                                                                                                                                                                                                                                        |                                                               |
|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|
| 1                                                                              | Are you between the ages of 10 and 49 years?                                                                                                                                                                                                                                                                                                                                                           | Yes <input checked="" type="radio"/> No <input type="radio"/> |
| 2                                                                              | If you are between the ages of 10 and 17 years, do you take aspirin or aspirin containing medications daily? (Please inform the healthcare provider of any medications you take daily so we can carefully screen for any aspirin containing products)                                                                                                                                                  | Yes <input type="radio"/> No <input type="radio"/>            |
| 3                                                                              | Have you received the 2009-2010 seasonal influenza vaccine? If so, did you receive the nasal _____ or injection <u>X</u> . How long has it been since this vaccination? <u>50</u> (days)                                                                                                                                                                                                               | Yes <input checked="" type="radio"/> No <input type="radio"/> |
| 4                                                                              | Do you currently feel sick or have a fever?                                                                                                                                                                                                                                                                                                                                                            | Yes <input type="radio"/> No <input checked="" type="radio"/> |
| 5                                                                              | Are you taking any prescription medications to prevent or treat influenza? (Amantadine, Rimantidine, Tamiflu®, Relenza®) Have you taken any antivirals in the past 48 hours?                                                                                                                                                                                                                           | Yes <input type="radio"/> No <input checked="" type="radio"/> |
| 6                                                                              | Have you ever had a serious reaction to the flu vaccine? Please describe: _____                                                                                                                                                                                                                                                                                                                        | Yes <input type="radio"/> No <input checked="" type="radio"/> |
| 7                                                                              | Do you have an allergy to any of the following: eggs, chicken or egg protein, gentamicin, gelatin, arginine, neomycin, polymyxin B, thimerosal, formaldehyde? List any allergies: _____                                                                                                                                                                                                                | Yes <input type="radio"/> No <input checked="" type="radio"/> |
| 8                                                                              | Do you have a chronic health problem such as: heart disease, lung disease, asthma, kidney disease, diabetes, anemia, or other blood disorder?                                                                                                                                                                                                                                                          | Yes <input type="radio"/> No <input checked="" type="radio"/> |
| 9                                                                              | Do you have an active neurological disease (a disease of the brain, nervous system, etc.)?                                                                                                                                                                                                                                                                                                             | Yes <input type="radio"/> No <input checked="" type="radio"/> |
| 10                                                                             | Do you have a history of Guillain-Barre Syndrome (GBS)?                                                                                                                                                                                                                                                                                                                                                | Yes <input type="radio"/> No <input checked="" type="radio"/> |
| 11                                                                             | Has your doctor ever told you that you have an immune system disorder? Are you currently taking long-term corticosteroids (prednisone, methylprednisolone, etc.); immunosuppressants; chemotherapy; biologic immune modulating medications such as Remicade®, Enbrel®, Humira®, etc? If you have an inflammatory condition such as arthritis, asthma, psoriasis, inflammatory intestinal disease, etc. | Yes <input type="radio"/> No <input checked="" type="radio"/> |
| <b>Please tell the healthcare provider now.</b>                                |                                                                                                                                                                                                                                                                                                                                                                                                        |                                                               |
| 12                                                                             | Do you have HIV, cancer, or have you received an organ transplant?                                                                                                                                                                                                                                                                                                                                     | Yes <input type="radio"/> No <input checked="" type="radio"/> |
| 13                                                                             | Do you live with, care for, or have close contact with anyone who is severely immunocompromised or someone who has to be in protective environment (such as transplant patients)?                                                                                                                                                                                                                      | Yes <input type="radio"/> No <input checked="" type="radio"/> |
| 14                                                                             | Have you received any vaccines in the past 30 days or do you plan to receive any vaccines in the next 4 weeks?                                                                                                                                                                                                                                                                                         | Yes <input type="radio"/> No <input checked="" type="radio"/> |
| 15                                                                             | Is there any chance that you are currently pregnant?                                                                                                                                                                                                                                                                                                                                                   | Yes <input type="radio"/> No <input checked="" type="radio"/> |
| 16                                                                             | Please list all of the medications that you currently take for any disease state (so the healthcare provider administering the vaccine can conduct a medication screening to ensure you are a candidate)?<br><u>Wellbutrin Ceflexa Flonase</u>                                                                                                                                                         |                                                               |

"I have read (or have had explained to me) the information in the 2009 H1N1 Influenza Monovalent Information Statement (VIS). I have also had an opportunity to ask questions and they were answered to my satisfaction. I understand the benefits and risks of the influenza vaccine, and I consent to receive the vaccine. I have also been provided a copy of the Auburn University Pharmaceutical Care Center (AUPCC) privacy policy for my review before vaccine administration and offered a copy for my records."

Signature: [Signature] Date: \_\_\_\_\_

| ASSESSMENT BY IMMUNIZATION CERTIFIED HEALTHCARE PROVIDER: |                                                    |                                                                                                                                                        |
|-----------------------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|
| ✓                                                         | Give <u>intranasal</u> Live H1N1 flu vaccine today | Vaccine Information Statement (VIS) Provided:<br>_____ Inactivated, H1N1 Influenza Monovalent Vaccine<br>_____ Live, H1N1 Influenza Monovalent Vaccine |
| ✓                                                         | Give <u>injectable</u> H1N1 flu vaccine today      | Interviewer's Signature: <u>Alissa Baldock</u> Date: <u>11-11-09</u>                                                                                   |
| ✓                                                         | Do NOT give either H1N1 vaccine today              |                                                                                                                                                        |

| DOCUMENTATION OF VACCINE ADMINISTRATION                                                                                                                                                                                            |                                                                                                                                                                                                                         |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Live Intranasal H1N1 Influenza (MedImmune)</b><br>NDC# 66019-200-10 Lot #: 500757<br>Expiration Date: January 25, 2010<br>Dose: 0.2 ml Route: <u>Intranasal</u><br>Administered By: <u>[Signature]</u><br>Date: <u>11-11-09</u> | <b>Inactivated H1N1 Influenza:</b><br>Manufacturer: (circle) Sanofi-Pasteur Novartis CSL<br>NDC# _____ Lot#: _____ Exp Date: _____<br>Dose: 0.5 ml Route: IM Site: Left/ Right Deltoid<br>Preceptor: <u>[Signature]</u> |

AUM NURSING CARE CENTER  
PROBLEM VISIT RECORD

DATE: 8/7/07 TIME: 1120 PT. HISTORY REVIEWED / UPDATED           /          /          

PATIENT NAME: Erin Reilly DOB: \_\_\_\_\_ AGE: \_\_\_\_\_

PRESENT COMPLAINT: P+ needing refill of Anaprox for cramps. Goes through a bottle about every 2 yrs. on

MEDICATIONS:

LMP:

| Temp | Pulse | Respn | B/P | HT | WT | Allergies |
|------|-------|-------|-----|----|----|-----------|
|      |       |       |     |    |    |           |

## INITIAL VISIT

Skin 5-14-08 330  
Sinuses Called 20 may #30 + 80  
Ears W added 150mg 1 p. 29  
Eyes Called into W  
Nose GTP Hwy 409-6144.  
Throat Continued at  
Neck/Back  
Heart  
Lungs 5/22/08  
Abdomen Pt called requesting a refill  
GU/GI of Anaprox. States it helps  
Extremities w. the cramping. — KRON  
Continued at

12/18/07 Requesting  
refill of Amproxi 1000

NAPROXEN SODIUM 550MG  
20 Tablets  
NDC: 51855-827-52  
Lot: H01250601  
Exp: 07/31/2009

2-25-08  
F. Donnell  
Regis x Le  
Landed into  
Loat-Haven  
P. Brown  
@ 409-Dell  
C. Stewart

NAPROXEN SODIUM 550MG  
20 Tablets  
NDC: 51855-827-52  
Lot: H01250601  
Exp: 07/31/2009

DIAGNOSIS: \_\_\_\_\_

## TESTS

## RESULTS

PLAN:

CALL BACK:

NAPROXEN SODIUM  
550MG  
30 Tablets  
NDC: 51855-827-24  
Lot: H01250501  
Exp: 03/31/2008

PRACTITIONER

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

## STAFF

SIGNATURE] 

AUDIT DATE: COMMENTS:

COMMENTS:

PHYSICIAN SIGNATURE: \_\_\_\_\_

PREPARED BY AUM NCC  
REVISED/ADOPTED 10/98

AUBURN UNIVERSITY MONTGOMERY

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

Vivian Hamlett, M.D.  
(334) 409-2800  
DEA #BH 1075197  
AL #13467

Maryluz Fuentes, M.D.  
(334) 265-5577  
DEA #BF 8451520  
AL #24127

Name Erin Rabbey Date 7-3-07

Address \_\_\_\_\_

Rx

Z: bromax 2 tabs  
Disp: 1  
Sig: 1 - see no directed  
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.

**AUM NURSING CARE CENTER  
PROBLEM VISIT RECORD**

DATE: 7-3-07 TIME: 12:00 PT. HISTORY REVIEWED / UPDATED \_\_\_\_\_

PATIENT NAME: Erin Rainey DOB: \_\_\_\_\_ AGE: \_\_\_\_\_

PRESENT COMPLAINT: 90 upper resp. symp. 13 wks  
has used etc med - now green  
discharge, pressure, pain  
from chest, upper abdomen, LMP: 2 wks ago

| Temp        | Pulse | Resp | B/P           | HT | WT | Allergies   |
|-------------|-------|------|---------------|----|----|-------------|
| <u>97.5</u> |       |      | <u>120/70</u> |    |    | <u>NKMD</u> |

| INITIAL VISIT |                                       |  |  |  |  | RETURN VISIT |
|---------------|---------------------------------------|--|--|--|--|--------------|
| Skin          |                                       |  |  |  |  |              |
| Slashes       | <u>(+) pressure over max RLL</u>      |  |  |  |  |              |
| Ears          | <u>TM's &amp; redness, &amp; eff.</u> |  |  |  |  |              |
| Eyes          | <u>Clear</u>                          |  |  |  |  |              |
| Nose          | <u>patent</u>                         |  |  |  |  |              |
| Throat        | <u>&amp; redness</u>                  |  |  |  |  |              |
| Neck/Back     | <u>&amp; cervical adenopathy</u>      |  |  |  |  |              |
| Heart         | <u>3'5" 3B</u>                        |  |  |  |  |              |
| Lungs         | <u>Clear</u>                          |  |  |  |  |              |
| Abdomen       |                                       |  |  |  |  |              |
| GU/GI         |                                       |  |  |  |  |              |
| Extremities   |                                       |  |  |  |  |              |

| DIAGNOSIS:        | TESTS | RESULTS |
|-------------------|-------|---------|
| <u>Diphtheria</u> |       |         |
|                   |       |         |
|                   |       |         |

PLAN: Amoxicillin 2p 11/07 - lgt over up to case  
rec. @  
11/07 - Pt. returned phone call,  
stated she feels much better. will  
RTE if need to. @

PRACTITIONER SIGNATURE: [Signature] STAFF SIGNATURE: \_\_\_\_\_

AUDIT DATE: \_\_\_\_\_ COMMENTS: \_\_\_\_\_

PHYSICIAN SIGNATURE: \_\_\_\_\_

DATE: 9-6-05 TIME: 10<sup>00</sup> PT. HISTORY REVIEWED / UPDATED           /          /          

PRESENT COMPLAINT: Onion & (L) index fungus

EDICATIONS: *has become red drawing powder + P.D. & P.D., P.D.* LMP:

| MEDICATIONS: |       |      |     |    |    | LMF       |
|--------------|-------|------|-----|----|----|-----------|
| Time         | Pulse | Resp | R/P | HT | WT | Allergies |
|              |       |      |     |    |    | NKMA      |

| INITIAL VISIT |  |
|---------------|--|
|               |  |

Skin : area on ② index finger RETURN VISIT

Species 7 3 mm area, very thermophilic

Enr ~~XXXXXXXXXX~~ ~~XXXXXX~~ ~~XXXXXX~~

XOLOLO  
DS + PO RD PRN #60  
to file Ad

Eyes purple 3 1 2 called me 396-8415 to Srefills

[illegible]

|           |  |
|-----------|--|
| Throat    |  |
| Neck/Back |  |

|           |  |
|-----------|--|
| Neck Back |  |
| Heart     |  |

|       |  |
|-------|--|
| Lungs |  |
|-------|--|

|         |  |
|---------|--|
| Abdomen |  |
|---------|--|

|       |
|-------|
| GU/GI |
|-------|

Extremities

---

|                                           | TESTS | RESULTS |
|-------------------------------------------|-------|---------|
| 1. <u>General appearance</u>              |       |         |
| 2. <u>Color</u>                           |       |         |
| 3. <u>Consistency</u>                     |       |         |
| 4. <u>Reaction to heat</u>                |       |         |
| 5. <u>Reaction to cold</u>                |       |         |
| 6. <u>Reaction to moisture</u>            |       |         |
| 7. <u>Reaction to acids</u>               |       |         |
| 8. <u>Reaction to alkalis</u>             |       |         |
| 9. <u>Reaction to organic solvents</u>    |       |         |
| 10. <u>Reaction to inorganic solvents</u> |       |         |
| 11. <u>Reaction to oxidizing agents</u>   |       |         |
| 12. <u>Reaction to reducing agents</u>    |       |         |
| 13. <u>Reaction to flame</u>              |       |         |
| 14. <u>Reaction to light</u>              |       |         |
| 15. <u>Reaction to air</u>                |       |         |
| 16. <u>Reaction to water</u>              |       |         |
| 17. <u>Reaction to oil</u>                |       |         |
| 18. <u>Reaction to grease</u>             |       |         |
| 19. <u>Reaction to dirt</u>               |       |         |
| 20. <u>Reaction to dust</u>               |       |         |
| 21. <u>Reaction to sand</u>               |       |         |
| 22. <u>Reaction to gravel</u>             |       |         |
| 23. <u>Reaction to rocks</u>              |       |         |
| 24. <u>Reaction to shells</u>             |       |         |
| 25. <u>Reaction to bones</u>              |       |         |
| 26. <u>Reaction to teeth</u>              |       |         |
| 27. <u>Reaction to nails</u>              |       |         |
| 28. <u>Reaction to tools</u>              |       |         |
| 29. <u>Reaction to machinery</u>          |       |         |
| 30. <u>Reaction to equipment</u>          |       |         |
| 31. <u>Reaction to structures</u>         |       |         |
| 32. <u>Reaction to vehicles</u>           |       |         |
| 33. <u>Reaction to aircraft</u>           |       |         |
| 34. <u>Reaction to ships</u>              |       |         |
| 35. <u>Reaction to submarines</u>         |       |         |
| 36. <u>Reaction to missiles</u>           |       |         |
| 37. <u>Reaction to weapons</u>            |       |         |
| 38. <u>Reaction to explosives</u>         |       |         |
| 39. <u>Reaction to chemicals</u>          |       |         |
| 40. <u>Reaction to biological agents</u>  |       |         |
| 41. <u>Reaction to nuclear agents</u>     |       |         |
| 42. <u>Reaction to space agents</u>       |       |         |
| 43. <u>Reaction to time</u>               |       |         |
| 44. <u>Reaction to space</u>              |       |         |

|                |       |           |
|----------------|-------|-----------|
| DIAGNOSIS:     | TESTS | TREATMENT |
| Directed wound |       |           |

|               |  |  |
|---------------|--|--|
| ② Index Range |  |  |
|---------------|--|--|

[illegible]

|       |            |                                 |
|-------|------------|---------------------------------|
| PLAY: | CALL BACK: | CEPHALEXIN 600MG<br>40 Capsules |
|-------|------------|---------------------------------|

1) Ref Dex 300mg  
1) 10 days

2) Keep under a Deer RTO if need to be

∴ done

PRACTITIONER SIGNATURE: \_\_\_\_\_

STAFF SIGNATURE: \_\_\_\_\_

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

ALERT DATE: \_\_\_\_\_ COMMENTS: \_\_\_\_\_

AUDIT DATE: \_\_\_\_\_ CONDUCTED BY: \_\_\_\_\_

PHYSICIAN SIGNATURE: \_\_\_\_\_

PREPARED BY: \_\_\_\_\_  
REVIEWED/ADOPTED: \_\_\_\_\_

CERTIFICATE FOR RETURN TO WORK / SCHOOL

Auburn University Montgomery  
Nursing Care Center  
Irma B. Moore Hall, Room 102  
(334) 244-3281

Name Erin Ruddy

was seen on 2-10-05 at 3:00 am ☒ pm

and is able to return to work / school on 2-14-05

Nature of illness or injury Viral Syndrome

☐ Restrictions ☐ Light work

Physical exertion: ☐ Limited ☒ Avoid x 3 Days

☐ Other

CRNP / RN Larry Stewart Date 2-10-05

Phone (334) 244-3281

Fax (334) 244-3243

6-27-05

Report of Latex allergy  
to #30 registered 5  
Called into Rita D. Rasmussen  
396-8415 @ 2:45 pm

Latex, CRNP

**AUM NURSING CARE CENTER  
PROBLEM VISIT RECORD**

DATE: 2/10/05 TIME: \_\_\_\_\_ PT. HISTORY REVIEWED / UPDATED: 2/4/04

PATIENT NAME: Erin Reilly DOB: \_\_\_\_\_ AGE: \_\_\_\_\_

PRESENT COMPLAINT: Symptoms began over the weekend, sore throat, congestion, HA, & taste or smell. No known allergen cough some sneezing

INDICATIONS: Danquil, Nyquil, Celebra, Flonase Wellbutrin LMP: 2/6/05

| Temp        | Pulse | Resp | B/P           | HT | WT | Allergies   |
|-------------|-------|------|---------------|----|----|-------------|
| <u>97.7</u> |       |      | <u>128/50</u> |    |    | <u>NKMA</u> |

**INITIAL VISIT**

| INITIAL VISIT                                  | RETURN VISIT                                                                                                                          |
|------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|
| Skin <u>W: D</u>                               | <u>2/21/05 @ 140 Pt reports "bad" HAs, sinus pressure, teeth hurting, greenish tinged mucus. T. 97.0 over all does not feel well.</u> |
| Sinuses <u>pressure</u>                        |                                                                                                                                       |
| Ears <u>tons</u>                               |                                                                                                                                       |
| Eyes <u>clear</u>                              |                                                                                                                                       |
| Nose <u>congested</u>                          |                                                                                                                                       |
| Throat <u>2+ red</u>                           |                                                                                                                                       |
| Neck/Back <u>2+ ant. Cervical nodes tender</u> |                                                                                                                                       |
| Heart <u>S1S2S3 @</u>                          |                                                                                                                                       |
| Lungs <u>clear, cough</u>                      |                                                                                                                                       |
| Abdomen                                        |                                                                                                                                       |
| GU/GI                                          |                                                                                                                                       |
| Extremities                                    |                                                                                                                                       |

AMOXICILLIN 500MG  
42 Capsules  
NDC: 51865-157-49  
Lot: 3083291  
Exp: 05/31/2005

| DIAGNOSIS:             | TESTS | RESULTS |
|------------------------|-------|---------|
| <u>Viral sinusitis</u> |       |         |
|                        |       |         |
|                        |       |         |

PLAN: 1) Cont. regular med  
2) Rest as much as possible  
3) RTC if symptoms not improving CRP

PRACTITIONER SIGNATURE: Donna Stewart STAFF SIGNATURE: [Signature]

AUDIT DATE: \_\_\_\_\_ COMMENTS: \_\_\_\_\_

PHYSICIAN SIGNATURE: \_\_\_\_\_

PREPARED BY AUM N  
REVISED/ADOPTED 11

Problem Visit Record Continued:

11-15-04

ERIN RAY

T.C. Requesting

Amprol DS for treatment

Amprol

Amprol DS 1

Carried into Rite Aid #120

@ 12<sup>40</sup> PM

supp X5. Ledworth  
CRW

**AUM NURSING CARE CENTER  
PROBLEM VISIT RECORD**

DATE: 8/3/04 TIME: 1345 PT. HISTORY REVIEWED / UPDATED: 1 / 1

PATIENT NAME: Reilly, Erin DOB: \_\_\_\_\_ AGE: \_\_\_\_\_

PRESENT COMPLAINT: pt, unable to obtain refill of Flonase (MD's office had not called rx in) and pt is due to leave the country tomorrow.

**MEDICATIONS:**

LMP: \_\_\_\_\_

| Item | Dose | Rate | BP | Ht | Wt | ABG |
|------|------|------|----|----|----|-----|
|      |      |      |    |    |    |     |

**INITIAL VISIT**

**RETURN VISIT**

Skin

Sinuses

Ears

Eyes

Nose

Throat

Neck/ Back

Heart

Lungs

Abdomen

GU/GI

Extremities

8-26-04

2:26 PM

Called Rita

Did P. exam.

to O.K. refilled

of medication

! Laxer

X5 refilled

Carters

CRW

**DIAGNOSIS:**

**TESTS**

**RESULTS**

**PLAN:**

**CALL BACK:**

Called in Rx for Flonase Neg  
sprays daily so he  
did

PRACTITIONER  
SIGNATURE: \_\_\_\_\_

STAFF

SIGNATURE: R. J. AN

AUDIT DATE: \_\_\_\_\_ COMMENTS: \_\_\_\_\_

REVIEWED BY: \_\_\_\_\_  
REVISED/ADDED: \_\_\_\_\_

**AUM NURSING CARE CENTER  
PROBLEM VISIT RECORD**

DATE: 12-5-03 TIME: 1:05 PM PT. HISTORY REVIEWED/UPDATED 1 / 1

PATIENT NAME: Erin Bradley DOB: \_\_\_\_\_ AGE: \_\_\_\_\_

PRESENT COMPLAINT: 4/5 sinus pressure & nasal drip  
now moving teeth (upper) pain last night  
& fever

MEDICATIONS: Fronson, Lofex, Wessington LMP: \_\_\_\_\_

| Temp        | Pulse | Resp | BP            | HR | WT | ABG          |
|-------------|-------|------|---------------|----|----|--------------|
| <u>97.6</u> |       |      | <u>106/70</u> |    |    | <u>NK MA</u> |

**INITIAL VISIT**

| INITIAL VISIT                            | RETURN VISIT |
|------------------------------------------|--------------|
| Skin <u>W: P</u>                         |              |
| Sinuses <u>(+) pressure over max</u>     |              |
| Ears <u>Ton's intact, &amp; eardrums</u> |              |
| Eyes <u>Clear</u>                        |              |
| Nose <u>congested</u>                    |              |
| Throat <u>&amp; eardrums</u>             |              |
| Neck/Back <u>&amp; Cervical</u>          |              |
| Heart <u>S1S2S3 (m)</u>                  |              |
| Lungs <u>Clear, &amp; cough</u>          |              |
| Abdomen                                  |              |
| GU/GI                                    |              |
| Extremities                              |              |

| DIAGNOSIS:       | TESTS | RESULTS |
|------------------|-------|---------|
| <u>sinusitis</u> |       |         |
|                  |       |         |
|                  |       |         |

PLAN: 1. Doxycycline 500mg tid x 10 days. 2. Limit  
3. Zyrtec 10 mg q 12h  
prn

PRACTITIONER SIGNATURE: Laura Stewart STAFF SIGNATURE: C. R. P.

AUDIT DATE: \_\_\_\_\_ COMMENTS: \_\_\_\_\_

AMOXICILLIN 500MG  
42 Capsules  
NDC: 51855-157-49  
Lot: 2PP488 3  
Exp: 06/30/2005

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

AUM  
NURSING CARE CENTER  
P.O. Box 244023  
Montgomery, AL 36124-4023  
(334) 244-3281

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

Vivian Hamlett, M.D.  
(334) 409-2800  
DEA #BH1075197  
AL #13467

Maryluz Fuentes, M.D.  
(334) 409-2800  
DEA #BF 6451520  
AL #24127

Name

Em. Randox

Date

8-1-03

Address

R

Waddentun SR 15mg  
Randox 60  
2.8 p.m. BID

Product Selection Permitted

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

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: 3/11/03 TIME: 4:00 PM PT. HISTORY REVIEWED / UPDATED: 1 / 1

PATIENT NAME: Brh Poley DOB: \_\_\_\_\_ AGE: \_\_\_\_\_

PRESENT COMPLAINT: c/o Severe Dizziness during  
periods. Has been using Anaprox  
1 requested new RX.

**MEDICATIONS:**

| Item | Dose | Route | BP | HR | WT | LMP: | Allergies |
|------|------|-------|----|----|----|------|-----------|
|      |      |       |    |    |    |      |           |

**INITIAL VISIT**

**RETURN VISIT**

Skin  
Sinuses  
Ears  
Eyes  
Nose  
Throat  
Neck/ Back  
Heart  
Lungs  
Abdomen  
GU/GI  
Extremities

**DIAGNOSIS:**

Dysmenorrhea

**TESTS**

**RESULTS**

**CALL BACK:**

**PLAN:**

Anaprox 1 p.o.  
q 12 hr. prn for  
dizziness

NAPROXEN SODIUM 550MG  
30 Tablets  
NDC: 51855-627-24  
Lot: 017834 1  
Exp: 06/30/2003

PRACTITIONER  
SIGNATURE: \_\_\_\_\_

STAFF  
SIGNATURE: \_\_\_\_\_

AUDIT DATE: \_\_\_\_\_ COMMENTS: \_\_\_\_\_

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

AUM  
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P.O. Box 244023  
Montgomery, AL 36124-4023  
(334) 244-3281

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

Lois J. Schulman, M.D.  
(334) 277-8390  
DEA #BS 4196235  
AL #20470

Zev David Nash, M.D.  
(334) 277-7811  
DEA #BN 1992963  
AL #22079

Name

Erin Ruddy

Date

6-11-02

Address

R

Lidexa 20mg

Disp # 30

Sig:  $\dot{\bar{p}} \dot{\bar{p}} \dot{\bar{p}}$

Product Selection Permitted

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

Label all prescriptions

Refill: 1 2 3 5 PRN NR

Dispense As Written

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

10-15-02 10<sup>45</sup> AM

Refill for Lidexa 20mg  $\dot{\bar{p}} \dot{\bar{p}} \dot{\bar{p}}$   
gd. called in to Rite Pharmacy  
Refill x5  
Loretta Stewart CRNP

4-21-03 3<sup>40</sup> PM

Refill for Lidexa 20mg  $\dot{\bar{p}} \dot{\bar{p}} \dot{\bar{p}}$   
gd. called in to Rite and Pharm  
Refill x5  
Loretta Stewart  
CRNP

## Problem Visit Record Continued:

Erin Ruddy

10-18-02

2 pm

S: Stated she has been having periods of extreme anxiety with behaviors of stress in confined spaces. Such as "clenching hands, biting nails, "sucking, nuzzling with teeth". Has become so debilitating that is affecting quality of life and fears she may have to avoid situations (church, meetings, etc) because of it. Has "some" feelings of depression. no A's in sleep pattern, no interest in usual activities.

A: OCD

? depression

D: Will try Lexapro 20 mg qd

X 3 mo + eval. response

David Stewart MD

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

AUM  
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P. O. Box 244023  
Montgomery, AL 36124-4023  
(334) 244-3281

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

Lois J. Schulman, J.  
(334) 277-8330  
DEA #BS 4196235  
AL #20470

Zev-David Nash, M.D.  
(334) 277-7811  
DEA #BN 1992963  
AL #22079

Name Eileen Reilly Date 2-8-02  
Address \_\_\_\_\_

Rx

Le Debarx 200mg

Disp # 20

Sig: 1 q.i.d. BID pm pain

Carol Stewart, 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.

Z. Riva. Prabhu

2-7-02 T.C.

Stated that the Derr harp  
 pain is from (A) hip for "a long  
 time" 7/1/87  
 I tried to pain the  
 latter - worse. Sometimes  
 pain is intermittent! sometimes  
 continuous. Exercise seems to  
 make pain worse. Will  
 refer to Dr. Hartzel and  
 to the ~~next~~ <sup>CO</sup> ~~same~~ <sup>CO</sup> ~~of~~ <sup>CO</sup> ~~for~~ <sup>CO</sup>  
~~need. L.D. 2000 13:00 pm~~  
 5

Lord Stewart +  
C.M.O.

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

AUM  
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P. O. Box 244023  
Montgomery, AL 36124-4023  
(334) 244-3281

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

Lois J. Schulman, M.D.  
(334) 277-8330  
DEA #BS 4196235  
AL #20470

Zev-David Nash, M.D.  
(334) 277-7811  
DEA #BN 1992963  
AL #22079

Name Evin Reilly Date 8-22-01  
Address \_\_\_\_\_

R Amprox DS 500mg  
Dose # 30  
sig: 1 po q 12° pm  
Carol Stewart M.D. or C.R.N.P.

Label all prescriptions  
Refill: 1 2 3 5 PRN NR

Product Selection Permitted  
Dispense As Written M.D. or C.R.N.P.

8-22-01

Requesting refill of  
Amprox DS 500mg  
discontinued.

P: Amprox DS 500mg  
1 q 12° pm pm

**AUM NURSING CARE CENTER  
PROBLEM VISIT RECORD**

DATE: 4/17/01 TIME: 1455 PT. HISTORY REVIEWED / UPDATED 1 / 1

PATIENT NAME: Erin Reilly DOB: \_\_\_\_\_ AGE: \_\_\_\_\_

PRESENT COMPLAINT: Difficulty sleeping for many years. Last 6 months noticeably more tired. On average gets 5-9 hours of sleep at night. Goes through phases where she will sleep well then not.

MEDICATIONS: Flonase, Ibv profen frequently. LMP: \_\_\_\_\_

| Temp | Pulse | Resp | BP | WT | Attended        |
|------|-------|------|----|----|-----------------|
|      |       |      |    |    | <u>11/12 MA</u> |

| INITIAL VISIT |                                                                                              | RETURN VISIT               |
|---------------|----------------------------------------------------------------------------------------------|----------------------------|
| Skin          | <u>No unusual amount of stress noted. No prior hx of anemia. Just defended dissertation.</u> | <u>8-2-01</u>              |
| Sinuses       |                                                                                              | <u>Called in</u>           |
| Ears          | <u>Over the past year, periods have become heavier.</u>                                      | <u>regard of</u>           |
| Eyes          | <u>Has not been in a relationship; sometimes experiences loneliness.</u>                     | <u>Flonase to Rib aid</u>  |
| Nose          |                                                                                              | <u>Pharm.</u>              |
| Throat        | <u>Has trouble falling asleep</u>                                                            | <u>Costwest CRP</u>        |
| Neck/Back     | <u>not staying asleep. S ↓</u>                                                               |                            |
| Heart         | <u>Interest in unusual activities</u>                                                        |                            |
| Lungs         | <u>Ø Coughing - Does feel sorely at times</u>                                                | <u>11-12-01</u>            |
| Abdomen       |                                                                                              | <u>Called in</u>           |
| GU/GI         |                                                                                              | <u>regard of</u>           |
| Extremities   |                                                                                              | <u>Flonase to Rib aid.</u> |
|               |                                                                                              | <u>Pharm.</u>              |
|               |                                                                                              | <u>Costwest CRP</u>        |

| DIAGNOSIS                    | TESTS | RESULTS |
|------------------------------|-------|---------|
| <u>Postpartum Depression</u> |       |         |
| <u>Uncomplicated</u>         |       |         |
|                              |       |         |
|                              |       |         |

PLAN: \_\_\_\_\_ CALL BACK: \_\_\_\_\_

① Tylenol PRN q. 4  
+ Air before nap  
Bedtime

② Uem 24-CBC, TRepsid  
Profiles today

PRACTITIONER SIGNATURE: Carol Stewart STAFF SIGNATURE: [Signature]

AUDIT DATE: \_\_\_\_\_ COMMENTS: \_\_\_\_\_

PHYSICIAN SIGNATURE: \_\_\_\_\_

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

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

AUM  
NURSING CARE CENTER  
P.O. Box 244043  
Montgomery, AL 36124-4023  
(334) 244-3281

Sandra Ivey, C.R.N.P.  
Lic. # 1-029005  
Rx # 0670

Lois J. Schulman, M.D.  
(334) 270-8081  
DEA # BS4196235  
AL # 20470

Kathy Windham, M.D.  
(334) 271-7051  
DEA # BW5714820  
AL # 16083

Patient's Name ERIN RIDLEY Date 9-12-00  
Address \_\_\_\_\_  
Rx \_\_\_\_\_

F. Donare

Diag: 16 yr  
Sig: 11 sprays qd.

Label all prescriptions

Refill: 2 5 PRN NR

Carol Stewart M.D. C.R.N.P.  
PRODUCT SELECTION PERMITTED

DISPENSE AS WRITTEN M.D. or C.R.N.P.

01  
3-26-00  
Refill for F. Donare 11 spray  
qd called in to Rite Aid  
Pharmacy  
Carol Stewart C.R.N.P.

DATE: 9-12-00 TIME: \_\_\_\_\_ PT. HISTORY REVIEWED / UPDATED \_\_\_\_\_ / \_\_\_\_\_

PRESENT COMPLAINT: 4/0 "ant" *[illegible]* on *[illegible]* Dept. 4/1/1

Also suggestive of viral encephalitis for  
differential diagnosis

MEDICATIONS: Fentanyl

| Temp | Phase | Resu | HL | WT | LMP:<br>Allerries |
|------|-------|------|----|----|-------------------|
| 972  |       |      |    |    | 10 K mpa          |

## INITIAL VISIT

Skin: 3 erythematous papules noted  
Sinuses on dorsum of R foot.  
Ears

**RETURN VISIT**

Sinuses on dorsum of 2nd foot.

Ears

## Ends

## Eyes

**Nose**

### Throat

### Neck/ Back

## Heart

## Lungs

## Abdomen

GU/GI

### Extremities

**DIAGNOSIS:**

## TESTS

## RESULTS

Cont 5 times  
Allergic Reaction

PLAN:

**CALL BACK:**

1) ~~Appary Rudi~~ Gop pr  
itening

a) ~~Fonare~~ H Sprays  
gd pr ~~Symptoms~~

PRACTITIONER

SIGNATURE:

SIGNATURE:

AUDIT DATE: \_\_\_\_\_ COMMENTS: \_\_\_\_\_

PHYSICIAN SIGNATURE: \_\_\_\_\_

**AUM NURSING CARE CENTER  
PROBLEM VISIT RECORD**

E: 8/4/00 TIME: 10:10 PT. HISTORY REVIEWED/UPDATED 1 / 1

IENT NAME: Erica Reilly DOB: 2/4/64 AGE: 36

SENT COMPLAINT: Burn on leg. Pt into clinic for treatment of burn to Right lower leg. Pt received wound last Saturday from history of motorcycle.

|                          |       |      |     |    |    |             |
|--------------------------|-------|------|-----|----|----|-------------|
| ICATIONS: <u>Flonase</u> |       |      |     |    |    | LMP:        |
| Temp                     | Pulse | Resp | B/P | HT | WT | Allergies   |
|                          |       |      |     |    |    | <u>NRMA</u> |

| INITIAL VISIT |                                        | RETURN VISIT                     |
|---------------|----------------------------------------|----------------------------------|
| in            | <u>Approx 6-7 cm Area on</u>           | <u>8/7/00 @ 11:00 Pt</u>         |
| causes        | <u>(L) medial lower leg burned</u>     | <u>in for rev of leg</u>         |
| signs         | <u>and exsiccated. Bordered</u>        | <u>wound. Minimal</u>            |
| yes           | <u>perforance erythematous</u>         | <u>eschar noted after</u>        |
| note          | <u>and exsiccating - Center 4-5 cm</u> | <u>lateral aspect of</u>         |
| throat        | <u>Waxing and waning Dried,</u>        | <u>the wound of the wound.</u>   |
| neck/back     | <u>erythematous (prob 3" diam)</u>     | <u>wet to dry dressing</u>       |
| heart         | <u>wound debrided Day A. massive</u>   | <u>placed on wound.</u>          |
| lungs         | <u>(see Report). tissue pink</u>       | <u>Pt instructed to</u>          |
| abdomen       | <u>feeling underneath</u>              | <u>continue w/ dressing</u>      |
| GU/GI         | <u>no obvious signs of</u>             | <u>and come for</u>              |
| extremities   | <u>infection noted</u>                 | <u>recheck on Wednesday. PM</u>  |
|               |                                        | <u>Estewart CRN</u>              |
|               |                                        | <u>8/9/00 @ 1400 Pt returned</u> |
|               |                                        | <u>for rev of leg wound.</u>     |
|               |                                        | <u>to eschar noted. site</u>     |
|               |                                        | <u>bleeding freely. Pt</u>       |
|               |                                        | <u>instructed to leave</u>       |
|               |                                        | <u>open to air during</u>        |
|               |                                        | <u>day and loosely</u>           |
|               |                                        | <u>cover at night. Continue</u>  |
|               |                                        | <u>to clean 1-2 x per day.</u>   |
|               |                                        | <u>RTC Friday. AM</u>            |
|               |                                        | <u>Estewart CRN</u>              |

|                                                      |       |         |
|------------------------------------------------------|-------|---------|
| DIAGNOSIS:<br><u>2-3" Diameter on (R) lower leg.</u> | TESTS | RESULTS |
|                                                      |       |         |
|                                                      |       |         |
|                                                      |       |         |

PLAN: wound treated to H<sub>2</sub>O<sub>2</sub> and debrided. wet to dry dress. Natch placed to site.  
Pt instructed in how to perform w/d  
and to D dress TID. RTC on Monday  
for recheck. OK

CALL BACK: RTC Monday for recheck

PRACTITIONER SIGNATURE: Estewart CRN STAFF SIGNATURE: Jay Mann RN

PHYSICIAN SIGNATURE: K. D. D. 500000 g/d x 10 days

8-18-00

Burn on (R) lower leg healing

5 diff. 0.5:5 of infection

P: RTC prr

Lawson CRMD

**AUM NURSING CARE CENTER**  
**ADOLESCENT/ADULT HEALTH HISTORY**

Date 8/4/00

Name Erin Reilly

1. What is the reason for your visit today? Burn on leg
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: N/A
4. List any medicines or drugs you take: Flonase

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? tonsils, gland in throat
8. Have you ever had a serious accident? no
9. Have you had serious or recent problems with:

ears or throat  
allergies  
lung infections

NO YES  
NO YES  
NO YES

cough  
thyroid  
skin problems

NO YES  
NO YES  
NO YES

kidneys  
weight loss  
ulcers

NO YES  
NO YES  
NO YES

gallbladder  
liver  
depression  
headaches

NO YES  
NO YES  
NO YES  
NO 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? 13 Date of your last period? 8/31  
How often do you have your periods? 28 ~~30~~ Are they regular? ye  
How many days do they last? 6  
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? \_\_\_\_\_  
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