

Auburn University Montgomery
Warhawk Health Services
Travel Health History

Name: Tammy Clark DOB: 1-8-70
Address: 2668 Lovelady Rd Tallahassee, AL 36078
Phone: 334-651-5630

1. **Travel Itinerary:** List **ALL** countries you might visit in order of travel. Include layovers IF in South America, Africa, or Panama.

Arrival Date	Country (list ALL you may visit)	City/Region	Departure Date from area
3-4-23	Parana City, Cienagueta, Chiriqui		3-11-23
	Parana		

Return date to the United States:

Reason for travel: ☐ Study abroad ☒ Medical/Dental work with patient contact ☐ Vacation ☐
Conference ☐ Business ☐ Visit family/friends ☐ Other:

2. **Immunization History (with dates)**

Tetanus (most recent): Tdap	<u>14</u> <u>5/07</u>	Varicella: 1: 2:
MMR: 1: <u>5/2/20</u> 2:		Pneumococcal:
Hepatitis B: 1: 2: 3:		Influenza (most recent):
Hepatitis A: 1: <u>5/11/07</u> 2: <u>11/16/07</u>	<u>*</u>	Typhoid (most recent): Injection: <u>5-6-2007</u> Oral:
<u>*</u> Polio:		Yellow Fever: <u>5/11/07</u>
<u>*</u> Meningococcal (MenACWY):		COVID: Brand: <u>Moderna</u> Date: <u>12-31-20 - 1-28-21</u>

3. **Risk assessment: Please check all that apply.** ☐ Work with animals ☐ Visit/work near swamps, rice, or pig farms ☐ Rural areas ☐ Urban areas ONLY ☐ Camp/hike ☐ Stay with local family ☐ High altitude (over 8,000ft), Dental work with local population

Accommodations: ☒ Hotel with air conditioning ☐ Hotels with screening ☐ Local housing/apartment ☐ Tent ☐ Unknown

4. **Medical Conditions: check all that apply.**

☐ Heart Problems	☐ HIV/AIDS	☐ Sickle Cell Anemia
☐ Seizure Disorder	☐ Cancer	☐ Splenectomy
☐ Diabetes	☐ Receiving Chemotherapy/Radiation	☐ Thymus Disorders: Myasthenia Gravis, DiGeorge Syndrome, Thymoma, Thymectomy
☐ Severe Headaches	☐ Immune Deficiency	☐ Gastrointestinal Disease
☐ Kidney Disease	☐ Transplant Recipient	☐ COPD or Asthma
☐ Cirrhosis of the Liver	☐ Psychiatric Disorder	☐ Tuberculosis

Medical Conditions not listed above: high blood pressure, cholesterol ☐ None

PATIENT HIPAA CONSENT FORM

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

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

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

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree with 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.

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 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.

Signature: Tammy Clark Date: 1/17/23

Print Patient's Name: Tammy Clark

Relationship to Patient (if you are the patient, write "self"): _____

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5. Allergies/reactions to medications, vaccines, food, and/or insects: None

6. Medications (including supplements and OTC medications): Amlodipine 10mg
Losartan 100 mg Atorvastatin 10mg Xanax .05mg

For Females Only

7. Date of your last period: 2001 Have you had a hysterectomy? ☐ Yes ☒ No

8. Are you currently pregnant? ☐ Yes ☒ No

9. Do you plan to become pregnant in the next 3 months? ☐ Yes ☒ No

10. Are you breastfeeding? ☐ Yes ☒ No

Travel Advise/ Risks Discussed

Risk/Advice	Yes	No	N/A	Risk/Advice	Yes	No	N/A
Bite Avoidance	☒	☐	☐	Sun Protection	☒	☐	☐
Food/Water Hygiene	☒	☐	☐	Bodily Fluid Infections	☒	☐	☐
Blood Borne Viruses	☒	☐	☐	Traveler's Diarrhea	☒	☐	☐
Rabies	☒	☐	☐	Other:	☐	☐	☐

For chronic conditions, I will check with my physician to discuss my care during travel, how to handle a worsening of symptoms, and if I should avoid specific vaccines. I read the CDC recommendations for my itinerary and relevant topics at cdc.gov/travel and the CDC Traveler Information Center.

Signature: Yammy Clark Date: 1-17-23

Reviewed by:

Robin Blackwell CRNP

Date:

1.17.23