



Phone: (479) 788- 7444 Fax: (479) 788 -7436 E-Mail: StudentHealth@uafs.edu

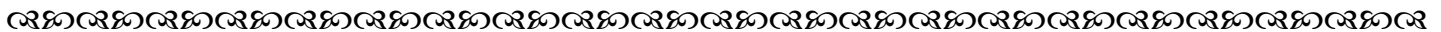
Today's Date: _____ Phone: _____ E-Mail: _____

Name: _____ SSN#: _____
Last First MI

Address: _____
Street City, State, Zip

Birthdate: _____ Ethnicity: _____ Sex: _____

Emergency Contact: _____
Name Phone Number Relationship



What are you being seen for today: _____

Medication Allergy: N/A _____ Food Allergy: N/A _____

Current Medications: Include supplements and over the counter taken within the past 48 hours. N/A

Diet: Please list dietary restrictions: (e.g. lactose intolerance, vegan, celiac): N/A _____

Surgeries, Fractures or Hospitalization: N/A Describe: _____

Currently Employed: Yes No Occupation: _____

Alcohol: N/A Beer / Wine / Spirits

Tobacco: N/A Cigarettes Vape Cigars Chewing Tobacco

Drugs: Do you currently smoke marijuana or use other illicit drugs: Yes No List: _____

Please check for each condition that applies:

| | | | | | | | |
|----------------------|--|---------------------|--|--------------|--|-----------------|--|
| Allergies | | Joint/ Back Pain | | Hypertension | | Appendectomy | |
| Sinusitis | | Chest Pain | | Dizziness | | Cholecystectomy | |
| Ear Infections | | Shortness of Breath | | Fainting | | Tonsillectomy | |
| Frequent Colds | | Heartburn | | Epilepsy | | Ulcers | |
| Asthma | | Nausea/Vomiting | | Head Injury | | Anemia | |
| Acne | | Constipation | | Anxiety | | Diabetes | |
| Eczema | | Diarrhea | | Fatigue | | Cancer | |
| Contacts/Glasses | | Kidney Stones | | Depression | | Thyroid | |
| Recent Wt. Loss/Gain | | Hemorrhoids | | Migraines | | Pregnancy | |

Family Medical History: No Knowledge of family medical history

Mark all conditions that apply to immediate members of your family. Please indicate member afflicted:

- | | | |
|---|---|--|
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Migraines _____ | <input type="checkbox"/> Hepatitis _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Seizures/ Epilepsy _____ | <input type="checkbox"/> Kidney Disease _____ |
| <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Stroke _____ | <input type="checkbox"/> Breast Disease (Benign) _____ |
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Thyroid Disorder _____ | <input type="checkbox"/> Cancer (List type) _____ |
| <input type="checkbox"/> Bleeding/Clotting Disorder _____ | <input type="checkbox"/> Tuberculosis _____ | <input type="checkbox"/> Alcoholism/ Substances _____ |
| <input type="checkbox"/> Anemia _____ | <input type="checkbox"/> Ulcers _____ | <input type="checkbox"/> Mental Illness _____ |

Authorization to Release information
for treatment, payment or healthcare operations

I hereby authorize the release or use of my individually identifiable health information (Protected Health Information or PHI) and medical information by Powell Student Health Clinic in order to carry out treatment, payment or healthcare operations.

You retain the right to request that we further restrict how your PHI is released or utilized to carry out treatment, payment or healthcare operations. Our practice is not required to agree to such requested restrictions, however if we do agree to our requested restrictions, such restrictions are then binding on the Notice of Privacy Practices.

Notice of Privacy Practices

EFFECTIVE DATE:

This notice is effective March 21, 2006

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document. To obtain a description of the use of your PHI please review the Privacy Practice Notice Prior to signing this consent form. We reserve the right to change the terms of the Notice of Privacy Practices at any time. If we do make changes to the Notice of Privacy Practices, you may obtain a copy of the revised notice by writing our practice or requesting a copy at the front desk.

I agree and consent to releasing information to me in the following manners:

- Via E-Mail to provided contact
- Phone callback number only

Medical Consent for Treatment

I, the undersigned, authorize and consent to the rendering of medical care, including diagnostic procedures and treatment by medical professionals staffing the Powell Student Health Clinic as may, in their professional judgement, be necessary for the above named patient. I acknowledge no guarantees to the effect of such examinations or treatment.

I hereby authorize any physician, hospital or medical care facility to provide necessary information on my medical history and treatment to medical professionals staffing the Powell Student Health Clinic. I further authorize the release of information acquired in the course of my examination or treatment to the Powell Student Health clinic and authorize physicians, hospitals or medical care facilities requiring such information.

By signing below, I consent to the above and have provided information that is true and accurate:

Patient Signature

Printed Name

Today's Date