University of Arkansas at Fort Smith

Powell Student Health Clinic

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:

❑ Asthma _____
❑ Diabetes_____
❑ High Blood Pressure_____
❑ Heart Disease_____
❑ Bleeding/Clotting Disorder____
❑ Anemia
❑ Migraines_____
❑ Seizures/ Epilepsy_____
❑ Stroke_____
❑ Thyroid Disorder_____
❑ Tuberculosis_____
❑ Ulcers_____
❑ Hepatitis_____
❑ Kidney Disease_____
❑ Breast Disease (Benign) _____
❑ Cancer (List type) _____
❑ Alcoholism/ Substances_____
❑ 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