Red Rocks Community College Student Health Clinics

Patient Demographics / Consent for Treatment / Acknowledgement of Policies

Name_____ **D.O.B**_____ **Student#**_____

Address_____ _____ _____**City**_____ **State**_____ **Zip**_____ _____

Phone Number_____ **May leave message: Yes ☐ No ☐**

Emergency Contact_____ **Phone Number** _____ **Relationship**_____

The following are conditions for services provided by the **Red Rocks Community College Student Health Clinics (RRCCSHC)** for the patient whose name appears at the bottom of this page.

Consent for Medical Treatment

I/we voluntarily consent to medical treatment and diagnostic procedures provided by **RRCCSHC** and its associated physicians, physician assistants, clinicians, and other personnel. I/we am/are aware that the practice of medicine is not an exact science and I/we acknowledge that no guarantees have been made as to the result of examinations or treatments.

Acknowledgement of Receipt of Privacy Policy

I/we have been presented with a copy of the **Privacy Policy** for the **RRCCSHC** detailing how my information may be used and disclosed as permitted under federal and state law. I/we understand that I/we should read it carefully.

Acknowledgement of Payment Responsibilities

I/we understand that I/we am/are responsible for any charges not covered under the student health fee or employee co-pay as decided by the **RRCCSHC.** I/we guarantee payment of all charges at the time of service. I/we understand that I/we am/are responsible for the cost of all outside laboratory tests and medical imaging. I/we acknowledge that **RRCCSHC** is not liable for any fees that Colorado Laboratory Services, other lab companies, or imaging company charges and that these fees and charges will be billed directly to me/us.

Cancellation and No Show Policy

I/we understand that if unable to make a scheduled appointment, I/we must inform **RRCCSHC** as soon as possible and no less than one hour prior to the appointment. I/We understand that if I/we do not show up for the appointment I/we will be considered a "no show." If three "no shows" are acquired, I/we understand that my/our use and privilege of the **RRCCSHC** may be suspended.

Use and Privilege Policy

I/We am/are a current and registered Red Rocks Community College (RRCC) Student or Employee. I/We understand that use of the clinic is only permitted to registered RRCC students and employees. **RRCCSHC** reserves the right to suspend or terminate the patient/provider relationship for a period of time or for the duration of student enrollment or employement at RRCC at the provider's discretion. If I/we withdraw from the school, I/we understand that I may no longer seek treatment at the **RRCCSHC.**

Signed: _____ **Date:** _____

Patient Guardian Signature (if under 18 years old): _____
Relationship: _____ **Date:**_____

RRCC STUDENT HEALTH CLINIC **TODAY'S DATE**_____

Patient Name: **Age:** **Sex:** **Gender:**

Medical History Form

PAST MEDICAL HISTORY: ex: diabetes, gallstones, high blood pressure, etc…	
1.	**4.**
2.	**5.**
3.	**6.**
PAST SURGICAL HISTORY: ex: ACL repair, heart valve replaced, appendix removed, C-section	
1.	**4.**
2.	**5.**
3.	**6.**

MEDICATION ALLERGIES: What happens when you take that medicine:	**OTHER ALLERGIES**: (such as bees/wasps, foods, latex, etc) What happens when you are exposed:

Current **MEDICATIONS**: Prescription and Non-Prescription (including aspirin, vitamins, birth control, herbs, supplements, etc.)

SOCIAL HISTORY:	
Married: Y N Partner Sig Other	Children:
Your Occupation:	Employed: Y N Where:
In school for:	Hobbies:

Recent Significant Changes/ Stresses in Your Life? Yes No explain:

Have you used any of the following substances?

Substance?	**Currently Use?**	**Previously Used?**	**Type/Amount/Frequency**	**How Long?** (Years)	**If stopped, when?** (Year)
Caffeine: coffee, tea, soda					
Tobacco					
Alcohol: beer, wine, liquor					
Recreational/Street Drugs					
Prescription Drug Abuse					

Second Hand Smoke: Have you <u>ever **regularly**</u> been exposed to secondhand smoke? Yes__ No__ if yes, #of years___

Patient Name:

FAMILY HISTORY

Please check any family members who have the following health problems.

	Father	Mother	Brother	Sister	Grandparent	SELF
Diabetes						
Glaucoma						
Cancer (List type)						
Heart attack						
Sudden Death						
Stroke						
High blood pressure						
High cholesterol						
Alcoholism						
Drug Abuse						
Depression						
Mental illness (please describe)						
Suicide						
Other health problems (please list)						

CURRENT HEALTH PRACTICES

Food, exercise, and safety can all play a role in your health.

Do you exercise regularly? Y N Type of exercise and frequency:

List any nutrition or diet concerns you would like help with:

If you are on a **special diet**, please explain:

Do you have regular **Dental** check-ups? Y__ N__ How often do you brush/day____ floss___

Do you wear your seatbelt: Always___ Sometimes___ Never___

Do you ride a motorcycle? Y__ N__ Bicycle? Y__ N__ Ski/Snowboard? Y__ N__
Skateboard? Y__ N__ If yes, do you wear a **helmet**? Y__ N____

Do you have a **smoke detector** in the home: Y__ N__ When was it last checked?

Patient Name:

REVIEW OF SYSTEMS:

If you are experiencing any of the symptoms below, please check the box, if not, you may leave it blank.

GENERAL:	Recent unintended Weight Change	Significant or Unusual Fatigue
BREASTS: Men & Women	Lumps/Tenderness	Do You Do Monthly Self Breast Exams? Y__N__
	Drainage from Nipple	Month and Year of Last Mammogram:_____
EYE, EAR, NOSE, AND THROAT		
Hearing Loss	Use Glasses or Contact Lenses	History of Radiation Therapy to Head / Neck
CARDIOPULMONARY	Abnormal Shortness Of Breath	Heart Palpitations
	Chest Pain	Wheezing
GASTROINTESTINAL:	Heartburn	Abdominal Pain
	Blood in Stool/Black Stool	
NEUROPSYCHIATRIC	Frequent Disabling Headaches	Often Feel Sad or Depressed
	Frequent Anxiety or Anxiety Attacks	

Treated in Past for Emotional or Psychological Problems: please describe

SKIN Mole that has changed color, size, shape, or won't heal? Yes No

GENITOURINARY: History of Multiple Sex Partners History of Kidney or Bladder Stones

Method of Birth Control: _____

Have you ever had any Sexually Transmitted Diseases: Yes___ No___
if yes, please describe:

MEN ONLY Pain or Lump in Testicles/Scrotum Do you do monthly Self Testicular Exam: Yes___ No ___

WOMEN ONLY

Age of First Period:	Frequency/Length of Menstrual Periods:
Date of Last Menstrual Period:	Change in Menstrual Pattern: Y N
Number of Pregnancies:	Number of Children:
Disabling Menstrual Cramps: Y N	Unusual Vaginal Discharge/Itching: Y N
Date of Last Pap Smear:	Heavy menstrual flow: Y N
History of Abnormal Pap Smear: Y N	Any Treatments for Abnormal Pap:

To the best of my knowledge, this is an accurate statement of my health:

Signature:_____ Date: _____