COMMUNITY OUTREACH MEDICAL CENTER
Bringing Community and Healthcare Together in Southern Nevada

1140 Almond Tree Lane Suite 306 Las Vegas NV 89104

CLIENT HISTORY

Full Name_____Today's Date_____

Other Names Used / Preferred Name _____

Address_____ City/Town_____ Zip_____

Home phone _____ Cell phone _____

Email Address_____

Date of Birth _____ Age_____ Marital Status: ☐ S ☐ M ☐ D ☐ W ☐ Sep

Pharmacy Address and Phone/Fax: _____

DEMOGRAPHICS

Current Gender Identity: ☐ Male ☐ Female ☐ Unknown | Sex at Birth: ☐ Male ☐ Female

☐ Transgender Male-to-Female (MTF) ☐ Transgender Female-to-Male (FTM)

☐ Transgender (trans*, gender queer, gender non-conforming) ☐ Other: _____

Ethnicity: _____ Race: _____

Language(s) Spoken _____

Occupation_____Social Security_____

Name of Spouse or Significant Other (if applicable) _____

Who should we contact in an emergency? _____Relation _____Phone_____

Father's Name _____Phone _____

Address_____ City_____ Zip_____

Mother's Name _____

Address_____ City_____ Zip_____

Where did you have HIV (AIDS virus) test done? _____ Date _____

Was it Positive? Yes No

What physician are you currently seeing? _____ Phone _____

Address_____ City_____ Zip_____

Symptoms

Please make a check mark next to anything, which you have experienced in the past 3 months.

					Comments
Fever higher than 100	Y		N		
Drenching night sweats degrees	Y		N		
Unexplained weight loss of more than 10 lbs.	Y		N		
Unusual skin rashes	Y		N		
New bumps or spots on the skin	Y		N		
Swollen lymph nodes	Y		N		
Easy brushing or bleeding	Y		N		
Swollen feet (shoes don't fit)	Y		N		
Cough	Y		N		
Shortness of breath walking or climbing stairs	Y		N		
White patches in the mouth	Y		N		
Pain behind breastbone when swallowing	Y		N		
Severe abdominal pain or cramps	Y		N		
Three or more watery stools per day	Y		N		
Painful bowel movements	Y		N		
Blood in stools	Y		N		
Loss of bowel control	Y		N		
Painful Urination	Y		N		
Usually frequent urination	Y		N		
Loss of urine control	Y		N		
Persistent, severe headaches	Y		N		
Unusual numbness or pain in the hands or feet	Y		N		
Weakness in the legs or difficulty standing up	Y		N		
Trouble thinking or concentrating	Y		N		
Changes in your vision	Y		N		
Hallucinations	Y		N		
Depression	Y		N		
High blood pressure	Y		N		
Diabetes	Y		N		
Stomach ulcer	Y		N		
Anemia or bleeding problem	Y		N		
Pancreatitis	Y		N		
Herpes zoster ("Shingles")	Y		N		
Herpes simplex (Oral or genital herpes)	Y		N		
Syphilis	Y		N		
Gonorrhea	Y		N		
Vaginal Infection or Chlamydia	Y		N		
Venereal warts	Y		N		
Tuberculosis or a positive skin test	Y		N		
Hepatitis (what type?)	Y		N		

Mental Illness (what type?)	Y		N	
Attempted suicide	Y		N	

Medical History

Please answer the following questions about your past medical history. If you don't understand any of the questions please ask your nurse or doctor to explain the question(s).

Previous Operations or Surgery	Date	Hospital

Hospitalizations / Illness	Date	Hospital

Current Medications

Medication	Dose	Instructions	Date	Medication	Dose	Instructions	Date
Ex. Atenolol	*50 mg*	*1 daily*	*1/1/11*	6.			
1.				7.			
2.				8.			
3.				9.			
4.				10.			
5.				11.			

Allergies to medications, food, or substance including type of reaction

Allergy	Reaction	Allergy	Reaction
Ex. Penicillin	*Rash, Shortness of breath*	3.	
1.		4.	
2.		5.	

How much beer, wine, or hard liquor (circle any you use) do you drink each day (average)?

Have you ever (check those true for you):

Drank enough to lose consciousness

Been arrested for driving under the influence of alcohol or drugs

Been in Alcoholics Anonymous or a similar program?

Have you ever smoked? ☐ Y ☐ N If yes, how many packs per day (average)? _____

Do you smoke now? ☐ Y ☐ N How many years have you smoked? _____

Do you use marijuana, cocaine, or other non-prescription drugs? Y ☐ N ☐

If yes, which ones? _____

Have you ever used drugs in the vein or skin? Y ☐ N ☐

First year you used injectable drugs _____

Last time you used injectable drugs _____

Does anybody in your family have (circle those that apply):

Diabetes High Blood Pressure Cancer (type) _____

High Cholesterol Heart Disease Sickle Cell Anemia or Trait

List date of most recent immunizations:

Tetanus _____

Hepatitis B _____

Influenza _____

Pneumococcus _____

Have you ever received a transfusion? Y ☐ N ☐ If so, when and where? _____

For women: Last menstrual period _____ Last Pap _____ Are periods regular? Y ☐ N ☐

A benefit of coming to this clinic is that you may be eligible to receive treatment with drugs or other therapies not available to the general public. Would you be interested in participating in studies of new drugs or other therapies? (saying yes does not obligate you to participate, and you will receive full care whether you chose "yes" or "no".) YES NO

Social History

Where were you born? _____

Where have you lived in the past 15 years? _____

Where do you live? (check one) ☐ Hotel ☐ Board and care ☐ Own home ☐ Rent/Lease ☐ Homeless
☐ With friends ☐ With Family ☐ Other

Who lives with you? _____

Support network (check all that apply)

☐ None ☐ Health care Provider ☐ Counselor/Therapy

☐ Partner/Significant Other ☐ Spouse ☐ Neighbors ☐ Support Groups

☐ Friends ☐ Work/School Associates ☐ Family/Relatives ☐ Church/Clergy

How do you support yourself financially? _____

Are you presently sexually active? Yes ☐ No ☐

Who do you have sex with? Men ☐ Women ☐ Both ☐

Do you always use a condom during anal or vaginal intercourse? Yes ☐ No ☐

Do you always use a spermicide? Yes ☐ No ☐

Have you ever had sex with someone infected with HIV (AIDS Virus)? Yes ☐ No ☐ Don't Know ☐

Have you ever had sex with someone who uses injectable drugs? Yes ☐ No ☐ Don't Know ☐

Do you have questions about safe sex? Yes ☐ No ☐

What else would you like us to know about your health?

_____

_____

_____

Patients Signature _____ Date: _____

Witness's Signature _____ Date: _____

Consent for Treatment

The following information is to be completed by the patient, or the patients legally authorized representative/parent:

I consent to medical treatment for myself or for the patient for whom I am the parent or legally authorized representative. I understand that Community outreach medical center will share patient health information according to federal and state law for treatment, payment, and operations.

I understand that it is my responsibility to obtain all recommended testing, further evaluation, and follow up recommended by my physician/practitioner. I also understand that if tests are taken for certain communicable diseases, sexually transmitted/diseases, law may require reporting of positive results to relevant public health agencies.

I hereby release Community Outreach Medical Center, its medical staff, and employees from ant and all liability arising out of or connected with my lack of follow up recommended for any abnormalities identified.

I hereby consent to and request examination by the Community Outreach Medical Center and ensure that, to the best of my knowledge, all information submitted by me is true.

Signature of Patient: _____ Date: _____

Signature of Legally Authorized Representative: _____

Relationship of Legally Authorized Representative to Patient: _____

Date: _____

COMMUNITY OUTREACH MEDICAL CENTER

Acknowledgment of

NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices explains how we may use and disclose protected health information about you. As provided in our Notice, the terms of our Notice may change. Copies of our Notice will always be available at our office and will reflect any updates we make to our Notice in the future. Please sign and date below to indicate that you have received a copy of the Community Outreach Medical Center Notice of Privacy Practices and an explanation of what it contains.

Signature Date

Printed Name

Please Circle:

Participant ☐ Parent ☐ Legal Guardian ☐ Personal Representative ☐ Agency ☐

Other _____

The following is to be completed by Community Outreach Medical Center personnel:

Please check the applicable box:

☐ The Notice of Privacy Practices was offered and accepted by the participant and the participant signed this Acknowledgement

☐ The Notice of Privacy Practices was offered and accepted by the participant and the participant refused to sign this Acknowledgment.

☐ The Notice of Privacy Practices was offered and refused by the participant and the participant agreed to sign this Acknowledgment.

☐ The Notice of Privacy Practices was offered to and refused by the participant and the participant refused to sign this Acknowledgement.

Staff Representative: _____ Title: _____ Date: _____

COMMUNITY OUTREACH MEDICAL CENTER
ADVANCE DIRECTIVES AGREEMENT

1) I have received written information on state law concerning Advance Directives advising me of my right to make decisions concerning my medical care including the right to accept or refuse medical or surgical treatment, and formulate advance directives.

YES ☐ NO ☐

2) I have formulated an Advance Directive:

YES (Declaration/Living Will) ☐

YES (Durable Power of Attorney for Health Care ☐

NO, I have not formulated any Type of Advance Directive ☐

If YES, I have provided a copy of my Advance Directive to hospital.

YES ☐ NO ☐ (If no is marked a copy should be provided to the hospital as soon as possible).

Patient Signature: _____ Date_____

Family and/or Significant other (If patient is unable to sign) _____
Date _____

Hospital Representative _____ Date _____

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RYAN WHITE PROGRAM
ADVANCE DIRECTIVES, LIVING WILLS AND DURABLE POWER OF ATTORNEY

As a competent adult (18 years old and over) it is your right to make decisions regarding your health care after you have been informed of all important aspects of that care. You may accept or refuse care on your own desires.

The best time to determine your desires regarding your choice of health care is before you are admitted to a health care facility. If you are incapable of expressing your desires you may develop a written statement that will dictate how you want decisions made. These statements are called Advance Directives.

There are two forms of Advance Directives:

Living Will

The Living Will is only in effect when your attending physician determines that your condition is terminal and there is no chance for recovery. The Living Will allows you to state what level of care you wish regarding life support, life containment, life containment, and life enhancement. (See the checklist attached to assist you in developing your Living Will.)

When writing a Living Will you may direct your physician to carry out directives are known and carried out. This individual is only designated to make decisions regarding withholding or withdrawal of treatment.

Durable Power of Attorney

The second form is the Durable Power of Attorney for Health Care. This statement allows you to name an individual and an alternate that will make decisions in case you are unable. It is recommended that you discuss your wishes with these persons so they can best serve you. This individual may make decisions regarding your health care whenever your condition be terminal. (See checklist attached to assist you in developing your desires for health care.)

Absence of Advance Directives

In the case that you have not prepared an Advance Directive, the closet living relative would be asked to give consents and make decisions for your health care.

GENERAL INFORMATION

- Advance Directives can be revoked at any time.

- The Living Will only become effective when it is communicated to the attending physician and you have been determined by that physician to be in a terminal condition and you are no longer able to make decisions regarding your health care.

- Durable Power of Attorney becomes effective when you are unable to communicate your desires, for example, you are in a coma.

- A Durable Power of Attorney must be notarized or witnessed by 2 adults.

- When you have developed an Advance Directive you should share it with:
    - Your physician
    - Your family
    - Your named persons in your Durable Power of Attorney
    - Any health care institution(s) you are being admitted to for health care

- The Living Will will not be effective in the case of a woman known to be pregnant as long as the fetus could develop to the point of a live birth.

- You may have either type pf Advance Directive or both. It is recommended that if you have a Durable Power of Attorney that you provide your representative with information that clearly describes your wishes. This can be done through a Living Will.

These are a few of the basic facts about Advance Directives. If you wish to know more information you may ask to view the movie “On Your Behalf”.

If you choose to develop a Living Will you may use one of the following samples or create your own. If you wish to develop a Durable Power of Attorney you may request the necessary forms from your nurse. This forms is the only State approved form.

LIVING WILL

A declaration that designates another person to make decisions governing with withholding or with drawal of life-sustaining treatment may, but need not, be in the following form