

AUM STUDENT HEALTH SERVICES

PATIENT INFORMATION (PLEASE PRINT LEGIBLY)

Date: July 16, 2019 Are you an AUM Student? ☐ Yes ☒ No S-Number: _____

Name: Dakiera Warren Preferred: _____ Birthdate: 02/06/1997 Main

Phone Number: (334) 308-1220 Email: dakierawarren@gmail.com

Local Mailing Address: 531 Thames St. Box or APT #: _____

City: Greenville State: Alabama Zip Code: 36037

Permanent/Home Address: _____ Box or APT #: _____

City: _____ State: _____ Zip Code: _____

Marital Status: Single ☒ Married ☐ Divorced ☐ Widowed ☐ Other: _____

Sex: Male ☐ Female ☒ Gender: Male ☐ Female ☒

Primary Physician: Dr. Chandra R. Shelkar City: Greenville Phone #: 382-0530

Patient's Employer: Ruby Tuesday Work Phone #: (334) 382-1450

Parent's ☒ Spouse's Name: ☐ Denetria Warren Phone #: (334) 206-2517

Parent's or Spouse's Employer: Ruby Tuesday Phone #: 382-1450

Emergency Contact: Denetria Warren Relationship: Mother Phone #: 406-2517

How did you hear about the clinic: Friend ☐ Faculty/Staff ☐ Orientation ☐ Other: Trenholm

INSURANCE INFORMATION

Do you have health insurance? ☒ YES ☐ NO

If yes, please give your card to the front desk in order for a copy to be made for your chart.

Insurance Company: Symetra Life Insurance Name on Card: Dakiera Warren

Policy or Contract Number: 070176781 Group Number: 12055000

Insurance Company's Address: Symetra Select Benefits P.O. Box 3245,
Milwaukee, WI 53201-3245

AUM Student Health Services

Medical Information Release

Form (HIPPA Release Form)

Name: DeKiera Warren Date of Birth 02/06/97

Release of Information

☒ I authorize the release of information including the diagnosis, records, examination rendered to me, and claims information. This information may be released to:

☐ Spouse: _____

☐ Child(ren): _____

☒ Other: Trenholm State Technical College

☐ Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call ☐ my home ☐ my work ☒ my cell number: (334) - 368 - 1220

If unable to reach me:

☒ you may leave me a detailed message

☐ please leave a message asking me to return your call

☐ other: _____

The best time to reach me is (day or days) Anytime between 10:00 am and 5:00 pm times.

Signed: DeKiera Warren

Date: 07/16/19

AUM Student Health Services

PATIENT HIPPAA 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 (HIPPA). 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 involve in my treatment)
- Obtaining payment from third party payers (e. g. my insurance company)
- The day-to-day healthcare operations of your practice

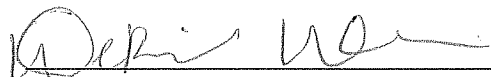
I have also been informed of and given the right to review and secure a copy of your *Summary of the HIPPA Privacy Rule*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA. I understand that you reserve the right to change 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.

Signed this 17 day of July 2019.
(day) (month) (last two digits of the year)

Print Patient's Name: DeKiera Warren

Signature: 

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

Name Dekiera Warren Date of birth _____

 Have you **EVER** had any of the following?

Medical: ☐ ADD/ADHD ☐ Adrenal disorders ☐ Alcohol abuse ☐ Allergies ☐ Anemia ☐ Anorexia ☐ Anxiety ☐ Arthritis ☒ Asthma ☐ Bladder disease ☐ Bleeding disorder ☐ Bulimia ☐ Cancer ☐ Celiac disease ☐ Chlamydia ☐ Clotting disorder ☐ Concussion ☐ Depression ☐ Diabetes ☐ Eczema ☐ Endometriosis ☐ Eye disorders ☐ Fractures/broken bones ☐ Genital warts ☐ Gonorrhea ☐ Headaches ☐ Hearing loss ☐ Heart disease ☐ Heart murmur ☐ Hepatitis ☐ Herpes ☐ HIV/AIDS ☐ Hives ☐ HPV ☐ High cholesterol ☐ High blood pressure ☐ Mononucleosis ☐ Irritable bowel syndrome ☐ Kidney stones ☐ Malaria ☐ Multiple sclerosis ☐ Mumps ☐ Muscular dystrophy ☐ Paget's disease of bone ☐ Pneumonia ☐ PCOS ☐ Pregnancy ☐ Psoriasis ☐ Radiation therapy ☐ Seizures ☐ Sinusitis (chronic) ☐ Stroke ☐ Thyroid disease ☐ Tuberculosis ☐ Typhoid fever ☐ Ulcerative colitis ☐ Ulcers ☐ Chicken pox	Anesthesia History: ☐ Difficult intubation ☐ Malignant hyperthermia ☐ Pseudocholinesterase deficiency ☐ Spinal headache	☐ I've had NO significant health problems
Surgical: ☐ Adenoidectomy ☐ Appendectomy ☐ Cholecystectomy ☐ Ear tubes ☐ Knee ACL tear ☐ Knee arthroscopy ☐ Organ transplant ☐ Ovarian cyst removal ☐ Splenectomy ☐ Tonsillectomy ☐ Weight loss surgery ☐ Other surgical history: _____ _____ _____ _____ _____		

Family History:

	Alcohol abuse	Clotting disorder	Breast cancer	Colon cancer	Melanoma	Other cancer:	Diabetes	Drug dependency	Heart disease	High cholesterol	High blood pressure	Learning disabilities	Mental illness	Stroke	Sudden cardiac arrest
Mother	☐	☐	☐	☐	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sister	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Brother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Grandfather	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Grandmother	☐	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Grandfather	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Grandmother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Aunt	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Uncle	☒	☐	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☒	☐	☐
Paternal Aunt	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Uncle	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

☐ Adopted ☐ Family history unknown



Have you **EVER** had any of the following?

EXERCISE:

Do you exercise regularly?

- ☐ Yes
☒ No

I moderately exercise:

- ☐ Less than three times per week
☐ Three or more times per week

I strenuously exercise:

- ☒ Less than three times per week
☐ Three or more times per week

SEXUAL ORIENTATION/GENDER:

What is your sexual orientation?

- ☒ Heterosexual (straight)
☐ Gay or lesbian
☐ Bisexual
☐ Other: _____

What is your gender?

- ☒ Female
☐ Male
☐ Transgender
☐ Other: _____

Preferred Pronoun:

- ☐ He/Him/His
☒ She/Her/Hers
☐ Other: _____

ABUSE HISTORY: *As violence is a problem in many families, we ask these questions to ALL patients. Please check all that apply.*

Verbal abuse:

- ☐ Currently experience
☐ Experienced in the past
☐ Never experienced
☐ Choose not to disclose

Physical abuse:

- ☐ Currently experience
☐ Experienced in the past
☐ Never experienced
☐ Choose not to disclose

Sexual abuse:

- ☐ Currently experience
☐ Experienced in the past
☐ Never experienced
☐ Choose not to disclose

ALCOHOL USE:

Do you drink? ☒ Yes ☐ No

If yes, how many per week?

Glasses of wine: 1

Cans of beer: _____

Shots of liquor: _____

RECREATIONAL DRUG USE:

Do you currently use? Yes ☐ No ☒ Times per week: _____

I use: (Check all that apply)

- | | | | | |
|--|---|--|--|--|
| ☐ Amphetamines | ☐ Amyl nitrate | ☐ Anabolic steroids | ☐ Barbiturates | ☐ Benzodiazepines |
| ☐ "Crack" cocaine | ☐ Cocaine | ☐ Fentanyl | ☐ Flunitrazepam | ☐ GHB |
| ☐ Hashish | ☐ Ketamine | ☐ LSD | ☐ Marijuana | ☐ Ecstasy |
| ☐ Mescaline | ☐ Methamphetamines | ☐ Methaqualone | ☐ Methylphenidate | ☐ Nitrous oxide |
| ☐ Opiates | ☐ Opium | ☐ PCP | ☐ Psilocybin | ☐ Solvent inhalants |

Other: _____

SEXUAL ACTIVITY/BIRTH CONTROL:

Sexually active?

- ☐ Yes
☒ No
☐ Not currently

Partners:

- ☐ Male
☐ Female
☐ Both

Date of last Pap test: N/A Normal: ☐ Yes ☐ No

Date of last menstrual period: 07/15

Birth control/method of contraception: (Check all that apply)

- | | | | | |
|--|------------------------------------|--|---|--|
| ☐ Abstinence | ☐ Diaphragm | ☐ Patch | ☐ Sponge | ☒ None |
| ☐ Birth control pills | ☐ Implant | ☐ Post-menopausal | ☐ Surgical | ☐ Other: _____ |
| ☐ Cervical cap | ☐ Injection | ☐ Rhythm | ☐ Vaginal condom | _____ |
| ☐ Condom | ☐ IUD | ☐ Spermicide | ☐ Withdrawal | _____ |

TOBACCO USE:

☐ Yes ☒ No Packs a day: (Check one)
☐ 0.25 ☐ 0.5 ☐ 1 ☐ 1.5 ☐ 2 ☐ 3

Smokeless tobacco?

- ☐ Yes ☒ No

Start date: _____

Quit date: _____

Comments: _____

Ready to quit?

- ☐ Yes ☐ No

Name Dekiera Warren

Date of birth 02/26/97

Have you **EVER** had any of the following?

MOBILITY:

Do you have a history of falls?

Have you had any recent decline in mobility?

Yes ☐ No ☒

Yes

No ☒

Have you had any recent changes in ability to perform activities of daily living?

Yes

No ☒

Assistive devices used: (Check all that apply) Contacts

Eyeglasses ☒ Brace LLE ☐ Brace RLE ☐ Cane ☐

C-collar ☐ Commode ☐ Crutches ☐ Dentures ☐

Other: _____

NUTRITION:

Any unintended weight loss (more than 10 pounds in the past two months)?

☐ Yes ☒ No

VACCINE:

Have you had a flu shot this season?

☐ Yes ☒ No

Have you ever had a pneumococcal vaccine?

☐ Yes ☒ No

COGNITIVE/FUNCTIONAL:

Are you deaf or hard of hearing?

☐ Yes ☒ No

Do you have difficulty walking or climbing?

☐ Yes ☒ No

Are you blind or have difficulty seeing, even wearing glasses?

☐ Yes ☒ No

Do you have difficulty dressing or bathing?

☐ Yes ☒ No

Do you have difficulty concentrating, remembering or making decisions?

☐ Yes ☒ No

Do you have difficulty doing errands alone, such as visiting a doctor's office or shopping?

☐ Yes ☒ No

DEPRESSION SCREENING:

Over the past two weeks, have you often been bothered by:

☐ Little interest or pleasure in doing things

☐ Feeling down, depressed or hopeless

☒ None of the above

HOME CARE:

Current type of residence:

☐ Off campus with roommates

☒ Off campus with parents

☐ Off campus without roommates

☐ On campus with roommates

☐ On campus without roommates

Support systems: (Check all that apply)

☐ Spouse/significant other ☒ Parent ☐ Children ☐ Family members

☐ Case manager/social worker ☐ Church/faith community

☐ Friends/neighbors ☐ Home care staff ☐ Organized support group

☐ Shelter ☐ Therapist ☐ None ☐ Other: _____

List current medications, including birth control, over the counter medications, vitamins, etc. (include dosage and frequency):

List allergies:

Chocolate

Walgreens Atlanta Hwy

CVS Atlanta Hwy

Pharmacy: 334-409-0611 ☐

334-271-5861 ☐

Wal-Mart Atlanta Hwy Publix Taylor Junction Wal-Mart Chantilly

334-272-2043 ☐

334-290-4507 ☐

334-272-7114 ☐

Other: CVS Greenville, AL (334)-382-3146