

AUM STUDENT HEALTH SERVICES

PATIENT INFORMATION (PLEASE PRINT LEGIBLY)

Date: 12/05/2019 Are you an AUM Student? ☒ Yes ☐ No S-Number: s00374997

Name: pinfeng Xu Preferred: Birthdate: 3/18/1999

Main Phone Number: 6465735394 Email:

Local Mailing Address: 749 Yeager lane Box or APT #: 749

City: Auburn State: AL Zip Code: 36832

Permanent/Home Address: 749 Yeager lane Box or APT #: 749

City: Auburn State: AL Zip Code: 36832

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

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

Primary Physician: City: Phone #:

Patient's Employer: Work Phone #:

Parent's ☐ Spouse's Name: ☐ Phone #:

Parent's or Spouse's Employer: Phone #:

Emergency Contact: Relationship: Phone #:

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

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: Name on Card:

Policy or Contract Number: Group Number:

Insurance Company's Address:

AUM STUDENT HEALTH SERVICES

CONSENT FOR SERVICES FORM

Patient Name:

Date of Birth:

	/		/	
Day		Month		Year

General Consent for Treatment

I request and authorize health care services by my provider and his/her designees(s) as my provider may deem advisable and in my best interest. This may include routine diagnostic, laboratory procedures, and administration.

I understand that excluding emergency or extraordinary circumstances, no substantial procedure will be performed without providing me an opportunity to give me informed consent for that procedure. Informed consent means that the medical provider must disclose information to me including benefits and risks of a particular procedure and/or treatment.

Payment

I am responsible for all bills incurred at the Student Health Center. Payment is due at the time that services are rendered unless prior arrangements have been made.

I have read the consent form, or it has been read to me, and I am satisfied that I understand its contents. My questions have been answered to my satisfaction.

[SIGN HERE]

Signature of Patient

Signature of Legal Representative (if patient is unable to sign)

12/05/2019

	/		/	
Day		Month		Year

Date of Signature

Relationship to Patient

AUM Student Health Services
Medical Information Release
Form (HIPAA Release Form)

Name: Date of Birth / /

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:
- ☐ 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: () - -

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) between and times.

Signed:

12/05/2019

Date: / /

AUM Student Health Services

PATIENT HIPAA 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 (HIPAA). 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 HIPAA Privacy Rule*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. 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 day of 20
(day) (month) (last two digits of the year)

Print Patient's Name:

Signature:

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

Name PINFENG XU

 Date of birth 03/18/1999
Have you EVER had any of the following?
Medical:

- | | | |
|--|---|--|
| ☐ ADD/ADHD | ☐ Endometriosis | ☐ Multiple sclerosis |
| ☐ Adrenal disorders | ☐ Eye disorders | ☐ Mumps |
| ☐ Alcohol abuse | ☐ Fractures/broken bones | ☐ Muscular dystrophy |
| ☐ Allergies | ☐ Genital warts | ☐ Paget's disease of bone |
| ☐ Anemia | ☐ Gonorrhea | ☐ Pneumonia |
| ☐ Anorexia | ☐ Headaches | ☐ PCOS |
| ☐ Anxiety | ☐ Hearing loss | ☐ Pregnancy |
| ☐ Arthritis | ☐ Heart disease | ☐ Psoriasis |
| ☐ Asthma | ☐ Heart murmur | ☐ Radiation therapy |
| ☐ Bladder disease | ☐ Hepatitis | ☐ Seizures |
| ☐ Bleeding disorder | ☐ Herpes | ☐ Sinusitis (chronic) |
| ☐ Bulimia | ☐ HIV/AIDS | ☐ Stroke |
| ☐ Cancer | ☐ Hives | ☐ Thyroid disease |
| ☐ Celiac disease | ☐ HPV | ☐ Tuberculosis |
| ☐ Chlamydia | ☐ High cholesterol | ☐ Typhoid fever |
| ☐ Clotting disorder | ☐ High blood pressure | ☐ Ulcerative colitis |
| ☐ Concussion | ☐ Mononucleosis | ☐ Ulcers |
| ☐ Depression | ☐ Irritable bowel syndrome | ☐ Chicken pox |
| ☐ Diabetes | ☐ Kidney stones | |
| ☐ Eczema | ☐ Malaria | |

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 cancer	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:
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:

Normal: ☐ Yes ☐ No

Date of last menstrual period:

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

- | | | | | |
|--|------------------------------------|--|---|-------------------------------|
| ☐ Abstinence | ☐ Diaphragm | ☐ Patch | ☐ Sponge | ☐ None |
| ☐ Birth control pills | ☐ Implant | ☐ Post-menopausal | ☐ Surgical | Other: <input type="text"/> |
| ☐ Cervical cap | ☐ Injection | ☐ Rhythm | ☐ Vaginal condom | <input type="text"/> |
| ☐ Condom | ☐ IUD | ☐ Spermicide | ☐ Withdrawal | <input type="text"/> |

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

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

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

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 allergies:

Walgreens Atlanta Hwy

CVS Atlanta Hwy

☐ 334-409-0611

☐ 334-271-5861

Pharmacy:
☐ Wal-Mart Atlanta Hwy

☐ Publix Taylor Junction

☐ Wal-Mart Chantilly

☐ 334-272-2043

☐ 334-290-4507

☐ 334-272-7114

 Other: