

AUM STUDENT HEALTH SERVICES

PATIENT INFORMATION (PLEASE PRINT LEGIBLY)

Date: 1/9/2016 Are you an AUM Student? ☐ Yes ☒ No S-Number: 418-98-4972

Name: Marilyn Lee Preferred: _____ Birthdate: 01-01-1966

Main Phone Number: 334 3966517 Email: mpickretna@yahoo.com

Local Mailing Address: 3138 Guyman Road Box or APT #: _____

City: Montgomery State: AL Zip Code: 36111

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

City: Monty State: AL Zip Code: 36111

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

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

Primary Physician: Lois Schulman City: Montgomery Phone #: _____

Patient's Employer: Dialysis Center Inc Work Phone #: 265-9190

Parent's ☐ Spouse's Name: ☐ _____ Phone #: _____

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

Emergency Contact: Stephanie Williams Relationship: daughter Phone #: 320-7770

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

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: BCBS-Tennessee Name on Card: _____

Policy or Contract Number: _____ Group Number: 82089

Insurance Company's Address: _____

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 9th day of January 2020.
(day) (month) (last two digits of the year)

Print Patient's Name: Marilyn Lee

Signature: Marilyn Lee

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

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

Name: Marilyn Lee Date of Birth 01-01-1966

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): Stephanie Williams - daughter
Brenda Range - daughter
- ☐ 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: Marilyn Lee

Date: 01/09/2020

AUM STUDENT HEALTH SERVICES

CONSENT FOR SERVICES FORM

Patient Name: Marilyn Lee Date of Birth: 01 / 01 / 1966
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.

Marilyn Lee

Signature of Patient

01 / 09 / 2020
Day Month Year

Date of Signature

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

Relationship to Patient

Name Marilyn Lee

Date of birth 01-01-1966

Have you EVER had any of the following?

Medical:			Anesthesia History:
☒ ADD/ADHD	☒ Endometriosis	☒ Multiple sclerosis	☐ I've had NO significant health problems
☐ Adrenal disorders	☐ Eye disorders	☐ Mumps	
☐ Alcohol abuse	☐ Fractures/broken bones	☐ Muscular dystrophy	☒ Difficult intubation ☒ Malignant hyperthermia ☒ Pseudocholinesterase deficiency ☒ Spinal headache
☐ Allergies	☐ Genital warts	☐ Paget's disease of bone	
☐ Anemia	☐ Gonorrhea	☐ Pneumonia	Surgical: ☒ Adenoidectomy ☒ Appendectomy ☒ Cholecystectomy ☒ Ear tubes ☒ Knee ACL tear ☒ Knee arthroscopy ☒ Organ transplant ☒ Ovarian cyst removal ☒ Splenectomy ☒ Tonsillectomy ☒ Weight loss surgery
☐ Anorexia	☐ Headaches	☐ PCOS	
☐ Anxiety	☐ Hearing loss	☐ Pregnancy	☐ Other surgical history: heart cath hysterectomy
☐ 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		

[illegible]☐ Adopted ☐ Family history unknown

Name _____

Date of birth _____

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

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

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 allergies:

None

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: _____

Marilyn Lee

01-01-1966

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: 2 yrs ago 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: _____ |
| ☐ 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