

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT LEGIBLY)

Date: 12-3-18 Are you an AUM Student? ☒ Yes ☐ No S-Number: _____

Name: Mark E. Jones Birthdate: 9-29-02

Main Phone Number: 334-649-9250 Alternate Phone Number: _____

Local Mailing Address: 3672 Fernway Dr. Box or APT #: _____

City: Montgomery State: AL Zip Code: 36111

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

City: _____ State: _____ Zip Code: _____

Marital Status (Please Circle): Single Married Divorced Widowed Other: _____

Sex (Please Circle): Male Female Gender: Male Female

Primary Physician: Alicia Hughes City: Mont AL Phone #: 334-293-5033
Physician to Children

Patient's Employer: N/A Work Phone #: _____

Parent's or Spouse's Name (Circle which): Danyal Jones Phone #: 334-649-9250

Parent's or Spouse's Employer: AUM Phone #: 334-244-5479

Emergency Contact: Danyal Jones Relationship: Mother Phone #: 334-649-9250

How did you hear about the clinic (Circle which): Friend Faculty/Staff Orientation Other: Mother

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 Name on Card: Danyal Jones

Policy or Contract Number: QAV83008278 Group Number: 37655

Insurance Company's Address: 450 Riverchase Pkwy E. Birmingham, AL 35244

AUM STUDENT HEALTH CENTER

CONSENT FOR SERVICES FORM

Patient Name: Mark E. Jones Date of Birth: 9 / 29 / 02
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.

Mark E. Jones
Signature of Patient

12 / 03 / 18
Day Month Year
Date of Signature

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

Mother
Relationship to Patient

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

Name: Mark R. Jones Date of Birth 9/29/02

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: Parents

☐ 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)-649-9280

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: Mark Jones

Date: 12/23/18

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 3rd day of December 20 18.
(day) (month) (last two digits of the year)

Print Patient's Name: Mark E. Jones

Signature: Mark Jones

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

NAME: Mark E. JonesDate: 12-3-18Family History: Have YOU or anyone in your family ever been treated for any of the following?

	You	Father	Mother	Aunt	Uncle	Brother	Sister	Children	Grandparent	Other
Depression			✓							
Anxiety										
Panic Attacks										
Post-traumatic stress										
Bipolar										
Schizophrenia										
Alcohol/Drug problems										
ADHD/ADD			✓							
Suicide attempts										
Suicide										

☐ Check here if there is no known family historySubstance Abuse HistoryRegarding alcohol, when was your last drink? N/AIn the past 30 days, about how many of those days have you had at least one alcoholic drink? N/AWhat is the maximum number of drinks you have had in one day in the past month? N/A

Have you ever experienced the following? DUI DWI Public Intoxication Seizures DT's

Please check the appropriate boxes that apply to you for the following substances:

	Never Used	Age first used	Last used on this date (approximately)	Age peak use	History of abuse	Current use and frequency
Cocaine	✓					
Amphetamine or Speed	✓					
Marijuana	✓					
Pain Pills	✓					
Cigarettes, Cigars or Tobacco	✓					
Heroin	✓					
Benzodiazepines (Xanax, Valium, Ativan, Restoril, Librium)	✓					
Other:	✓					

Pharmacy Name and Number

Please List all current medications below

(include birth control pills, over the counter medication and herbal remedies (i.e. decongestants, St. John's Wort etc.)

Name of Medication	Dosage (Mg)	Times per Day	Dates of Use	Side Effects (if any)	Prescribing Physician
Mucinex	2 tablets	1	12/30/18 - present	none	_____
Thera-Flu	1 packet	1	11/30/18 -	none	_____

Preferred pharmacy? Winn-DixiePhone #: 334-272-5979

NAME: Mark E. JonesDate: 12-31-18

AUM Student Health Services Comprehensive Health History Form

Medical History: Do you have, or have you ever had any of the following? (check all that apply)

Cardiovascular ☐ High Blood Pressure ☐ Congestive Heart Failure ☐ Atrial Fibrillation ☐ Other: _____	Gastrointestinal ☐ Ulcers ☐ Pancreatitis ☐ Irritable Bowel ☐ Colitis ☐ Crohn's ☐ Reflux	Respiratory ☒ Asthma ☐ COPD / Emphysema ☐ TB (Tuberculosis)	Immunologic / Viral ☐ HIV / AIDS ☐ Herpes ☐ Epstein-Barr	Endocrine ☐ Diabetes ☐ Thyroid (Hyper/Hypo) Musculoskeletal ☐ Arthritis
Neurologic ☐ Stroke ☐ Parkinson's Disease ☐ Alzheimer's / Dementia ☐ Seizure Disorder ☐ Headaches ☐ Migraines ☐ Sleep Apnea ☐ Fibromyalgia ☐ Insomnia (Can't Sleep)	Kidney & Urologic ☐ Kidney Stones ☐ Enlarged Prostate ☐ Urinary Tract Infections Liver ☐ Gallstones ☐ Cirrhosis Hepatitis: ☐ A ☐ B ☐ C	Reproductive ☐ Hysterectomy ☐ Contraceptives Used: Menstrual Cycle: ☐ Regular ☐ Irregular ☐ Genital Disease(s) ☐ Infertility ☐ Erectile Dysfunction	Ear/Nose/Throat/Eye ☐ Glaucoma ☐ Cataract ☐ Chronic Sinus Infection ☐ Upper Airway Infections ☐ Dizziness	Other ☐ Cancer (explain): ☐ Anemia ☐ High Cholesterol ☐ Sickle Cell ☐ On Anticoagulants ☐ Chronic Pain (explain): ☐ Skin Conditions (explain):

Review of Systems: (check all SYMPTOMS that apply)

Systemic Weight: ☐ gain ☐ loss ☐ Fever ☐ Chills ☐ Night Sweats ☐ Pain	Gastrointestinal Appetite: ☐ good ☐ fair ☐ poor ☐ Difficulty Swallowing ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Heartburn ☐ Rectal Bleeding ☐ Abdominal Pain	Cardiovascular ☐ Chest Pain ☐ Palpitations (irregular heartbeat)	Skin ☐ Dry Skin ☐ Itchy Skin ☐ Peeling Skin ☐ Scaling Skin ☐ Discolored Skin ☐ Rash(es) on Skin	Endocrine ☐ Excessive Thirst ☐ Heat Intolerance ☐ Cold Intolerance ☐ Excessive Sweating ☐ Feelings of Weakness
Neurologic / Head ☐ Involuntary Movements ☐ Speech Problems ☐ Paralysis ☐ Dizziness ☐ Fainting ☐ Vertigo ☐ Confusion ☐ Memory Loss ☐ Limb Weakness ☐ Balance Problems ☐ Tingling ☐ Numbness ☐ Headache ☐ Sinus Pain	Genitourinary ☐ Blood in Urine ☐ Odor in Urine ☐ Frequent Urination ☐ Difficult Urination ☐ Small Amount of Urine ☐ Night Time Urination ☐ Incontinent of Urine	Pulmonary ☐ Difficulty Breathing ☐ Short of Breath ☒ Dry Cough ☐ Productive Cough ☐ Cough with Blood ☐ Wheezing	Eye and Ears-Nose-Throat ☐ Vision ☐ Diplopia ☐ Blurry Vision ☐ Red Eyes ☐ Hearing Loss ☐ Tinnitus (ringing in ear) ☐ Epistaxis (nose bleeds) ☐ Nasal Itching ☒ Sore Throat ☐ Mouth Sores ☐ Mouth Dryness ☒ Runny Nose	Musculoskeletal ☐ Back Pain ☐ Muscle Aches ☐ Muscle Cramps ☐ Joint Pain - localized ☐ Joint Swelling - localized ☐ Joint Stiffness - localized ☐ Arthritis Pain

Please list all prior surgeries and hospitalizations for medical illnesses:

Nasal Polyps removed

Do you have any allergies to food or medications? If so, please list below & the type(s) of reaction (ie: hives, tongue swelling, etc.).

N/A

NAME: Mark E. Jones Date: 12-3-18

FAMILY HISTORY: Indicate illnesses in blood relatives. Check those that apply.

- | | | |
|--|---|---|
| ☐ Anemia | ☐ Diabetes (type 1 or 2) | ☐ Migraines/headaches |
| ☐ Bleeding or clotting abnormally | ☐ Heart disease | ☐ Stroke |
| ☐ Breast disease | ☐ High cholesterol | ☐ Thyroid disorder (Hypo or Hyper) |
| ☐ Cancer | ☐ High blood pressure | ☐ Arthritis |
| ☐ Prostate | | ☐ Rheumatoid |
| ☐ Skin | | ☐ Osteoarthritis |
| ☐ Colon | | |
| ☐ Lung | | ☐ Connective Tissue |
| ☐ Breast | | ☐ Lupus |
| ☐ Other _____ | | Other: _____ |

SEXUAL HISTORY:

Have you ever been sexually active? __Yes ✓ No

Are you currently sexually active? __Yes ✓ No

Do you use protection and or contraceptives? __Yes ✓ No

- | | | |
|--|-----------------------------------|---------------------------------------|
| ☐ birth control pills | ☐ IUD | ☐ Condoms |
| ☐ DepoProvera | ☐ Implants | ☐ Other: _____ |

Complete the following questions if you are sexually active:

Are you currently having sexual relations with one partner or multiple partners? __one __multiple

Number of partners in last year: _____

Are/Is your sexual partner(s): __men __women __both

Have you ever had a sexually transmitted infection (STI)(ie: HPV, Herpes, Chlamydia, Gonorrhea or other)? __Yes __No

List STI: _____ Treated: __Yes __No

GYNECOLOGICAL HISTORY:

Do you a period every month? __Yes __No

Number of days of flow: _____

Menstrual cramps: __mild __moderate __severe __normal

Date of last PAP smear: _____ Last PAP smear results: _____ Have you ever had an abnormal Pap smears? __Yes __No

If yes, explain clinical history (including test location, date, what was done) for any abnormal PAP smear?

Are you presently trying to become pregnant or will be trying soon? __Yes __No

Have you had a mammogram? __Yes __No

If applicable, indicate the date and result of your last mammogram: