

AUM WARHAWK HEALTH SERVICES

PATIENT INFORMATION (PLEASE PRINT LEGIBLY)

Date: Oct 5 2020 Are you an AUM Student? ☒ Yes ☐ No S-Number: 5003 77 089

Name: Tatiana P. Delapiedra Preferred: _____ Birthdate: 08/25/1985

Main Phone Number: 334.300.3870 Email: tatypdelapiedra@gmail.com

Local Mailing Address: 2928 US Highway 31N Box or APT #: _____

City: Marbury State: AL Zip Code: 36051

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

City: _____ State: _____ Zip Code: _____

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: ☒ Maurio F. Lapolla Phone #: 334.300.3962

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

Emergency Contact: Tais Swinning Relationship: sibling Phone #: 334.224.1283

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: United Healthcare Name on Card: Tatiana Delapiedra

Policy or Contract Number: 8416904 / 2020-38-4 Group Number: _____

Insurance Company's Address: _____

AUM Warhawk HEALTH SERVICES

CONSENT FOR SERVICES FORM

Patient Name: tatiana Delapiedra Date of Birth: 25 / 08 / 85
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.

tatiana Delapiedra

Signature of Patient

25 / 08 / 85
Day Month Year

Date of Signature

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

Relationship to Patient

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

Name: Tatiana Delapiedra Date of Birth 25/08/85

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: Mauro F. Lapolla
☐ 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: (334)-300 - 3870

If unable to reach me:

- ☐ you may leave me a detailed message
☐ please leave a message asking me to return your call
☒ other: taty p delapiedra @ gmail . com

The best time to reach me is (day or days) _____ between _____ and _____ times.

Signed: Tatiana Delapiedra

Date: 10/5/2020

AUM Warhawk 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 05 day of Oct 2020.
(day) (month) (last two digits of the year)

Print Patient's Name: Satiana P. Delapiedre

Signature: SP Delapiedre

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



AUM Warhawk Health Services - Confidential Medical History Form

Name Tatiana Delapiedra

Date of birth 08/25/85

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

Name Latiame OkapidaDate of birth 08/25/85Have 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: July 2019Normal: ☒ Yes ☐ NoDate of last menstrual period: IUD

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 _____

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**HOME CARE:**

Current type of residence:

☐ Off campus without roommates☐ On campus with roommates☐ Off campus with roommates☐ On campus without roommates☐ Off campus with parents

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):

IUD

plant base vitamins (daily 1x)

List allergies:

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: _____