

AUM STUDENT HEALTH SERVICES

PATIENT INFORMATION (PLEASE PRINT LEGIBLY)

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

Name: Lisa B. Smith Preferred: Lisa Birthdate: 9-29-1967

Main Phone Number: 706-585-0398 Email: lsmit127@aum.edu

Local Mailing Address: 1802 29th St. Box or APT #: _____

City: Valley State: AL Zip Code: 36854

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

City: _____ State: _____ Zip Code: _____

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

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

Primary Physician: Bartol S. Baliga City: Columbus Ga Phone #: _____

Patient's Employer: Aum Work Phone #: 334-244-3663

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

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

Emergency Contact: Gerry Smith Relationship: Spouse Phone #: 706-501-9420

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: BCBS Name on Card: Lisa Brand Smith

Policy or Contract Number: QAU853002711 Group Number: 37650

Insurance Company's Address: 450 Riverchase Pkwy East, B'ham AL

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

Name: Lisa B. Smith Date of Birth 9/29/67

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: Gerry Smith
☐ 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.

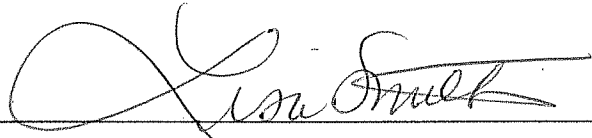
Messages

Please call ☐ my home ☐ my work ☒ my cell number: (706)-585-0398

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 _____ and _____ times.

Signed: 

Date: 12/7/2020

Name Lisa Smith

 Date of birth 9-29-67

 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 - 2003 ☐ Ear tubes ☐ Knee ACL tear ☐ Knee arthroscopy ☐ Organ transplant ☐ Ovarian cyst removal ☐ Splenectomy ☐ Tonsillectomy ☐ Weight loss surgery ☒ Other surgical history: <u>Nissen Fundoplication</u> <u>4290</u> <u>173-1</u>	

Family History:

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

☐ Adopted ☐ Family history unknown

Name Lisa SmithDate of birth 9-29-67Have 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*With spouse*

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

Losartan 100mg qdSpiroonolactone 50mg qdSimvastatin 5 2x wkMetformin 500 qd

Support systems: (Check all that apply)

☒ Spouse/significant other ☐ Parent ☐ Children ☐ Family members☐ Case manager/social worker ☐ Church/fairh community☐ Friends/neighbors ☐ Home care staff ☐ Organized support group☐ Shelter ☐ Therapist ☐ None ☐ Other: _____**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: _____