

AUM STUDENT HEALTH SERVICES

PATIENT INFORMATION (PLEASE PRINT LEGIBLY)

Date: 12-7-20 Are you an AUM Student? ☐ Yes ☒ No S-Number: _____

Name: Gerry L. Smith Preferred: Gerry Birthdate: 6-16-1963

Main Phone Number: 706-501-9420 Email: gerrysmithlawrs@gmail.com

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: _____ City: _____ Phone #: _____

Patient's Employer: Self-employed Work Phone #: 706-501-9420

Parent's ☐ Spouse's Name: ☒ Lisa Smith Phone #: 706-585-0398

Parent's or Spouse's Employer: Aum Phone #: 334-244-3663

Emergency Contact: Lisa Smith Relationship: wife Phone #: 706-585-0398

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 - AL Name on Card: _____

Policy or Contract Number: QUA853002711 Group Number: 37655

Insurance Company's Address: _____

AUM STUDENT HEALTH SERVICES

CONSENT FOR SERVICES FORM

Patient Name: Gerry Smith Date of Birth: 6 / 16 / 1963
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.

X Gerry Smith
Signature of Patient

7 / Dec / 2020
Day Month Year
Date of Signature

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

Relationship to Patient



AUBURN
MONTGOMERY

Name

Gerry Smith

Date of birth

6-16-63

Have you EVER had any of the following?

EXERCISE:

Work outside

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: N/A

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:

NEVER

☐ Yes ☒ No

Packs a day: (Check one)

☐ 0.25 ☐ 0.5 ☐ 1 ☐ 1.5 ☐ 2 ☐ 3

Smokeless tobacco?

☐ Yes ☒ No

Start date: _____

Quit date: _____

Ready to quit?

☐ Yes ☐ No

Comments: _____

Name Gerry Smith Date of birth 6-16-63

 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 | <i>Tendonitis</i> |
| ☐ Eczema | ☐ Malaria | <i>Plantar Fasciitis</i> |

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:
<u>Hernia as infant</u>
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|--|--|

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

AUM Student Health Services

Medical Information Release

Form (HIPAA Release Form)

Name: Gerry Smith Date of Birth 6/16/63

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: Lisa 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 - 501 - 9420

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) Day or evening between _____ and _____ times.

X Signed: Gerry L. Smith

Date: 12/7/20

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 7th day of Dec 20 20.
(day) (month) (last two digits of the year)

Print Patient's Name: Gerry Smith

X Signature: Gerry Smith

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



Name Gerry Smith Date of birth 6-16-63
Have you **EVER** had any of the following?

MOBILITY:

Have you had any recent decline in mobility?

Yes ☒ No ☐

Do you have a history of falls?

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 Reading Glasses/Bifocals

Eyeglasses ☐ Brace LLE ☐ Brace RLE ☐ Cane ☐

C-collar ☐ Commode ☐ Crutches ☐ Dentures ☐

Other: Pain in left foot

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):

Rosuvastatin 20mg

MVI

Fish Oil

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

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: Kroger - Lanett AL

334-642-6888

RESET FORM

Auburn University Healthy Tigers- Provider Screening Form

Instructions: If you can not or choose not to participate in the Healthy Tigers screenings through the AUPCC, you may submit your health screening results through your physician. You are to complete **Section 1** of the form and your provider is to complete **Section 2**.

Certain lab tests associated with the Healthy Tigers Program when performed by your physician may only be covered once every 5 years by AUBCBS and you may be responsible for additional lab costs.

NAME (PLEASE PRINT): Gerry Smith SUBSCRIBER BANNER NUMBER: _____

AGE: 57 DATE OF BIRTH: 6-16-63 GENDER (CHECK ONE): ☒ MALE ☐ FEMALE

SUBSCRIBER NAME (AS APPEARS ON AU BCBS INSURANCE CARD): Lisa Brand Smith

AU BCBS CONTRACT NUMBER: QUA 85300 2711

DAYTIME OR CAMPUS PHONE NUMBER: 706-501-9420 E-MAIL ADDRESS: gerrysmithlawns@gmail.com

What best describes your race/ethnicity?

- ☒ White ☐ Black/African American ☐ Asian ☐ Indian or Alaska Native
☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ Other

Do you HAVE (or have you been told you had) any of the following? (Mark all that apply.)

- ☒ High Cholesterol ☐ High Blood Pressure or Hypertension ☐ Diabetes

Do you take MEDICATION for any of the following? (Mark all that apply.) Optional: Please provide a list of all of your medications on the back of this form (including prescription, over the counter, vitamins, and minerals)

- ☒ High Cholesterol ☐ High Blood Pressure or Hypertension ☐ Diabetes

SECTION 2 (To Be Completed by Healthcare Provider)

REQUIRED DATA

Blood Pressure _____ / _____ mmHg

Height _____ ft _____ in

Total Cholesterol _____ mg/dL

Weight _____ pounds

Blood Glucose _____

BMI _____

Alarm values: Total Cholesterol ≥ 250

Blood glucose ≥ 200

Blood pressure - Systolic ≥ 160 mm Hg

Diastolic ≥ 100 mm Hg

BMI ≥ 35

OPTIONAL DATA

HDL Cholesterol _____ mg/dL

TC/HDL Ratio _____

The above mentioned member has been evaluated in my office and counseled regarding his/her risk factors. In particular, I have noted any values that were above alarm values and responded as clinically indicated.

DATE TESTS PERFORMED BY PHYSICIAN (THIS DATE IS REQUIRED) _____ / _____ / _____

Healthcare Provider's Name: (Please Print) _____

Healthcare Provider Signature: _____

Healthcare Provider Address / Phone: _____

Please return completed form to:
 AUBURN UNIVERSITY PHARMACEUTICAL CARE CENTER (AUPCC)
 Attention: Healthy Tigers Program

2155 Walker Building, HSOP, 362 West Thach Avenue
 Auburn University, Alabama 36849-5506

PHONE: (334) 844-4099 FAX: (334) 844-4019 E-MAIL: healthytigers@auburn.edu

For AUPCC use only: Banner ☐ EMR ☐