

AUM STUDENT HEALTH SERVICES

PATIENT INFORMATION (PLEASE PRINT LEGIBLY)

Date: JAN 6, 2021 Are you an AUM Student? Yes ☒ No ☐ S-Number: 423 90 3740

Name: DONALD G. ODOM Preferred: DON Birthdate: JAN 11, 1959

Main Phone Number: 205 294 0110 Email: WODD59@ICLOUD.COM

Local Mailing Address: 1569 US HWY 31 Box or APT #: _____ City: VERBENA State: AL Zip Code: 36091

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: DR. JANI City: CLANTON Phone #: 205 280 1080

Patient's Employer: NONE Work Phone #: _____

Parent's Spouse's Name: MARIE ODOM Phone #: 205 529 8796

Parent's or Spouse's Employer: AUM Phone #: 334 244 3799

Emergency Contact: MARIE ODOM Relationship: SPOUSE Phone #: 205 529 8796

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: MEDICARE TRICARE FOR LIFE Name on Card: DONALD GENE ODOM

Policy or Contract Number: 423 90 3740 Group Number: _____

Insurance Company's Address: _____

AUM STUDENT HEALTH SERVICES

CONSENT FOR SERVICES FORM

Patient Name: DONALD G. ODOM Date of Birth: 11 / 01 / 1959
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.

Donald G. Odom

Signature of Patient

06 / 01 / 2021
Day Month Year

Date of Signature

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

Relationship to Patient

AUM Student Health Services

Medical Information Release

Form (HIPPA Release Form)

Name: _____ Date of Birth ____/____/____

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: MARIE ODOM

☐ 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: (205)-294-0110 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) ANY TIME between
_____ and _____ times.

Signed: Donald G. Odom

Date: 01 / 06 / 2021

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 06 day of 01 20 21.
(day) (month) (last two digits of the year)

Print Patient's Name: DONALD G. ODOM

Signature: Donald G. Odom

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

AUM Student Health Services - Confidential Medical History Form

Name DONALD G. ODOM Date of birth JAN 11, 1959 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 ☐ Ear tubes ☐ Knee ACL tear ☒ Knee arthroscopy ☐ Organ transplant ☐ Ovarian cyst removal ☐ Splenectomy ☐ Tonsillectomy ☐ Weight loss surgery						☐ Other surgical history: <u>5 BACK SURGERIES</u> <u>1 (R) ELBOW SURGERY</u>			

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 ar-
Mother															
Father						X		X		X					
Sister															
Brother															
Maternal Grandfather															
Maternal Grandmother															
Paternal Grandfather															
Paternal Grandmother															
Maternal Aunt															
Maternal Uncle															
Paternal Aunt															
Paternal Uncle															

☐ Adopted Family history unknown

December 2018



AUBURN
MONTGOMERY

Name DONALD G. ODOM

Date of birth JAN 11, 1959 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:

is a problem in many families, we ask these questions to ALL patients. & all that apply.

Verbal abuse:

- ☐ Currently experience
☐ Experienced in the past
☒ Never experienced
☒ Choose not to disclose

Please check 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: _____

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? No ☒ Yes ☐ Partners: _____ Date of last Pap test: _____ Normal: ☐ Yes
☐ Male ☒ Female Date of last menstrual period: _____
☐ Not currently ☐ Both

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? Start date: _____ Quit date: _____
☐ Yes ☐ No

Comments: _____

Ready to quit?
☐ Yes ☐ No

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Name _____ Date of birth _____

Have you EVER had any of the following?

MOBILITY:

Have you had any recent decline in mobility?

☒ Yes ☐ No

Have you had any recent changes in ability to perform activities of daily living?

☒ Yes ☐ No

Do you have a history of falls?

☒ Yes ☐ No

Assistive devices used: (Check all that apply) Contacts

☒ Eyeglasses ☐ Brace LLE ☐ Brace RLE ☐ Cane
☐ C-collar ☐ Commode ☐ Crutches ☒ Dentures
Other: WHEEL CHAIR

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? Have you ever had a pneumococcal vaccine?

☒ Yes ☐ No

☐ 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.):

—

—

—

—

—

HOME CARE:

Off campus without roommates

Current type of residence:

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

C Case manager/social worker ☒ Church/faith community

Friends/neighbors

Home care staff

Organized support group

S. Shelter

Therapist

☒ None

Other: _____

List allergies:

Walgreens Atlanta Hwy

CVS Atlanta Hwy

Pharmacy:

334-409-0611

334-271-5861

Wal-Mart Atlanta Hwy

334-272-

0263

Other: _____

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