

# AUM STUDENT HEALTH SERVICES

## PATIENT INFORMATION (PLEASE PRINT LEGIBLY)

Date: 01-08-2020 Are you an AUM Student? ☒ Yes ☐ No S-Number: 500377331

Name: Revanth Antham Preferred: Revanth Birthdate: 07-25-1993

Main Phone Number: 442 230 8769 Email: anthamrevanth@gmail.com

Local Maining Address: 7040 - D. Taylor Gossing rd Box or APT #: D

City: Montgomery State: Alabama Zip Code: 36117

Permanent/Home Address: 1-40, Lingapoor, Shankarapalnam Box or APT #: \_\_\_\_\_

City: Karimnagar State: Telangana Zip Code: 505468

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: ☐ \_\_\_\_\_ Phone #: \_\_\_\_\_

Parent's or Spouse's Employer: \_\_\_\_\_ Phone #: \_\_\_\_\_

Emergency Contact: Aitha Sharath kumar Relationship: Friend Phone #: 9568909172

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: \_\_\_\_\_ Name on Card: \_\_\_\_\_

Policy or Contract Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Insurance Company's Address: \_\_\_\_\_

# AUM STUDENT HEALTH SERVICES

## CONSENT FOR SERVICES FORM

Patient Name: Revanth Antham Date of Birth: 08 / 01 / 2020  
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.

Revall  
Signature of Patient

08 / 01 / 2020  
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: Revanth Antham Date of Birth 25/07/1993

**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: friend

☐ 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: (442) - 230 - 8769.

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: Revanth

Date: 08/01/2020

# 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 (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 08 day of 01 2020.  
(day) (month) (last two digits of the year)

Print Patient's Name: Revanth Antham

Signature: Revall

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

Name Revanth Antham

 Date of birth 25-07-1993  
July
**Have you EVER had any of the following?**
**Medical:**

- |                                            |                                                   |                                                  |
|--------------------------------------------|---------------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> ADD/ADHD          | <input type="checkbox"/> Endometriosis            | <input type="checkbox"/> Multiple sclerosis      |
| <input type="checkbox"/> Adrenal disorders | <input type="checkbox"/> Eye disorders            | <input type="checkbox"/> Mumps                   |
| <input type="checkbox"/> Alcohol abuse     | <input type="checkbox"/> Fractures/broken bones   | <input type="checkbox"/> Muscular dystrophy      |
| <input type="checkbox"/> Allergies         | <input type="checkbox"/> Genital warts            | <input type="checkbox"/> Paget's disease of bone |
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> Gonorrhea                | <input type="checkbox"/> Pneumonia               |
| <input type="checkbox"/> Anorexia          | <input type="checkbox"/> Headaches                | <input type="checkbox"/> PCOS                    |
| <input type="checkbox"/> Anxiety           | <input type="checkbox"/> Hearing loss             | <input type="checkbox"/> Pregnancy               |
| <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Heart disease            | <input type="checkbox"/> Psoriasis               |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Heart murmur             | <input type="checkbox"/> Radiation therapy       |
| <input type="checkbox"/> Bladder disease   | <input type="checkbox"/> Hepatitis                | <input type="checkbox"/> Seizures                |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Herpes                   | <input type="checkbox"/> Sinusitis (chronic)     |
| <input type="checkbox"/> Bulimia           | <input type="checkbox"/> HIV/AIDS                 | <input type="checkbox"/> Stroke                  |
| <input type="checkbox"/> Cancer            | <input type="checkbox"/> Hives                    | <input type="checkbox"/> Thyroid disease         |
| <input type="checkbox"/> Celiac disease    | <input type="checkbox"/> HPV                      | <input type="checkbox"/> Tuberculosis            |
| <input type="checkbox"/> Chlamydia         | <input type="checkbox"/> High cholesterol         | <input type="checkbox"/> Typhoid fever           |
| <input type="checkbox"/> Clotting disorder | <input type="checkbox"/> High blood pressure      | <input type="checkbox"/> Ulcerative colitis      |
| <input type="checkbox"/> Concussion        | <input type="checkbox"/> Mononucleosis            | <input type="checkbox"/> Ulcers                  |
| <input type="checkbox"/> Depression        | <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> Chicken pox             |
| <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Kidney stones            |                                                  |
| <input type="checkbox"/> Eczema            | <input type="checkbox"/> 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               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Father               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sister               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Brother              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Maternal Grandfather | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Maternal Grandmother | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Paternal Grandfather | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Paternal Grandmother | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Maternal Aunt        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Maternal Uncle       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Paternal Aunt        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Paternal Uncle       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

☐ Adopted    ☐ Family history unknown



**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:** *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)

- |                                          |                                           |                                            |                                          |                                            |
|------------------------------------------|-------------------------------------------|--------------------------------------------|------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Amphetamines    | <input type="checkbox"/> Amyl nitrate     | <input type="checkbox"/> Anabolic steroids | <input type="checkbox"/> Barbiturates    | <input type="checkbox"/> Benzodiazepines   |
| <input type="checkbox"/> "Crack" cocaine | <input type="checkbox"/> Cocaine          | <input type="checkbox"/> Fentanyl          | <input type="checkbox"/> Flunitrazepam   | <input type="checkbox"/> GHB               |
| <input type="checkbox"/> Hashish         | <input type="checkbox"/> Ketamine         | <input type="checkbox"/> LSD               | <input type="checkbox"/> Marijuana       | <input type="checkbox"/> Ecstasy           |
| <input type="checkbox"/> Mescaline       | <input type="checkbox"/> Methamphetamines | <input type="checkbox"/> Methaqualone      | <input type="checkbox"/> Methylphenidate | <input type="checkbox"/> Nitrous oxide     |
| <input type="checkbox"/> Opiates         | <input type="checkbox"/> Opium            | <input type="checkbox"/> PCP               | <input type="checkbox"/> Psilocybin      | <input type="checkbox"/> Solvent inhalants |

Other: \_\_\_\_\_

**SEXUAL ACTIVITY/BIRTH CONTROL:**

**Sexually active?**

- ☐ Yes  
☐ No  
☐ Not currently

**Partners:**

- ☐ Male  
☐ Female  
☐ Both

**Date of last Pap test:** \_\_\_\_\_ **Normal:** ☐ Yes ☐ No

**Date of last menstrual period:** \_\_\_\_\_

**Birth control/method of contraception:** (Check all that apply)

- |                                              |                                    |                                          |                                         |                                       |
|----------------------------------------------|------------------------------------|------------------------------------------|-----------------------------------------|---------------------------------------|
| <input type="checkbox"/> Abstinence          | <input type="checkbox"/> Diaphragm | <input type="checkbox"/> Patch           | <input type="checkbox"/> Sponge         | <input type="checkbox"/> None         |
| <input type="checkbox"/> Birth control pills | <input type="checkbox"/> Implant   | <input type="checkbox"/> Post-menopausal | <input type="checkbox"/> Surgical       | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Cervical cap        | <input type="checkbox"/> Injection | <input type="checkbox"/> Rhythm          | <input type="checkbox"/> Vaginal condom | _____                                 |
| <input type="checkbox"/> Condom              | <input type="checkbox"/> IUD       | <input type="checkbox"/> Spermicide      | <input type="checkbox"/> 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 Revanth AnthamDate of birth 25<sup>th</sup> July 1999Have 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 aboveList current medications (including birth control, over the counter medications, vitamins, etc.):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_**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

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 ☐ Other: \_\_\_\_\_  
334-272-0263 ☐