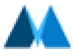


AUM International Foundation, Inc.
Health Clinic

New Patient Registration

Last Name: ______________________________ **First Name**: _____________________**Mid Initial**______

Address: ____

City: _________________________ **State**: ____________ **Zip Code**____________________________

DOB: ________________________ **SSN**: ________________________ **Sex:** _____________________

Race: ____________________**Ethnicity:** __________________________ **Language**__________________

Email: ____

Home Phone_______________________ **Work Phone**: ________________**Mobile Phone**: _____________

Preferred Phone Method: ☐ Home ☐ Work ☐ Mobile **Communicate by**: ☐ Voice ☐ Email ☐ Text

EMPLOYER INFORMATION -

Name: **Phone#:**

EMGERGENCY CONTACT INFORMATION: (In case of emergency who should be notified?)

Name: _________________________________ **Phone:** _________________ **Relationship**: _________________

Name of Primary Care or Last Treating Provider ____

Phone: ____

PLEASE PROVIDE THE RECEPTIONIST YOUR CURRENT INSURANCE CARD AND YOUR DRIVER LICENSE

Plan/Policy Name: ____

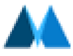
Subscriber ID: ____

Group # ____

Plan/Policy Phone: ____

Subscriber Name: ______________________________ **Subscriber DOB**: ________________________

483 N Semoran Blvd Suite 104 Winter Park, FL 32792
Phone 407-930-4055 www.aumif.org



AUM International Foundation, Inc.
Health Clinic

New Patient Registration

PREFERRED PHARMACY

Pharmacy Name: ____ **Pharmacy Phone**: ________________________

PATIENT METHOD OF DISCLOSURES

The HIPAA Privacy Rule gives the individual the right to request their confidential communications be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

Home Phone: __________________
☐ Ok to leave detailed message
☐ Leave message with call back number only

Work Phone: _________________
☐ Ok to leave detailed message
☐ Leave message with call back number only

Mobile Phone: __________________
☐ Ok to leave detailed message
☐ Leave message with call back number only

☐ **Ok to mail to my home address listed above**

☐ **Ok to E-mail to «Patient Email»**

☐ **Ok to sign up for patient portal**

☐ **I have a Power of Attorney (POA)** **Name:** ________________________________

☐ **I have an Advance Directive (Living Will)**

Please provide the names and contact numbers of individuals authorized to access your health information on your behalf

____

____

____

I am aware that AUM International Foundation Health Clinic uses a third-party call center to confirm appointments. I am aware that by providing my home and mobile phone number and email, I am agreeing to receive automated phone calls, text messages and email reminders. I am aware if at any time I no longer want these services, it is my responsibility to notify the office in writing or reply to third-party Company to opt out.

By Signing below, I acknowledge the above information is accurate and true

Patient Name: ____________________________ **Date:** __________

Signature: _______________________________

Representative/Guardian Name: _______________________ **Date:** __________

Signature: ________________________________

AUM International Foundation, Inc.
Health Clinic

Initial History and Physical

Primary Care or Last Treating Provider

Provider Name: ____ **Phone**: ____________________________

Provider Name: ____ **Phone**: ____________________________

Provider Name: ____ **Phone**: ____________________________

Provider Name: ____ **Phone**: ____________________________

Provider Name: ____ **Phone**: ____________________________

Reason for Visit

____

____

____

Allergies

List your allergies and describe the reaction to your body

Allergy:____ **Reaction**: ____________________________

Allergy:____ **Reaction**: ____________________________

Allergy:____ **Reaction**: ____________________________

Allergy:____ **Reaction:** ____________________________

Allergy:____ **Reaction**: ____________________________

Medications

List all medications currently taking and dosage. Including any vitamins and supplement

Medication: ____ **Dosage:** __________________________

Medication: ____ **Dosage**: __________________________

Medication: ____ **Dosage**: __________________________

Medication: ____ **Dosage**: __________________________

Medication: ____ **Dosage**: __________________________

AUM International Foundation, Inc.
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Family History

Please check all that apply

Are you adopted? ☐ Yes

Father ☐ Living ☐ Deceased ☐ Cause of Death / Age ____

☐ Cardiac Illnesses: ____

Mother ☐ Living ☐ Deceased ☐ Cause of Death / Age: ____

☐ Cardiac Illnesses: ____

Siblings ☐ Living ☐ Deceased ☐ Cause of Death / Age: _______________________________________

☐ Cardiac Illnesses: ____

Surgical History

List any surgeries that you have had

Surgery: ____ **Date:** ________________

Surgery: ____ **Date**: ________________

Surgery: ____ **Date**: ________________

Surgery: ____ **Date**: ________________

Surgery: ____ **Date**: ________________

Surgery: ____ **Date**: ________________

Social History

Please check all that apply

Marital Status ☐ Single ☐ Widower ☐ Divorced

Employment Status ☐ Full Time ☐ Part Time ☐ Student ☐ Retired

Occupation ____

Are you a smoker ☐ Yes ☐ No If Yes, how many cigarettes per day ___________________________________

☐ Former Smoker When did you quit? ____

Do you drink Alcohol? ☐ Yes ☐ No If Yes, how many drinks and frequency ____________________________

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Health Clinic

Do you use illicit drugs? ☐ Yes ☐ No If Yes, What drugs and frequency ________________________________

In the last year, have you had any HIV testing? ☐ YES ☐ NO
If Yes, results, when and where?
____

In the last year, have you had any Hep C testing? ☐ YES ☐ NO
If Yes, results, when and where?
____

In the last year, have you had you use PrEP/nPEP? ☐ YES ☐ NO
If Yes, what, when and where?
____

Have you recently been admitted to the hospital? ☐ YES ☐ NO
If Yes, when and where?
____

When was your last eye exam? ________________ Do you have: ☐ Eyeglasses ☐ Contacts

Review of Systems

Constitutional:	☐Weight Loss	☐ Weight Gain	☐ Fatigue
Cardiovascular:	☐ Angina, Chest Pain	☐ Abnormal blood pressure	☐ Abnormal heart rate
	☐ Abnormal EKG	☐ Hypertension	☐ Palpitations
	☐ Heart Attack	☐ Edema, Swelling in legs or feet	☐ Arrhythmia
	☐ Heart Murmur	☐ Edema, Swelling in abdominal	☐ Passing out or Black-out Spells
	☐ Congenital Heart defects	☐ Claudication issues	☐ Leg pain ☐ R ☐ L
	☐ Varicose ☐ R ☐ L	☐ Restless legs ☐ R ☐ L	☐ Leg discoloration ☐ R ☐ L
Respiratory:	☐ Cough	☐ Coughing up blood	☐ Shortness of Breath
	☐ COPD	☐ Asthma	☐ Pneumonia
Ear, Nose and Throat (ENT):	☐ Difficulty hearing	☐Ringing in ears	☐ Vertigo
	☐ Bleeding Gums	☐ Sore Throat	☐ Allergies
Gastrointestinal:	☐ Heartburn	☐ Nausea/Vomiting	☐ Blood in Stool
	☐ Change in bowel movement	☐ Constipation	☐ Diarrhea
	☐ Abdominal Pain	☐ Hemorrhoids	☐ Ulcers
Genitourinary:	☐ Pain while Urinating	☐ Burning while Urinating	☐ Difficult Urinating

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Hematologic:	☐ Bruising Easily	☐ Anemia	☐ Enlarged Glands
Musculoskeletal:	☐ Arthritis	☐ Decreased Motion	☐ Gout
	☐ Back Pain	☐ Muscle Pain	☐ Neck Pain
	☐ Joint Pain	☐ Joint stiffness	
Skin:	☐ Rash or Sores	☐ Itching/Burning Skin	☐ Psoriasis
Neurological:	☐ Dizziness	☐ Seizures	☐ Weakness
	☐ Numbness	☐ Tremor	☐ Headache
	☐ Spasticity (Spasm)	☐ Memory Loss	☐ Stroke
	☐ Speech impairment	☐ Difficulty with walking	☐ Difficulty with balance
Psychiatric:	☐ Anxiety	☐ Depression	☐ Insomnia

Patient or authorized person's Name (Printed): ____

Patient or authorized person's Signature: ____

Date: ____