We would like to thank you for choosing Lehigh Valley Urology Specialty Care.

Please complete the attached forms before your first appointment with us. In order to provide you with the most complete and comprehensive evaluation on the day of your visit, it is **very important** that we have your complete medical information regarding your past and present health.

If you have had any of the following tests we will need to have them before your appointment. All ultrasounds, X-rays, CT scans, MRIs or a previous NOT performed at:

Lehigh Valley Hospital
Lehigh Valley Diagnostic Imaging
Lehigh Magnetic Imaging Center

We may request that these records be delivered prior to your visit. Without the ability to review your images AND reports, the office evaluation will not be complete and your consultation may be rescheduled.

You may be asked to provide a urine sample.

Please bring your **insurance card(s)** and **photo identification** with you on the day of your visit. **If your insurance requires that you have a referral**, please request this from your primary care physician as soon as possible and have it faxed to our office prior to your appointment.

If you need to cancel or reschedule for any reason, **please call at least 24 hours in advance**. Do not hesitate to call our office if you have any questions or concerns. We look forward to meeting you in the near future.

Thank you
AUTHORIZATION OF TREATMENT/ASSIGNMENT OF BENEFITS/
RELEASE OF INFORMATION/PRIVACY NOTICE

CONSENT FOR TREATMENT: By this document, I do hereby request and authorize LVPG (Lehigh Valley Physician Group),
its medical practices and providers including physicians, surgeons, technicians, nurses, and other qualified personnel to perform
evaluation and treatment services and procedures as may be necessary in accordance with the judgment of the attending medical
practitioner(s). I understand the explanation(s) given and I acknowledge that no guarantee can be given to me by anyone
concerning the results of treatments, examinations or procedures.

PRIVACY NOTICE: I acknowledge receipt of the Health Information Privacy Notice for Lehigh Valley Health Network & the Common
Medical Staff of Lehigh Valley Hospital & Lehigh Valley Hospital-Muhlenberg on or after 04/14/03.

INSURANCE AUTHORIZATION AND ASSIGNMENT: I request that payment of authorized medical benefits is made on my
behavior directly to the LVPG provider of all service(s) furnished to me. I authorize LVPG to release any medical information
directly to my health insurance carrier and/or its legitimate agents that is necessary to process related health insurance claims
and/or to determine plan benefits in accordance with HIPAA release of protected health information standards. Further, I
authorize payment of service(s), otherwise payable to me under the terms of my private, group employer’s or group health
insurance plan, directly to the LVPG provider of service(s). I hereby authorize the photocopies of this form to be valid as the original.

PAYMENT GUARANTEE: I do hereby guarantee payment of all fees and charges related to all services and durable goods
provided to me through LVPG medical practices and providers from my first date of examination or treatment. I agree to make
full payment immediately upon receipt of an LVPG billing statement whether it is an interim or final bill. In the event that I fail
to make full payment or fail to comply with other payment arrangements made with LVPG’s approval, I understand that
appropriate collection measures may be initiated.

ELECTRONIC HEALTH RECORD: I have been made aware and understand that the medical practices and offices within LVPG may use an
Electronic Health Record. LVPG medical practices and providers may share my health information to serve my medical needs. I further
understand that my protected health information will remain secure as required by law.

ELECTRONIC PRESCRIBING: I have been made aware and understand that the medical practices and offices within LVPG may use an
electronic prescription system which allows prescriptions and related information to be electronically sent between my LVPG providers and
my pharmacy. I have been informed and understand that my LVPG providers using the electronic prescribing system will be able to see
information about medications I am already taking, including those prescribed by other providers. I give my consent to my LVPG providers
to see this protected health information.

IMMUNIZATION REGISTRY: I understand that LVPG participates in the Pennsylvania Dept. of Health’s statewide immunization registry
that collects vaccination history and information to serve the public health goal of preventing the spread of vaccine preventable diseases. The
registry complies with federal health information privacy laws.

RELEASE OF RESPONSIBILITY FOR PERSONAL VALUABLES: I have been made aware and understand that all LVPG medical
practices and offices provide no facilities for safekeeping of valuables. I do hereby release LVPG from any responsibility due to loss or
damage of any valuables that I, or anyone accompanying me, may bring to an LVPG medical practice, office or facility.

PERMISSION TO FAX CHILDHOOD IMMUNIZATION RECORD TO SCHOOLS: I do hereby grant permission for LVPG to send or fax
childhood immunization records to schools, upon request.
I, or my legal representative, certify that I have read this document, that it has been fully explained to me and that I understand its contents,
and hereby agree to all terms and conditions set forth above and acknowledge the receipt of a copy if requested

Signature of Patient or Parent/Legal Guardian/Authorized Representative  Relationship to Patient if Applicable

Witness to Signature  Date of Signing  Revised 01/06/2010
LVPG Medical Information Communication Preferences

As our patient, we may need to communicate with you when you are not in the practice. To maintain your privacy, please indicate your preferred method for us to communicate confidential medical information, such as test or lab results, to you and/or others involved in your care. Please note that “appointment reminder telephone calls” may be left at the contact number(s) you list below.

**PLEASE INDICATE YOUR COMMUNICATION PREFERENCES BELOW:**

- I give permission to **leave medical information** pertaining to **me, my dependent or child**, at the numbers listed below:

<table>
<thead>
<tr>
<th>Method</th>
<th>Yes</th>
<th>No</th>
<th>Area Code, Phone #, Ext, E-mail</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home telephone</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Answering Machine</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Work Phone</td>
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<td></td>
<td></td>
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<tr>
<td>Cell Phone</td>
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<tr>
<td>Secure E-mail (Patient Portal secure email registration only)</td>
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<tr>
<td>Pager</td>
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</table>

Without specific permission, we will **not** release any medical information to anyone other than you. In some cases you may wish for another person to have access to your medical information. Please identify those individuals and their relationship to you (i.e. spouse, parent, son, daughter, partner etc.):

- Do not release medical information to anyone other than myself.
- I give permission to release medical information pertaining to me to the individuals listed below.

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship (i.e. spouse, parent, son, daughter, etc.)</th>
<th>Area Code, Phone # - Extension</th>
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</table>

I assume responsibility to inform the practice of changes in my phone number(s) or my preferences or to revoke this specific medical information authorization at any time.

Signature of Patient or Patient's Legal Representative ___________________________ Date ___________________________ (Please Print Signer’s Name)
Lehigh Valley Urology Specialty Care
Medical History Questionnaire

Name: __________________________    Date: ______________
Date of birth: ______________    Age: ________   Social Security #: _______________
Address: ___________________________  City / State / Zip: __________________________
Phone: (H) _____________________  (C) ___________________ (W) __________________
Marital status: ________________________   Employer: _____________________________
Employer’s address: _____________________ City / State / Zip: _______________________

Emergency Contact (someone not living at the same address)
Name: ____________________  Relationship: ___________________
Phone: (H) ________________________   (C) ________________________

<table>
<thead>
<tr>
<th>Primary Care Physician</th>
<th>Address &amp; Phone</th>
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<tbody>
<tr>
<td>Name:</td>
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<tr>
<td>□ Forward a copy of my reports to this doctor.</td>
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<tr>
<td>Referring Physician</td>
<td>Address &amp; Phone</td>
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<td>Name:</td>
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<td>□ Forward a copy of my reports to this doctor.</td>
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<tr>
<td>OB /GYN</td>
<td>Address &amp; Phone</td>
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<td>Name:</td>
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<td>□ Forward a copy of my reports to this doctor.</td>
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<tr>
<td>Other Physician</td>
<td>Address &amp; Phone</td>
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<tr>
<td>Name:</td>
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<td>□ Forward a copy of my reports to this doctor.</td>
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<td>Other Physician</td>
<td>Address &amp; Phone</td>
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<td>Name:</td>
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<td>Other Physician</td>
<td>Address &amp; Phone</td>
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<tr>
<td>Name:</td>
<td></td>
</tr>
<tr>
<td>□ Forward a copy of my reports to this doctor.</td>
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</table>
Do you have an advance directive?  □ Yes  □ No
Are you a victim of violence or abuse?  □ Yes  □ No
Had a flu shot this year?  □ Yes  □ No
Had a pneumonia shot?  □ Yes  □ No

Describe briefly in your own words, the major medical problem or need that brings you to see our physicians, and when the problem began?

Medical History
Please list any medical problems you have; add any details that might be helpful.
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

Surgical History
Please list any surgeries you have had.

<table>
<thead>
<tr>
<th>Surgery</th>
<th>Reason</th>
<th>Hospital / State</th>
<th>Year</th>
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Medications
Please list medications and supplements you take.

Instead of writing your medications you may bring a list of them with you to your appointment.

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</table>
Allergies
Please list any medications, foods, or other substance to which you have had an allergic reaction to.

<table>
<thead>
<tr>
<th>Medication / Other</th>
<th>Reaction</th>
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Social History

1. How many children do you have? ____________
2. Are you currently employed outside the home? □ Yes □ No
3. Are you retired? □ Yes □ No
4. Have you ever smoked? □ Yes □ No
   If yes, number per day ______
   How many years did you smoke? ______
   Have you quit? □ Yes □ No
5. Do you drink alcoholic beverages? □ Yes □ No
   Amount per day/week? ______
6. If you previously drank heavily, how much, when did you quit? ______________
7. Do you use illegal substances or drugs? □ Yes □ No
   If yes, which one(s)? __________________________

Family History
List any relatives who have or previously had cancer, indicate the location of cancer or tumor, and how the individual was related to you.

<table>
<thead>
<tr>
<th>Relative</th>
<th>Location of cancer / tumor</th>
<th>Age of diagnosis</th>
</tr>
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<tr>
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</table>
### General, constitutional
- Fever
- Fatigue
- Good general health lately
- Recent weight change
- Nausea or vomiting
- Wear glasses or contact lenses
- Blurred or double vision
- Good general health lately

### Gastrointestinal
- Change in bowel movements
- Nausea or vomiting
- Frequent diarrhea
- Painful bowel movements or constipation
- Loss of appetite
- Blood in stool
- Stomach pain
- Jaundice / Hepatitis

### Neurological
- Tremors
- Frequent or recurrent headaches
- Stroke
- Head injury
- Paralysis
- Light headed or dizzy
- Convulsions or seizures

### Eyes and vision
- Fever
- Fatigue
- Good general health lately
- Recent weight change
- Nausea or vomiting
- Wear glasses or contact lenses
- Blurred or double vision

### Genitourinary
- Kidney stones
- Burning or painful urination
- Blood in urine
- Change in force or strain with urination
- Kidney Problems

### Psychiatric
- Nervousness
- Memory loss or confusion
- Sleep problems
- Depression
- Endocrine
- Change in hat or glove size

### Ears, nose, throat
- Difficulty swallowing
- Ringing in the ears
- Sinus problems
- Nose bleeds
- Hearing loss
- Mouth sores
- Bleeding gums
- Bad breath or bad taste
- Earaches or drainage
- Sore throat or voice change

### Musculoskeletal
- Bone pain
- Cold extremities
- Difficulty in walking
- Joint pain
- Back pain
- Muscle pain or cramps
- Weakness of muscles/joints
- Joint stiffness or swelling

### Heart and Cardiovascular
- Chest pains
- Sudden heartbeat changes
- Swelling of feet, ankles, hands
- Heart trouble
- Swollen glands in neck
- Cold extremities
- Difficulty in walking
- Joint pain
- Back pain
- Muscle pain or cramps
- Weakness of muscles/joints
- Joint stiffness or swelling

### Skin and breasts
- Rash or itching
- Change in skin color
- Varicose veins
- Breast pain
- Breast lump
- Breast discharge
- Change in hair or nails
- Skin tumors

### Please Elaborate:
For women only
Please complete the following questions.

1. How many times have you been pregnant? _______
2. How many times have you delivered a baby? _______
3. How old were you when you delivered your first baby? ______
4. When was your last PAP smear? ______
5. When was your first menstrual period? ______
6. When was your last menstrual period? ______
7. Had you previously had a breast biopsy? ______
   If so, when and where?
   _____________________________________________
8. Have you gone through menopause? Y / N
9. Do you do self-breast examinations? Y / N
   How frequently? _______________________
10. Do you use birth control? Y / N If yes, type __________________________
    Length of duration ______________________
11. Have you used hormone replacement therapy? Y / N
    If yes, what type __________________________
    How long? _______________________________