LVPG GYNECOLOGIC ONCOLOGY
A practice of Lehigh Valley Physician Group

1240 S. Cedar Crest Blvd.
Suite 401
Allentown, PA 18103

Ph: 610-402-3650
Fax: 610-402-3673
www.gynoncologyspecialists.com

Dear Patient:

Thank you for choosing LVPG Gynecologic Oncology for your medical needs.

It is important that we have complete information about all of your past and present health problems to provide the best care for you. Please take a few minutes to fill out the enclosed forms and bring them with you to your first office visit. This will help us learn more about you and better meet your individual needs.

We will also need you to bring along your photo ID, health insurance cards, and any referral forms from your primary care physician, if necessary, to your appointment.

Please be advised that we will expect you to arrive on time for your appointment. If you are more than 10 minutes late, we may need to reschedule your visit. We appreciate your cooperation.

Please be assured that all information will be kept strictly confidential. If you have any question about your upcoming visit, please do not hesitate to contact us at (610) 402-3650.

We look forward to seeing you.

Sincerely,

LVPG Gynecologic Oncology

Enclosures

Cancer Center Registration Form

Please complete the following information.

Patient Name:		
Medical Record Number:	**Date of Birth:**	
Gender:	**SSN:**	
Street Address:		
City:	**State:** **Zip Code:**	
Home Phone:	**Cell Phone:**	
Patient's E-mail:		
Employer:	**Occupation:**	
☐ Full-time ☐ Part-time ☐ Not employed ☐ Self-employed ☐ Retired ☐ Active ☐ Military ☐ Disabled		
Employer Address:		☐ n/a
Work Phone:		☐ n/a
Religion/Faith Community		☐ decline ☐ none
Name/Address of Congregation/Community		☐ decline ☐ none
Race: ☐ American Indian/Alaskan ☐ Asian ☐ Black/African American ☐ Multi-racial		
☐ Pacific Islander/Hawaiian ☐ White ☐ Decline to answer ☐ Other_____		
Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unavailable ☐ Decline to answer		
Preferred Language: ☐ English ☐ Spanish ☐ Other_____		
SPOUSE / NEXT of KIN Information		
Name:		
Relationship:	**Gender:**	
Date of Birth:	**SSN:**	
Street Address:		
City:	**State:** **Zip Code:**	
Home Phone:	**Cell Phone:**	
Employer: ☐ n/a ☐ retired	**Occupation:**	
Work Phone:		
EMERGENCY CONTACT (Other than someone in your household)		
Name:		
Relationship:	**Home Phone:**	
Street Address:		
City:	**State:** **Zip Code:**	

Patient Name:	**MR#:**	**DOB:**

Primary Care Physician:	Name:	
	Address:	
	Phone:	Fax:
Referring Physician:	Name:	
	Address:	
	Phone:	Fax:
Other Physician:	Name:	
	Address:	
	Phone:	Fax:
Local Pharmacy:	Name:	
	Address:	
	Phone:	Fax:
Mail Order Pharmacy:	Name:	
	Address:	
	Phone:	Fax:

MEDICARE Patient ONLY --- Please answer the following questions		
Yes	***No***	
☐	☐	**1. Are you or your spouse employed or self-employed?**
		*Date of your retirement:
		*Date of your spouse's retirement:
☐	☐	**2. Do you have health insurance through your/your spouse's employer?**
☐	☐	a. Does this employer employ 20 or more employees?
☐	☐	b. Does this employer employ 100 or more employees?
		Insurance Co: Group #:
		Policy #:
		Holder:
		Relationship to Patient:
☐	☐	**3. Are you a member of a Medicare Replacement Plan?**
☐	☐	**4. Is this condition related to your occupation?**
☐	☐	**5. Is it related to an accident?** If YES, ☐ Fall ☐ Auto Accident
☐	☐	**6. Is patient undergoing Kidney Dialysis for End Stage Renal Disease?**
		If YES, how long: Date Dialysis Began:
☐	☐	**7. Has the patient received a Kidney Transplant?** Date of transplant:
☐	☐	**8. Is the patient on the Federal Black Lung Program?**
☐	☐	**9. Has the Department of Veterans Affairs (VA) authorized & agreed to pay for care at this facility?**

LVPG Medical Information Communication Preferences

Patient Name:	**MR#:**	**DOB:**

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:

Method	***Yes***	***No***	***Area Code, Phone #, Ext, E-mail***
Home telephone			
Answering Machine			
Work Phone			
Cell Phone			
Secure E-mail (Patient Portal secure email registration only)			
Pager			

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:

Name	***Relationship*** *(spouse, parent, son, daughter, etc.)*	***Area Code, Phone #, Extension***

Comments

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)

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

PATIENT:		DOB:	MEDICAL RECORD #:
DATE:	TIME:	LOCATION: LVPG Gynecologic Oncology	

CONSENT FOR TREATMENT: By this document, I do hereby request and authorize LVPG (Lehigh Valley Physician Group), its medical practices and providers including physicians, 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 acknowledge that no guarantee can be made 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 behalf directly to the LVPG provider of service(s) furnished to me. I authorize LVPG to release any medical information to my health insurance carrier and/or its legitimate agents that is necessary to process related health insurance claims and/or to verify plan benefits in accordance with HIPAA health information standards. 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 LVPG. I hereby authorize that 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: Healthcare providers require access to patient medical information whenever or wherever a patient presents for care to assure safety, quality and to coordinate patient care across the provider network, avoiding duplication of services. LVHN has a system-wide electronic medical record that is available to caregivers on a "need to know" basis, to share information about patient care provided in the hospital, outpatient or physician office settings. Confidentiality of records including those reflecting treatment for behavioral health issues, HIV/AIDS or drug or alcohol problems is maintained per relevant governmental and regulatory standards. Patient care summaries are automatically sent to designated LVPG and other community primary care/family/referring physicians, as well as to physicians who are consulted by the attending physician for coordination of care. LVHN and/or the attending physician can furnish and release to federal and state healthcare oversight agencies, or upon written request, to all insurance companies or their representatives any information with respect to treatment of the patient herein named including copies of the medical record.

HEALTH INFORMATION EXCHANGE: LVHN may make your health information available electronically through a state, regional, or national Health Information Exchange (HEI) service or through *Care Everywhere*® Network to facilitate the secure exchange of your health information between and among several heath care providers or other health care entities for your treatment, payment, or other healthcare operations purposes. This means we may share information we obtain or create about you with a HIE, which will be made available to outside entities (such as hospitals, doctors offices, pharmacies or insurance companies) or we may receive information they create or obtain about you (such as medication history, medical history or insurance information) so each entity can provide better treatment and coordination of your health care services. In cases where your specific consent or authorization is required to disclose certain health information to others, we will not disclose that health information without first obtaining your consent. Information that requires additional consent in order to be shared includes psychotherapy notes, treatment for substance or alcohol abuse, and records of tests or treatment for sexually transmitted diseases.

IF YOU ARE NOT INTERESTED IN HAVING YOUR HEALTH INFORMATION SHARED WITH OTHER HEALTH CARE PROVIDERS IN THE HIE, PLEASE USE FORM BELOW TO OPT OUT:

Patient Name:_____
Date of Birth:_____

☐ I request that my medical information be excluded from *Care Everywhere*®. I understand this means that other health care providers will not be able to obtain my health information through *Care Everywhere*® but they may obtain it through other methods.

ELECTRONIC PRESCRIBING: I understand that LVPG medical practices and offices 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 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 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

September 2014 version

Lehigh Valley Health Network
A PASSION FOR BETTER MEDICINE.

Cancer Program Health Questionnaire
LVPG Gynecologic Oncology
LVPG Hematology Oncology
LVPG Surgical Oncology
Radiation Oncology
Multidisciplinary Clinic

Patient Name:	**MR#:**	**DOB:**

Date: _____

Race/Ethnicity:

☐ American Indian/Alaskan ☐ Asian ☐ Black/African American ☐ Caucasian

☐ Pacific Islander/Hawaiian ☐ Hispanic ☐ Latino ☐ Other:

Language Spoken: ☐ English ☐ Spanish ☐ Other:

Please tell us what brings you here today:

Past Medical History:

Vaccinations: ☐ HPV ☐ Hepatitis ☐ Chickenpox ☐ Herpes
☐ Flu Vaccine-year: _____ ☐ Pneumonia-year: _____ ☐ Other: _____

Please check any of the following you have had or currently have: ☐ NONE

☐ Congestive Heart Failure
☐ Heart Attack
☐ High Blood Pressure
☐ High Cholesterol
☐ Irregular Heart Rate
☐ Mini Stroke
☐ Pacemaker
☐ Blood Clots
☐ Pneumonia
☐ Emphysema
☐ Asthma
☐ COPD
☐ Tuberculosis
☐ Other:

☐ Sleep apnea
☐ Diverticulitis/Diverticulosis
☐ Ulcerative Colitis
☐ Crohns Disease
☐ Stomach Ulcers
☐ Chronic Renal Insufficiency
☐ Kidney Stones
☐ Enlarged Prostate
☐ Jaundice/Hepatitis/Pancreatitis
☐ Cirrhosis
☐ Overactive Thyroid
☐ Underactive Thyroid
☐ Cancer: Type:

☐ Parkinson's
☐ Multiple Sclerosis
☐ Rheumatoid Arthritis
☐ Lupus
☐ Anxiety
☐ Depression
☐ Cataracts
☐ Macular Degeneration
☐ Chronic Fatigue
☐ Seizures
☐ Seasonal Allergies
☐ Diabetes

Patient:	MR#:	DOB:

Women Only:

Age of menstruation onset: _____ Number of Pregnancies: _____ Age at first pregnancy: _____
Number of live births: _____ ☐ Vaginal Delivery ☐ C-section
Number of years on birth control pills: _____ Number of years on other hormones: _____
Date last taken: _____
How many days between your periods: _____ How many days are your periods: _____
Date of your last period: _____
Date of last pap test: _____ Have you had any abnormal pap tests: _____
How was it treated: _____
Date of last mammogram: _____ Do you get yearly mammograms: ☐ Yes ☐ No
Do you do breast self-exams: ☐ Yes ☐ No

Surgical History Summary: Please List all Previous Surgeries ☐ None

Date	*Surgery*	*Reason*	*Facility/Surgeon*

Personal History:

Social History

Tobacco Products: ☐ **Never** ☐ **Yes**

☐ Indicate all types of tobacco products you've ever used:
- ☐ Cigarettes/Cigar ☐ Pipe
- ☐ Chewing tobacco ☐ Snuff

☐ How many years have you used tobacco products? _____

☐ If you smoke(d) Cigarettes:
- ☐ packs per day: _____
- ☐ Year you quit smoking: _____
- ☐ Currently a smoker:
  - ☐ every day ☐ some days

☐ Have you been to a Smoking Cessation Class?
- ☐ Yes ☐ No

☐ Have you been exposed to second hand smoke?
- ☐ Yes ☐ No

☐ How many years have you been exposed? ___

Alcohol/Recreational Drugs/Tanning Exposure:

☐ **Do you or have you ever consumed alcohol?**
- ☐ Yes ☐ No

☐ Drinks per week? _____
- ☐ Beer ☐ Liquor ☐ Wine

☐ Do you use any "street" or recreational drugs?
- ☐ Yes ☐ No

☐ If yes, type: _____
☐ How often? _____
☐ Have you used a Tanning Bed? ☐ Yes ☐ No
☐ Do you use sun screen? ☐ Yes ☐ No

Living Arrangements

☐ Alone ☐ Nursing Home Facility ☐ Spouse
☐ Relative ☐ Assisted Living Facility ☐ Family
☐ Other _____

Do you have an emotional support system? _____
If yes, with whom? _____

Are you being hurt or frightened by anyone in your life?
☐ Yes ☐ No
If yes, by whom? _____

Help: Call Turning Point Counseling Services for Victims of Domestic Violence: 610-437-3369

Transportation

☐ Ambulance ☐ Friend/Family ☐ Metro
☐ Self ☐ Other _____

Work History

☐ Working Full Time ☐ Retired
☐ Working Part Time ☐ Unemployed
☐ Lifts greater than 10 lbs. at work or home
☐ Life occupation _____
☐ Previous exposure to environmental hazards _____

Patient Name:	MR#:	DOB:

Personal History -- Continued:

Venous Access Devices

Do you currently have: ☐ None

☐ PICC ☐ Port ☐ Hickman

☐ Groshong ☐ Dialysis Catheter

☐ Other: _____

Fall Risk

Do you use an assistive device to walk? ☐ Yes ☐ No

Are you unsteady on your feet? ☐ Yes ☐ No

Have you fallen in the past year? ☐ Yes ☐ No

Assistive Devices

☐ Walker ☐ Wheelchair ☐ Cane

☐ Other: _____

Family History:

What is your family ancestry? (Example: Irish, German, etc.) _____

Please complete the section below about the health of your family members.

	Living	Cancer Type?	Diabetes	High Blood Pressure	Lung Disease	Thyroid Disease	Stroke	Alcoholism and/or Drug Habit	Mental Health Problems	Heart Disease
Father	☐		☐	☐	☐	☐	☐	☐	☐	☐
Mother	☐		☐	☐	☐	☐	☐	☐	☐	☐
Brother	☐		☐	☐	☐	☐	☐	☐	☐	☐
Sister	☐		☐	☐	☐	☐	☐	☐	☐	☐
Child	☐		☐	☐	☐	☐	☐	☐	☐	☐
Mother's Father	☐		☐	☐	☐	☐	☐	☐	☐	☐
Mother's Mother	☐		☐	☐	☐	☐	☐	☐	☐	☐
Father's Mother	☐		☐	☐	☐	☐	☐	☐	☐	☐
Father's Father	☐		☐	☐	☐	☐	☐	☐	☐	☐
	☐		☐	☐	☐	☐	☐	☐	☐	☐
	☐		☐	☐	☐	☐	☐	☐	☐	☐
	☐		☐	☐	☐	☐	☐	☐	☐	☐

Patient Name:	MR#:	DOB:

Review of Systems:

Check any of the following that you had or have:

Heart/Circulation Health
Have you had or do you have: ☐ **None**

- ☐ Chest pain
- ☐ Poor circulation
- ☐ Dizziness
- ☐ Palpitations
- ☐ Swelling of the ankles or feet
- ☐ Other: _____

Lung Health
Have you had or do you have: ☐ **None**

- ☐ Chronic coughing
- ☐ Coughing up mucus
- ☐ Coughing up blood
- ☐ Chronic shortness of breath
- ☐ Home oxygen
- ☐ Sleeping with head elevated to breathe easier
- ☐ Wheezing
- ☐ Other: _____

Stomach/Bowel Health
Have you had or do you have: ☐ **None**

- ☐ Colonoscopy, year of most recent: _____
- ☐ Change in bowel habits
- ☐ Difficulty passing your stool
- ☐ Watery loose stool
- ☐ Constipation
- ☐ Blood in stool
- ☐ Loss of control of bowels
- ☐ Excess gas or belching
- ☐ Belly pain
- ☐ Upset stomach
- ☐ Vomiting
- ☐ Other: _____

Brain Health
Have you had or do you have: ☐ **None**

- ☐ Chronic headaches
- ☐ Numbness in fingertips and/or toes
- ☐ Confusion
- ☐ Difficulty speaking your thoughts verbally
- ☐ Alzheimer's
- ☐ Parkinson's Disease
- ☐ Multiple sclerosis
- ☐ Mini stroke
- ☐ Stroke
- ☐ Loss of feeling and/or movement
- ☐ Seizures
- ☐ Weakness arms or legs
- ☐ Other: _____

Constitutional
Have you had or do you have: ☐ **None**

- ☐ Weight loss
- ☐ Fever
- ☐ Change in appetite
- ☐ Other: _____
- ☐ Fatigue
- ☐ Night sweats

Skin Health
Have you had or do you have: ☐ **None**

- ☐ New skin growths
- ☐ Changes in a mole
- ☐ Rashes
- ☐ Psoriasis
- ☐ Annual skin screening
- ☐ Severe sunburn, when? _____
- ☐ Other: _____

Vision, Hearing and Throat Health
Have you had or do you have: ☐ **None**

- ☐ Change in vision
- ☐ Spots or floaters
- ☐ Hearing Loss
- ☐ Chronic hoarseness
- ☐ Problems swallowing
- ☐ Other: _____
- ☐ Glasses/Contacts
- ☐ Cloudy vision
- ☐ Hearing Aid
- ☐ Voice change
- ☐ Sore throat

Urinary Health
Have you had or do you have: ☐ **None**

- ☐ Leaking of urine/dribbling
- ☐ Urinating often
- ☐ Burning with urination
- ☐ Change in force or strain with urination
- ☐ Getting up at night frequently to urinate
- ☐ Blood in urine
- ☐ Kidney problems
- ☐ Other: _____

Patient Name:	MR#:	DOB:

Review of Systems – Continued:

Check any of the following that you had or have:

Endocrine/Diabetes/Thyroid Health

Have you had or do you have: ☐ **None**

Please check the type of Diabetes you have:

☐ Diet controlled ☐ Insulin controlled
☐ Diabetes during pregnancy
☐ Type I ☐ Type II
☐ Related to medication
☐ Goiter
☐ Other: _____

Please check the type of Thyroid Condition you have, if any:

☐ Overactive Thyroid ☐ Underactive Thyroid

Musculoskeletal

Have you had or do you have: ☐ **None**

☐ Muscle weakness
☐ Joint Swelling
☐ Muscle/joint stiffness
☐ Back pain
☐ Bony pain
☐ Arthritis
☐ Fibromyalgia
☐ Other: _____

Female Reproductive Health ☐ **Not applicable**

Have you had or do you have: ☐ **None**

☐ Breast lumps
☐ Nipple discharge
☐ Abnormal vaginal bleeding
☐ Painful periods
☐ Vaginal discharge
☐ Hot flashes
☐ Leaking urine
☐ Painful intercourse
☐ Currently sexually active
☐ Fertility issues
☐ Other: _____

Male Reproductive Health ☐ **Not applicable**

Have you had or do you have: ☐ **None**

☐ Prostate exam, date last done: _____
☐ PSA blood test, date last done: _____
☐ Enlarged prostate
☐ Able to acquire an erection
☐ Able to maintain an erection
☐ Discharge from penis
☐ Pain/swelling in the testicles(s)
☐ Perform self-testicular exams
☐ Currently sexually active
☐ Fertility issues
☐ Other: _____

Blood Disorders/Infectious Disease

Have you had or do you have: ☐ **None**

☐ Below/above normal amount of red blood cells
☐ Clotting/bleeding disorder
☐ History of blood transfusion
☐ Reaction to a blood transfusion
☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C
☐ Genital Herpes ☐ HIV/AIDS ☐ Herpes Zoster
☐ Human Papilloma Virus (HPV)
☐ Vancomycin Resistance Enterococci (VRE)
☐ Methicillin Resistant Staphylococcus Aureus (MRSA)
☐ Mumps ☐ Measles ☐ Chicken Pox
☐ Rheumatic Fever ☐ Polio
☐ Other: _____

Mental Health

Have you had or have you been: ☐ **None**

☐ Feeling anxious
☐ Feeling sad most of the time
☐ Treated for any Mental Health Issues
☐ Recent loss or life change
☐ Had thoughts of or attempted to hurt yourself
☐ Hospitalized for any of the above conditions
☐ Difficulty sleeping or Sleep Disturbance

Rate your level of stress:

☐ None ☐ Mild ☐ Moderate ☐ Extreme

If you have checked off any of the above:

Are you currently under care ☐ Yes ☐ No

If YES, with whom? _____

If NO, do you wish to talk to someone? ☐ Yes ☐ No

Patient Name:	MR#:	DOB:

Review of Systems – Continued:

Check any of the following that you had or have:

Diet

- ☐ Don't feel hungry/loss of appetite
- ☐ Unplanned weight gain _____ pounds
- ☐ Unplanned weight loss _____ pounds
- ☐ Difficult or painful ☐ chewing/ ☐ swallowing
- ☐ Taste changes
- ☐ Religious/cultural dietary preference: _____
- ☐ Dentures ☐ Any removable teeth
- ☐ Other:
- ☐ Feeding tube insertion date: _____
  - ☐ Bolus ☐ Gravity ☐ Pump
- ☐ Type of formula: _____
- ☐ Amount of formula daily: _____
- ☐ Amount of water taken daily: _____
- ☐ Type of diet: _____
  - ☐ Regular ☐ Soft ☐ Other: _____

Past and Current Cancer Treatment: ☐ None

When were you diagnosed with cancer? Year/Month: _____ Type of Cancer: _____

Initial symptoms: _____

What tests were done: _____

What treatments have been recommended: _____

What surgeries and/or biopsies have been done: _____

Have you had prior radiation therapy? ☐ Yes ☐ No

If yes, when and to what part of your body? _____ Year: _____

Facility: _____

Physician: _____

Have you had prior Chemotherapy or Biotherapy? ☐ Yes ☐ No

If yes, indicate the year: _____

Name of the chemotherapy or biotherapy: _____

Name of Hematology/Oncology Physician who prescribed chemotherapy: _____

Have you ever participated in a Clinical Trial? ☐ Yes ☐No If yes, name of trial: _____

Have you had a Bone Marrow Transplant (Allogeneic or Autologous)? ☐ Yes ☐No

If yes, indicate date: _____ Hospital: _____

Physician: _____

Health Care Directives:

Do you have:

Durable Power of Attorney for Health Care?	☐ **Yes** ☐**No**
Living Will?	☐ **Yes** ☐**No**
Organ Donor Card?	☐ **Yes** ☐**No**
Advanced Directives?	☐ **Yes** ☐**No**

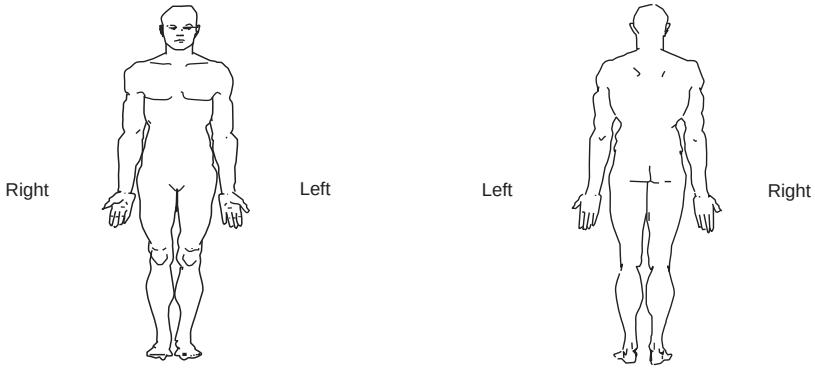
If you answered yes to any of the above questions, please provide us with a copy.

Would you like information about any of the above? ☐ Yes ☐No

Patient Name:	MR#:	DOB:

Pain Assessment ☐ No Pain

Please mark the area (s) with an (x) on the pictures below where you are experiencing your pain.



	0	1	2	3	4	5	6	7	8	9	10
Verbal Descriptor Scale	NO PAIN		MILD PAIN		MODERATE PAIN		MODERATE PAIN		SEVERE PAIN		WORST PAIN POSSIBLE
WONG-BAKER FACIAL GRIMACE SCALE											
	Alert Smiling		No humor serious flat		Furrowed brow pushed lips breath holding		Wrinkled nose raised upper lip rapid breathing		Slow blink open mouth		Eye closed moaning crying
ACTIVITY TOLERANCE SCALE	NO PAIN		CAN BE IGNORED		INTERFERES WITH TASK		INTERFERES WITH CONCENTRATION		INTERFERES WITH BASIC NEEDS		BEDREST REQUIRED
Check if face scale used:	☐		☐		☐		☐		☐		☐

According to the scale above, what is your pain score today? (1-10) _____
According to the scale above, what is a tolerable level of pain? (1-10) _____

What percent of your daily activity is **limited by pain**?

☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100%

What word(s) best describe your pain?

☐ Ache ☐ Cramping ☐ Pricking ☐ Throbbing ☐ Burning
☐ Pressure ☐ Sharp ☐ Pain is all the time ☐ Pain comes and Goes

What makes your pain **better**? ☐ Standing ☐ Walking ☐ Sitting ☐ Ice ☐ Heat ☐ Other ____
What makes your pain **worse**? ☐ Standing ☐ Walking ☐ Sitting ☐ Ice ☐ Heat ☐ Other ____

Doctor managing your pain/medications: _____

Medication List

Patient Name:	MR#:	DOB:

Pharmacy Name: Phone:

Pharmacy Address:

Allergies: ☐ None Known Latex: ☐ Yes ☐ No Iodine or Seafood: ☐ Yes ☐ No

Have you taken steroids previously: ☐ Yes ☐ No If yes, date last used:

Please list all FOOD and DRUG ALLERGIES:

Food / Drug Name	*Type of Reaction*

Please list all MEDICATIONS you currently take:

Name	*Date Started*	*Dose*	*Ordering Physician*	*How many a day do you take?*

Please list all VITAMINS, HERBALS and NUTRITIONAL SUPPLEMENTS you take:

Name	*Dose*	*How many a day do you take?*

LEHIGH VALLEY HEALTH NETWORK

Your Guide to Lehigh Valley Health Network–Cedar Crest

Valet Parking

FREE valet parking is available at the main hospital, Cancer Center and the 10 1210 building entrances.

- Valet parking is provided Monday to Friday, 5:30 a.m. to 6 p.m. at the main entrance and 6 a.m. to 4 p.m. at the Cancer Center.
- Handicapped visitors and patients are encouraged to use valet parking.

Parking Decks

- Parking is available for patients and visitors of 60 1250 The Center for Advanced Health Care in the five-story parking deck near Cedar Crest Blvd.
- Patients and visitors may use either of the two parking decks located directly in front of the main hospital entrance and the Kasych Family Pavilion.

Getting Around Inside Is Easy, Too

- Once inside the building, golf carts and visitor assistants are available to drive people to the Cancer Center, Diagnostic Care Center and the Kasych Family Pavilion.

Emergency, 1230 Building and MRI Parking

- Parking lots are located at the rear of the hospital for the 30 1230 medical office building, 20 MRI and emergency department patient parking.

Patient Drop-off and Pick-up

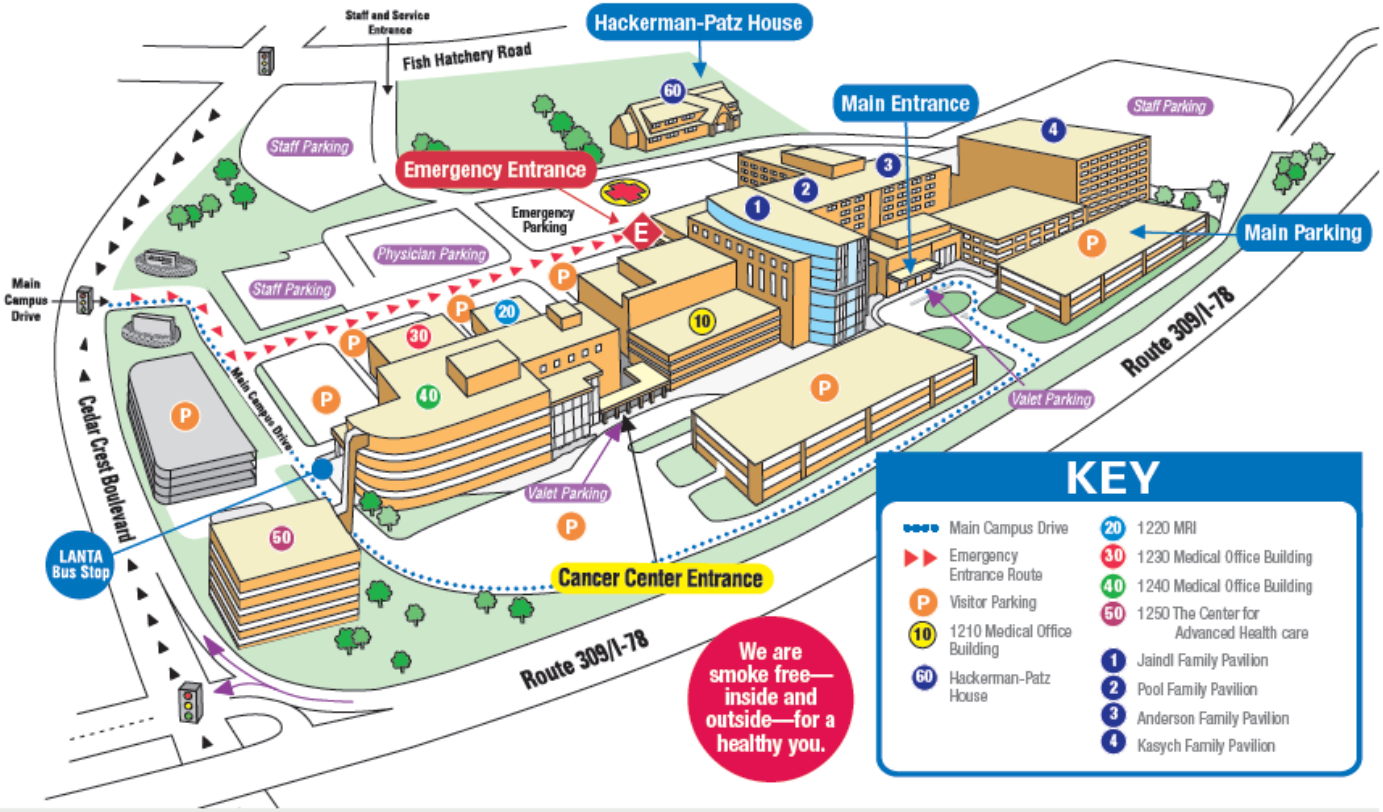
- Patients may be dropped off and picked up at the hospital main entrance.

See other side for driving directions.

Questions? Call 610-402-CARE (2273) or log on to lvhn.org

Health Spectrum Pharmacy Services

- Visitors to Health Spectrum Pharmacy Services may use 15-minute parking spaces on the bottom level of the parking deck located to the left of the main hospital entrance.
- Pharmacy Hours: Monday–Friday, 7 a.m.–7 p.m.
  Saturday–Sunday, 9 a.m.–3 p.m.



A PASSION FOR BETTER MEDICINE.™

Lehigh Valley Health Network

610-402-CARE LVHN.org

LEHIGH VALLEY HEALTH NETWORK

Directions to Lehigh Valley Health Network–Cedar Crest

From the Northeast Extension of the Pennsylvania Turnpike:

- Take the Northeast Extension to the Lehigh Valley exit.
- Take Route 22 East to Route 309 South.
- Follow 309 South (which merges with I-78 East) to the Cedar Crest Blvd. exit 55.
- Turn right at the end of the exit ramp.
- Turn right at the traffic light onto the hospital's main entrance road.
- Follow signs to visitor parking.

From Route 309 (I-78):

- Take the Cedar Crest Blvd. exit 55.
- If you're traveling north on Route 309 (I-78 West), turn left at the end of the exit ramp. If you're traveling south on Route 309 (I-78 East), turn right at the end of the exit ramp.
- Turn right at the traffic light onto the hospital's main entrance road.
- Follow signs to visitor parking.

From Route 22:

If you're coming from points west of the Pennsylvania Turnpike's Northeast Extension:

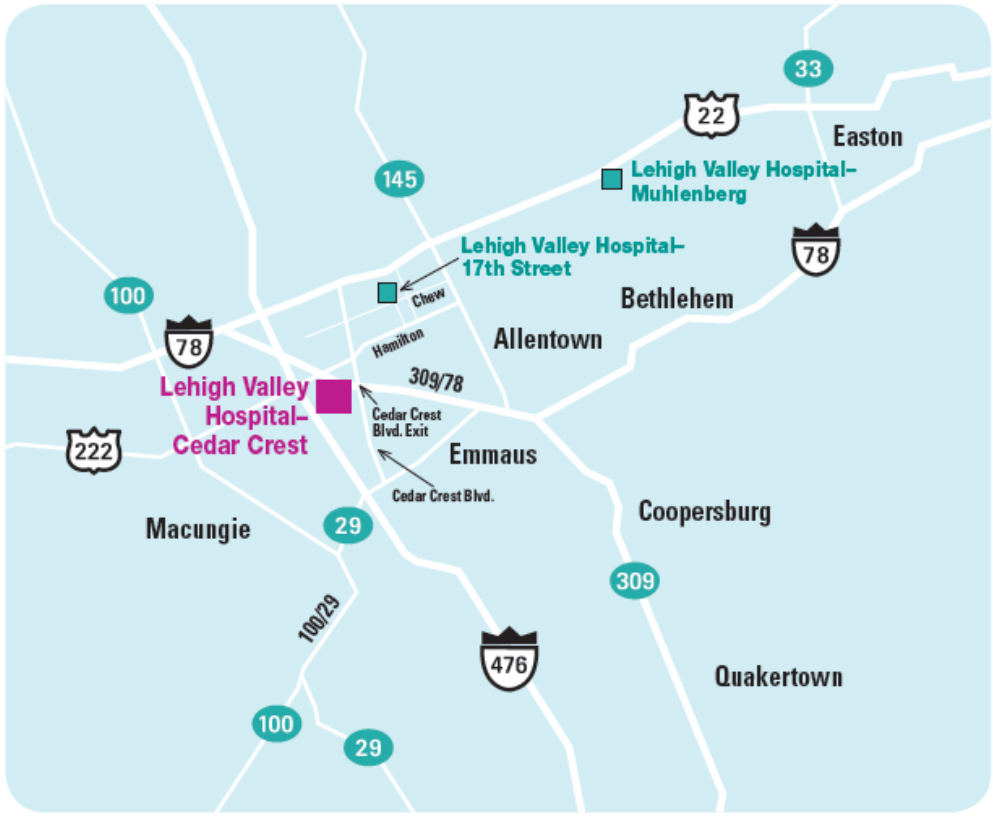
- Take Route 22 East to Route 309 South (merges with I-78 East).
- Follow Route 309 South (I-78 East) to the Cedar Crest Blvd. exit 55.
- Turn right at the end of the exit ramp.
- Turn right at the traffic light onto the hospital's main entrance road.
- Follow signs to visitor parking.

If you're coming from points east of the Pennsylvania Turnpike's Northeast Extension:

- Take Route 22 West to Route 309 South (merges with I-78 East).
- Follow Route 309 South (I-78 East) to the Cedar Crest Blvd. exit 55.
- Turn right at the end of the exit ramp.
- Turn right at the traffic light onto the hospital's main entrance road.
- Follow signs to visitor parking.

From Route 33:

- Take Route 33 South to I-78 West.
- Follow I-78 West to the Cedar Crest Blvd. exit 55.
- Turn left at the end of the exit ramp.
- Turn right at the traffic light at the hospital's main entrance.
- Follow signs to visitor parking.



Lehigh Valley Hospital–Cedar Crest
P.O. Box 689
Allentown, PA 18105-1556

Lehigh Valley Hospital–17th Street
P.O. Box 7017
Allentown, PA 18105-7017

Lehigh Valley Hospital–Muhlenberg
2545 Schoenersville Road
Bethlehem, PA 18017

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