



## LVPG SURGICAL ONCOLOGY

*A practice of Lehigh Valley Physician Group*

John & Dorothy Morgan Cancer Center  
1240 S. Cedar Crest Blvd., Suite 205  
Allentown, PA 18103

2545 Schoenersville Rd, Third Floor  
Bethlehem, PA 18017

ph: 610-402-7884

fax: 610-402-8876

*Lori C. Alfonse, D.O., FACOS*

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Dear Patient:

We would like to thank you for choosing LVPG Surgical Oncology.

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. Please complete the included forms and bring them with you to your first appointment. If you have not completed the paperwork, **please arrive for your visit 30 minutes early.**

Please provide us with **all images** (digital or films) related to your visit that were done outside of the Lehigh Valley Health Network. **If you bring them with you on the day of your appointment, please arrive 30 minutes early.** We may request that these records be delivered prior to the day of your visit. Pathology slides and reports may also be necessary if you have had a previous biopsy or surgery.

For your convenience, our physicians are available to see you at two locations.

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,

LVPG Surgical Oncology

## Cancer Center Registration Form

Please complete the following information.

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

<b>Patient Name:</b>	<b>MR#:</b>	<b>DOB:</b>
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<b>Primary Care Physician:</b>	Name:	
	Address:	
	Phone:	Fax:

<b>Referring Physician:</b>	Name:	
	Address:	
	Phone:	Fax:

<b>Other Physician:</b>	Name:	
	Address:	
	Phone:	Fax:

<b>Local Pharmacy:</b>	Name:	
	Address:	
	Phone:	Fax:

<b>Mail Order Pharmacy:</b>	Name:	
	Address:	
	Phone:	Fax:

**MEDICARE Patient ONLY --- Please answer the following questions**

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

# LVPG Medical Information Communication Preferences

<b>Patient Name:</b>	<b>MR#:</b>	<b>DOB:</b>
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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 <small>(spouse, parent, son, daughter, etc.)</small>	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 Surgical 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.

**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

**Cancer Program Health Questionnaire**  
**LVPG Gynecologic Oncology**  
**LVPG Medical Oncology**  
**LVPG Surgical Oncology**  
**Radiation Oncology**  
**Multidisciplinary Clinic**

<b>Patient Name:</b>	<b>MR#:</b>	<b>DOB:</b>
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**Date:** \_\_\_\_\_

**Race/Ethnicity:**

- |  |                                   |   |                                    |
|--|-----------------------------------|---|------------------------------------|
| <input type="checkbox"/> American Indian/Alaskan   | <input type="checkbox"/> Asian    | <input type="checkbox"/> Black/African American | <input type="checkbox"/> Caucasian |
| <input type="checkbox"/> Pacific Islander/Hawaiian | <input type="checkbox"/> Hispanic | <input type="checkbox"/> Latino                 | <input type="checkbox"/> 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

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Sleep apnea                     | <input type="checkbox"/> Parkinson's          |
| <input type="checkbox"/> Heart Attack             | <input type="checkbox"/> Diverticulitis/Diverticulosis   | <input type="checkbox"/> Multiple Sclerosis   |
| <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> Ulcerative Colitis              | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> High Cholesterol         | <input type="checkbox"/> Crohns Disease                  | <input type="checkbox"/> Lupus                |
| <input type="checkbox"/> Irregular Heart Rate     | <input type="checkbox"/> Stomach Ulcers                  | <input type="checkbox"/> Anxiety              |
| <input type="checkbox"/> Mini Stroke              | <input type="checkbox"/> Chronic Renal Insufficiency     | <input type="checkbox"/> Depression           |
| <input type="checkbox"/> Pacemaker                | <input type="checkbox"/> Kidney Stones                   | <input type="checkbox"/> Cataracts            |
| <input type="checkbox"/> Blood Clots              | <input type="checkbox"/> Enlarged Prostate               | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> Pneumonia                | <input type="checkbox"/> Jaundice/Hepatitis/Pancreatitis | <input type="checkbox"/> Chronic Fatigue      |
| <input type="checkbox"/> Emphysema                | <input type="checkbox"/> Cirrhosis                       | <input type="checkbox"/> Seizures             |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Overactive Thyroid              | <input type="checkbox"/> Seasonal Allergies   |
| <input type="checkbox"/> COPD                     | <input type="checkbox"/> Underactive Thyroid             | <input type="checkbox"/> Diabetes             |
| <input type="checkbox"/> Tuberculosis             | <input type="checkbox"/> Cancer: Type:                   |   |
| <input type="checkbox"/> Other:                   |  |   |

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**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:**

<p><b>Social History</b></p> <p><b>Tobacco Products:</b> <input type="checkbox"/> Never <input type="checkbox"/> Yes  <input type="checkbox"/> Indicate all types of tobacco products you've ever used:  <input type="checkbox"/> Cigarettes/Cigar <input type="checkbox"/> Pipe  <input type="checkbox"/> Chewing tobacco <input type="checkbox"/> Snuff  <input type="checkbox"/> How many years have you used tobacco products? _____  <input type="checkbox"/> If you smoke(d) Cigarettes:  <input type="checkbox"/> packs per day: _____  <input type="checkbox"/> Year you quit smoking: _____  <input type="checkbox"/> Currently a smoker:  <input type="checkbox"/> every day <input type="checkbox"/> some days  <input type="checkbox"/> Have you been to a Smoking Cessation Class?  <input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Have you been exposed to second hand smoke?  <input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> How many years have you been exposed? _____</p> <p><b>Alcohol/Recreational Drugs/Tanning Exposure:</b>  <input type="checkbox"/> Do you or have you ever consumed alcohol?  <input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Drinks per week? _____  <input type="checkbox"/> Beer <input type="checkbox"/> Liquor <input type="checkbox"/> Wine  <input type="checkbox"/> Do you use any "street" or recreational drugs?  <input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> If yes, type: _____  <input type="checkbox"/> How often? _____  <input type="checkbox"/> Have you used a Tanning Bed? <input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Do you use sun screen? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><b>Living Arrangements</b>  <input type="checkbox"/> Alone <input type="checkbox"/> Nursing Home Facility <input type="checkbox"/> Spouse  <input type="checkbox"/> Relative <input type="checkbox"/> Assisted Living Facility <input type="checkbox"/> Family  <input type="checkbox"/> Other _____  Do you have an emotional support system? _____  If yes, with whom? _____  Are you being hurt or frightened by anyone in your life?  <input type="checkbox"/> Yes <input type="checkbox"/> No  If yes, by whom? _____</p> <p><b>Help: Call Turning Point Counseling Services for Victims of Domestic Violence: 610-437-3369</b></p> <p><b>Transportation</b>  <input type="checkbox"/> Ambulance <input type="checkbox"/> Friend/Family <input type="checkbox"/> Metro  <input type="checkbox"/> Self <input type="checkbox"/> Other _____</p> <p><b>Work History</b>  <input type="checkbox"/> Working Full Time <input type="checkbox"/> Retired  <input type="checkbox"/> Working Part Time <input type="checkbox"/> Unemployed  <input type="checkbox"/> Lifts greater than 10 lbs. at work or home  <input type="checkbox"/> Life occupation _____  <input type="checkbox"/> Previous exposure to environmental hazards _____</p>
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**Personal History -- Continued:**

<p><b><u>Venous Access Devices</u></b>  <b>Do you currently have:</b>      <input type="checkbox"/> None  <input type="checkbox"/> PICC      <input type="checkbox"/> Port      <input type="checkbox"/> Hickman  <input type="checkbox"/> Groshong      <input type="checkbox"/> Dialysis Catheter  <input type="checkbox"/> Other: _____</p>	<p><b><u>Fall Risk</u></b>  Do you use an assistive device to walk? <input type="checkbox"/> Yes <input type="checkbox"/> No  Are you unsteady on your feet? <input type="checkbox"/> Yes <input type="checkbox"/> No  Have you fallen in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b><u>Assistive Devices</u></b>  <input type="checkbox"/> Walker      <input type="checkbox"/> Wheelchair      <input type="checkbox"/> Cane  <input type="checkbox"/> Other: _____</p>
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**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	<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"/>
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"/>
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"/>
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"/>
Child	<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"/>
Mother's 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"/>
Mother's 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"/>
Father's 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"/>
Father's 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"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



<b>Patient Name:</b>	<b>MR#:</b>	<b>DOB:</b>
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**Review of Systems:**

Check any of the following that you had or have:

<p><b><u>Heart/Circulation Health</u></b>  <b>Have you had or do you have:</b> <input type="checkbox"/> None</p> <p><input type="checkbox"/> Chest pain  <input type="checkbox"/> Poor circulation  <input type="checkbox"/> Dizziness  <input type="checkbox"/> Palpitations  <input type="checkbox"/> Swelling of the ankles or feet  <input type="checkbox"/> Other: _____</p>	<p><b><u>Lung Health</u></b>  <b>Have you had or do you have:</b> <input type="checkbox"/> None</p> <p><input type="checkbox"/> Chronic coughing  <input type="checkbox"/> Coughing up mucus  <input type="checkbox"/> Coughing up blood  <input type="checkbox"/> Chronic shortness of breath  <input type="checkbox"/> Home oxygen  <input type="checkbox"/> Sleeping with head elevated to breathe easier  <input type="checkbox"/> Wheezing  <input type="checkbox"/> Other: _____</p>
<p><b><u>Stomach/Bowel Health</u></b>  <b>Have you had or do you have:</b> <input type="checkbox"/> None</p> <p><input type="checkbox"/> Colonoscopy, year of most recent: _____  <input type="checkbox"/> Change in bowel habits  <input type="checkbox"/> Difficulty passing your stool  <input type="checkbox"/> Watery loose stool  <input type="checkbox"/> Constipation  <input type="checkbox"/> Blood in stool  <input type="checkbox"/> Loss of control of bowels  <input type="checkbox"/> Excess gas or belching  <input type="checkbox"/> Belly pain  <input type="checkbox"/> Upset stomach  <input type="checkbox"/> Vomiting  <input type="checkbox"/> Other: _____</p>	<p><b><u>Brain Health</u></b>  <b>Have you had or do you have:</b> <input type="checkbox"/> None</p> <p><input type="checkbox"/> Chronic headaches  <input type="checkbox"/> Numbness in fingertips and/or toes  <input type="checkbox"/> Confusion  <input type="checkbox"/> Difficulty speaking your thoughts verbally  <input type="checkbox"/> Alzheimer's  <input type="checkbox"/> Parkinson's Disease  <input type="checkbox"/> Multiple sclerosis  <input type="checkbox"/> Mini stroke  <input type="checkbox"/> Stroke  <input type="checkbox"/> Loss of feeling and/or movement  <input type="checkbox"/> Seizures  <input type="checkbox"/> Weakness arms or legs  <input type="checkbox"/> Other: _____</p>
<p><b><u>Constitutional</u></b>  <b>Have you had or do you have:</b> <input type="checkbox"/> None</p> <p><input type="checkbox"/> Weight loss                      <input type="checkbox"/> Fatigue  <input type="checkbox"/> Fever                                      <input type="checkbox"/> Night sweats  <input type="checkbox"/> Change in appetite  <input type="checkbox"/> Other: _____</p>	<p><b><u>Skin Health</u></b>  <b>Have you had or do you have:</b> <input type="checkbox"/> None</p> <p><input type="checkbox"/> New skin growths  <input type="checkbox"/> Changes in a mole  <input type="checkbox"/> Rashes  <input type="checkbox"/> Psoriasis  <input type="checkbox"/> Annual skin screening  <input type="checkbox"/> Severe sunburn, when? _____  <input type="checkbox"/> Other: _____</p>
<p><b><u>Vision, Hearing and Throat Health</u></b>  <b>Have you had or do you have:</b> <input type="checkbox"/> None</p> <p><input type="checkbox"/> Change in vision                      <input type="checkbox"/> Glasses/Contacts  <input type="checkbox"/> Spots or floaters                      <input type="checkbox"/> Cloudy vision  <input type="checkbox"/> Hearing Loss                              <input type="checkbox"/> Hearing Aid  <input type="checkbox"/> Chronic hoarseness                      <input type="checkbox"/> Voice change  <input type="checkbox"/> Problems swallowing                      <input type="checkbox"/> Sore throat  <input type="checkbox"/> Other: _____</p>	<p><b><u>Urinary Health</u></b>  <b>Have you had or do you have:</b> <input type="checkbox"/> None</p> <p><input type="checkbox"/> Leaking of urine/dribbling  <input type="checkbox"/> Urinating often  <input type="checkbox"/> Burning with urination  <input type="checkbox"/> Change in force or strain with urination  <input type="checkbox"/> Getting up at night frequently to urinate  <input type="checkbox"/> Blood in urine  <input type="checkbox"/> Kidney problems  <input type="checkbox"/> Other: _____</p>

<b>Patient Name:</b>	<b>MR#:</b>	<b>DOB:</b>
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**Review of Systems – Continued:**

Check any of the following that you had or have:

<p><b><u>Endocrine/Diabetes/Thyroid Health</u></b>  <b>Have you had or do you have:</b> <input type="checkbox"/> None</p> <p><b>Please check the type of <u>Diabetes</u> you have:</b>  <input type="checkbox"/> Diet controlled <input type="checkbox"/> Insulin controlled  <input type="checkbox"/> Diabetes during pregnancy  <input type="checkbox"/> Type I <input type="checkbox"/> Type II  <input type="checkbox"/> Related to medication  <input type="checkbox"/> Goiter  <input type="checkbox"/> Other: _____</p> <p><b>Please check the type of <u>Thyroid Condition</u> you have, if any:</b>  <input type="checkbox"/> Overactive Thyroid <input type="checkbox"/> Underactive Thyroid</p>	<p><b><u>Musculoskeletal</u></b>  <b>Have you had or do you have:</b> <input type="checkbox"/> None</p> <p><input type="checkbox"/> Muscle weakness  <input type="checkbox"/> Joint Swelling  <input type="checkbox"/> Muscle/joint stiffness  <input type="checkbox"/> Back pain  <input type="checkbox"/> Bony pain  <input type="checkbox"/> Arthritis  <input type="checkbox"/> Fibromyalgia  <input type="checkbox"/> Other: _____</p>
<p><b><u>Female Reproductive Health</u></b> <input type="checkbox"/> Not applicable</p> <p><b>Have you had or do you have:</b> <input type="checkbox"/> None</p> <p><input type="checkbox"/> Breast lumps  <input type="checkbox"/> Nipple discharge  <input type="checkbox"/> Abnormal vaginal bleeding  <input type="checkbox"/> Painful periods  <input type="checkbox"/> Vaginal discharge  <input type="checkbox"/> Hot flashes  <input type="checkbox"/> Leaking urine  <input type="checkbox"/> Painful intercourse  <input type="checkbox"/> Currently sexually active  <input type="checkbox"/> Fertility issues  <input type="checkbox"/> Other: _____</p>	<p><b><u>Male Reproductive Health</u></b> <input type="checkbox"/> Not applicable</p> <p><b>Have you had or do you have:</b> <input type="checkbox"/> None</p> <p><input type="checkbox"/> Prostate exam, date last done: _____  <input type="checkbox"/> PSA blood test, date last done: _____  <input type="checkbox"/> Enlarged prostate  <input type="checkbox"/> Able to acquire an erection  <input type="checkbox"/> Able to maintain an erection  <input type="checkbox"/> Discharge from penis  <input type="checkbox"/> Pain/swelling in the testicles(s)  <input type="checkbox"/> Perform self-testicular exams  <input type="checkbox"/> Currently sexually active  <input type="checkbox"/> Fertility issues  <input type="checkbox"/> Other: _____</p>
<p><b><u>Blood Disorders/Infectious Disease</u></b>  <b>Have you had or do you have:</b> <input type="checkbox"/> None</p> <p><input type="checkbox"/> Below/above normal amount of red blood cells  <input type="checkbox"/> Clotting/bleeding disorder  <input type="checkbox"/> History of blood transfusion  <input type="checkbox"/> Reaction to a blood transfusion  <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C  <input type="checkbox"/> Genital Herpes <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Herpes Zoster  <input type="checkbox"/> Human Papilloma Virus (HPV)  <input type="checkbox"/> Vancomycin Resistance Enterococci (VRE)  <input type="checkbox"/> Methicillin Resistant Staphylococcus Aureus (MRSA)  <input type="checkbox"/> Mumps <input type="checkbox"/> Measles <input type="checkbox"/> Chicken Pox  <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio  <input type="checkbox"/> Other: _____</p>	<p><b><u>Mental Health</u></b>  <b>Have you had or have you been:</b> <input type="checkbox"/> None</p> <p><input type="checkbox"/> Feeling anxious  <input type="checkbox"/> Feeling sad most of the time  <input type="checkbox"/> Treated for any Mental Health Issues  <input type="checkbox"/> Recent loss or life change  <input type="checkbox"/> Had thoughts of or attempted to hurt yourself  <input type="checkbox"/> Hospitalized for any of the above conditions  <input type="checkbox"/> Difficulty sleeping or Sleep Disturbance</p> <p><b>Rate your level of stress:</b>  <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme          If you have checked off any of the above:          Are you currently under care <input type="checkbox"/> Yes <input type="checkbox"/> No          If YES, with whom? _____          If NO, do you wish to talk to someone? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

<b>Patient Name:</b>	<b>MR#:</b>	<b>DOB:</b>
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**Review of Systems – Continued:**

Check any of the following that you had or have:

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

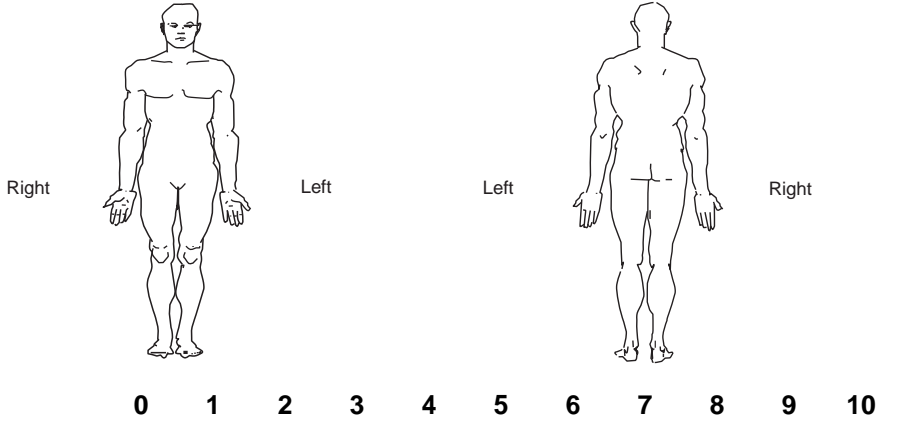
**If you answered yes to any of the above questions, please provide us with a copy.**

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

<b>Patient Name:</b>	<b>MR#:</b>	<b>DOB:</b>
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**Pain Assessment**     **No Pain**

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



**Verbal  
Descriptor  
Scale**

<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>
<b>NO PAIN</b>	<b>MILD PAIN</b>	<b>MODERATE PAIN</b>	<b>MODERATE PAIN</b>	<b>SEVERE PAIN</b>	<b>SEVERE PAIN</b>	<b>SEVERE PAIN</b>	<b>SEVERE PAIN</b>	<b>SEVERE PAIN</b>	<b>SEVERE PAIN</b>	<b>WORST PAIN POSSIBLE</b>

**WONG-BAKER  
FACIAL  
GRIMACE SCALE**



**ACTIVITY  
TOLERANCE  
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
<b>NO PAIN</b>	<b>CAN BE IGNORED</b>	<b>INTERFERES WITH TASK</b>	<b>INTERFERES WITH CONCENTRATION</b>	<b>INTERFERES WITH BASIC NEEDS</b>	<b>BEDREST REQUIRED</b>

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

<b>Patient Name:</b>	<b>MR#:</b>	<b>DOB:</b>
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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?



**LVPG SURGICAL ONCOLOGY**

*A practice of Lehigh Valley Physician Group*

John & Dorothy Morgan Cancer Center  
1240 S. Cedar Crest Blvd., Suite 205  
Allentown, PA 18103

2545 Schoenersville Rd., Third Floor  
Bethlehem, PA 18017

ph: 610-402-7884  
fax: 610-402-8876

*Lori C. Alfonse, D.O., FACOS*  
*Jeffrey T. Brodsky, M.D. FACS*  
*Heiwon Chung, M.D., FACS*  
*Rohit Sharma, M.D.*

Dear Patient,

We understand that there are times when you may need a form completed by the office or the physician, for example, medical leave or disability forms. We are willing to help you with your requests.

These forms require research and time by the staff and physician in order to be completed. As a result of the large volume and complexity of the forms we ask that we are given 7-10 business days to complete your forms.

Due to an increase in the volume of forms to be completed, we are establishing a fee for the completion of forms. The fee range is based on preset industry standards or on the length and complexity of the form. Payment is due after forms are completed to determine the amount being charged.

We appreciate your understanding and cooperation in this matter.

Sincerely,

LVPG Surgical Oncology

# 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.

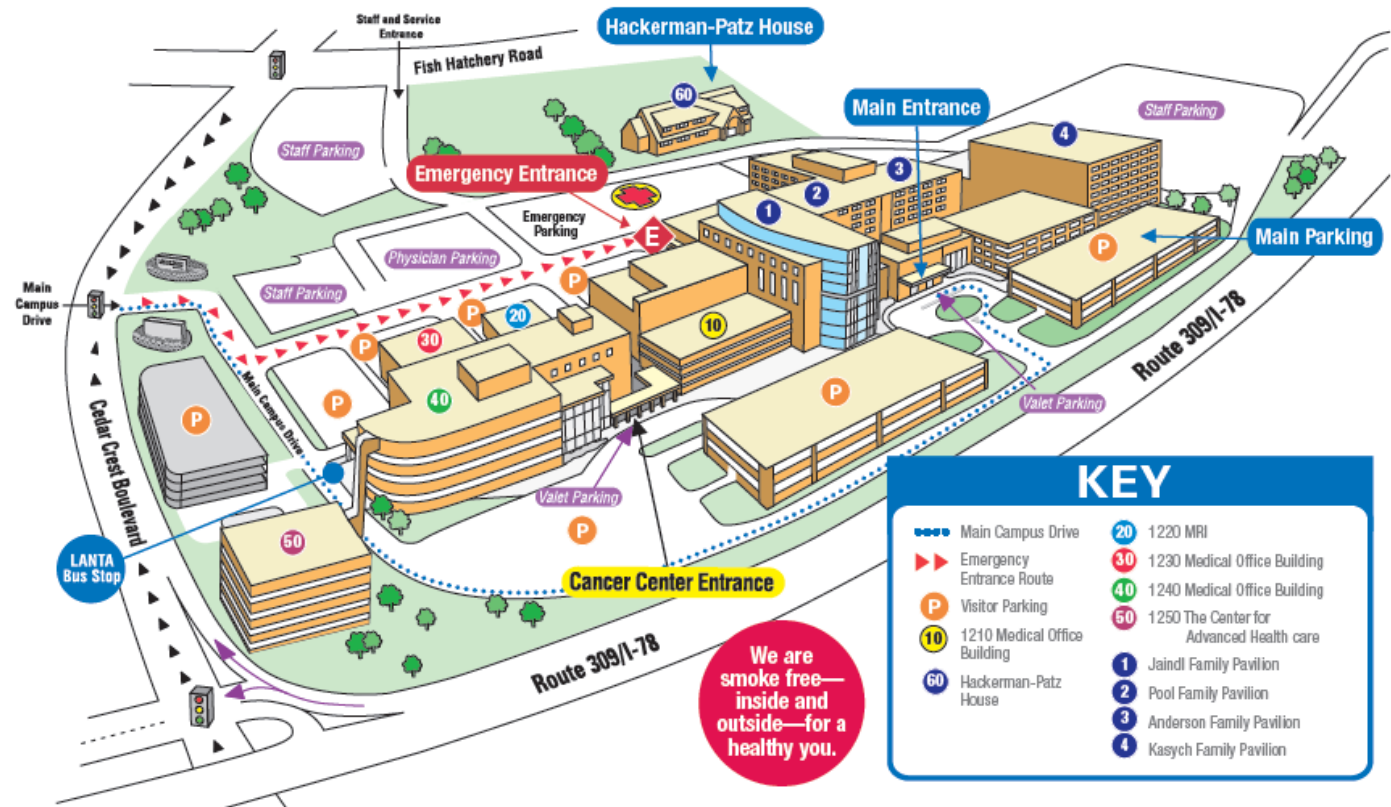
## Patient Drop-off and Pick-up

- 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.



## 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

MAPCC ENG : 3153 / 1.2012



# Your Guide to Lehigh Valley Health Network–Muhlenberg

### Valet Parking

FREE valet parking is available at the main entrance Monday through Friday from 5:30 a.m. to 3:30 p.m.

### Hospital Parking

- Self-parking is free in the lot directly in front of the H.
- Patients may be dropped off and picked up at the hospital main entrance behind the H.

### Westgate Drive Entrance

Take Westgate Drive to get to the Behavioral Health Science Center, hospital's south entrance, Good Shepherd Specialty Hospital and Banko Community Center.

### Emergency Parking

Follow signs to the emergency parking lot. Patients may be dropped off and picked up directly in front of the emergency room.

### Medical Office Building Parking

- 97 2597 medical office building parking is available in lot 97.
- 49 2649 medical office building parking is available in lot 49.
- 63 2663 medical office building parking is available in lot 63.
- 70 1770 medical office building parking is available in lot 70.
- The main hospital is also known as 2545 Schoenersville Road.
- Follow signs to parking for Good Shepherd Rehabilitation Center.

### Health Spectrum Pharmacy

- Visitors to the Health Spectrum Pharmacy may use 15-minute parking spaces located in the third row in front of the H.
- Pharmacy hours: Monday - Friday, 8 a.m. - 6 p.m.  
Saturday, 9 a.m. - 3 p.m.  
Closed Sunday

Questions? Call 610-402-CARE (2273) or log on to [lvh.org](http://lvh.org)

See other side for driving directions.



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610-402-CARE LVH.org

# Directions to Lehigh Valley Health Network–Muhlenberg

Route 22 and Schoenersville Road • Bethlehem, Pa. 18017

**From Route 22:**

If coming from Allentown and points west of Bethlehem

- Take Route 22 East to the Route 378/Schoenersville Road exit.
- Take the second right off the exit ramp to Schoenersville Road.
- Turn left at the stoplight onto Schoenersville Road.
- Make the first right onto the hospital campus and follow signs to visitor parking.

If coming from Easton and points east of Bethlehem

- Take Route 22 West to the Schoenersville Road exit.
- Turn left at the stoplight onto Schoenersville Road.
- Turn right onto the hospital campus and follow signs to visitor parking.

**From the Northeast Extension of the Pa. Turnpike:**

- Take exit 56 (Lehigh Valley).
- After the toll booth, take Route 22 East to the Route 378 Schoenersville Road exit.
- Take the second right off the exit ramp to Schoenersville Road.
- Turn left at the stoplight onto Schoenersville Road.
- Make the first right onto the hospital campus and follow signs to visitor parking.

**From Route 378:**

- Take Route 378 North to Route 22 East.
- Take the ramp to Route 22 East but stay to the right and exit immediately onto the ramp for Schoenersville Road.
- Turn left at the stoplight onto Schoenersville Road.
- Make the first right onto the hospital campus and follow signs to visitor parking.

**From Route 33:**

- Take Route 33 South to Route 22 West.
- Follow Route 22 West to the Schoenersville Road exit.
- Turn left at the stoplight onto Schoenersville Road.
- Turn right onto the hospital campus and follow signs to visitor parking.



Lehigh Valley Hospital–  
Cedar Crest and I-78  
P.O. Box 689  
Allentown, PA 18105-1556

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

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

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