Lehigh Valley Health Network
A PASSION FOR BETTER MEDICINE.

LEHIGH VALLEY HEART SPECIALISTS
A practice of Lehigh Valley Physician Group

DATE: _____________ MR# (FOR OFFICE USE)____________

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.)*: ☐ M ☐ F		**DOB:**
Address:		
City:	**State:** **Zip Code:**	
Home Phone:		**Work Phone:**
Cell Phone:		**Preferred Pharmacy:**
Referring Doctor:		**Phone Number:**
Emergency Contact:		**Relation/Contact Number:**

MEDICAL PROBLEMS Please check the boxes below if you have had a prior problem with or currently have the following:

☐ Rheumatic Fever	☐ Arrhythmia (abnormal heart beat)	☐ Stomach ulcers, reflux or hiatal hernia
☐ Heart Attack	☐ Blockage of neck arteries	☐ Blood clots
☐ High Blood Pressure	☐ Stroke or mini stroke	☐ Bleeding problems
☐ High Cholesterol	☐ Aneurysms of the blood vessels	☐ Anemia
☐ Diabetes	☐ Asthma or COPD	☐ Arthritis or Gout
☐ Tuberculosis	☐ Bronchitis or emphysema	☐ Cancer-specify type:
☐ Congestive Heart Failure	☐ Liver Disease or hepatitis	☐ Gallstones
☐ Heart Murmur	☐ HIV or AIDS	☐ Kidney Disease
☐ Peripheral Vascular Disease	☐ Thyroid	☐ Other – specify:
☐ Sleep Apnea	☐ Seizures	☐ Other – specify:

Please check and provide details if you have had any of the following:

☐ Heart Bypass Surgery: Date _______________ Facility Name/Location: _____________________ Surgeon: ____________________

☐ Heart Valve Surgery: Date _______________ Facility Name/Location: _____________________ Surgeon: ____________________

☐ Pacemaker: Date _______________ Facility Name/Location: _____________________ Surgeon: ____________________

☐ Heart Angioplasty/Stents: Date _____________ Facility Name/Location: _____________________ Surgeon: ____________________

List all other past surgeries/procedures:

Defibrillator type: _____________________________ **Date:** _____________ **Doctor:** ____________________________________

FAMILY HEALTH HISTORY Please check the boxes below if your family member had a prior problem with or currently have the following:

	FATHER	MOTHER	SIBLINGS	AGE DIAGNOSED
Diabetes				
Heart Disease				
Cholesterol				
High Blood Pressure				
Sudden Death				
Congenital Heart Defects				

SOCIAL HISTORY

Employment	Occupation:
	Physical demands of work: ☐ Sedentary ☐ Light ☐ Moderate ☐ Heavy
	Are you exposed to environmental hazards (i.e. heat, chemicals, dust)? ☐ Yes ☐ No

	Highest Level of Education:
Exercise	☐ Sedentary (No exercise)
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)
Alcohol	Do you drink alcohol? ☐ Yes ☐ No
	If yes, what kind?
	How many drinks per week?
Tobacco	Do you use tobacco? ☐ Yes ☐ No
	☐ Cigarettes – pks./day ☐ Chew - #/day ☐ Pipe - #/day ☐ Cigars - #/day
	☐ # of years ☐ Or year quit
Drugs	Do you currently use or have a history of using recreational or street drugs? ☐ Yes ☐ No
Personal Safety	Do you live alone?
	On whom can you rely for support? ___________________________
Hobbies	

List of Medications (prescriptions, over the counter, vitamins, herbs, etc)

Name	Strength	Frequency Taken	Name	Strength	Frequency Taken
1.			8.		
2.			9.		
3.			10.		
4.			11.		
5.			12.		
6.			13.		
7.			14.		

Allergies to Medications, Adhesive Tape or Latex: ☐ YES ☐ NO If yes, please list below:

Do you currently have or have a history of any of the following?

Chest Pain	☐ Yes	☐ No	Chills	☐ Yes	☐ No	Blurred Vision	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No	Night sweats	☐ Yes	☐ No	Difficulty Hearing	☐ Yes	☐ No
Leg swelling	☐ Yes	☐ No	Hay Fever	☐ Yes	☐ No	Lightheadedness	☐ Yes	☐ No
Leg pain when walking	☐ Yes	☐ No	Nausea	☐ Yes	☐ No	Dizziness	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No	Vomiting	☐ Yes	☐ No	Rash	☐ Yes	☐ No
Shoulder Pain	☐ Yes	☐ No	Diarrhea	☐ Yes	☐ No	Snoring	☐ Yes	☐ No
Back Pain	☐ Yes	☐ No	Bloody Stools	☐ Yes	☐ No	Daytime sleepiness	☐ Yes	☐ No
Cough	☐ Yes	☐ No	Palpitations	☐ Yes	☐ No	Restless leg	☐ Yes	☐ No
Fever	☐ Yes	☐ No	Headache	☐ Yes	☐ No	Muscle aches	☐ Yes	☐ No

Lehigh Valley Heart Specialists would like to thank you for sharing your personal history. The information in this form remains strictly confidential and will help us evaluate your cardiac health. If you have any other concerns, please feel free to list them below:

Patient's (or person completing form) Signature ______________________________________ Date: _____________

Physician's Signature ____ Date: _____________

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

PATIENT:		DOB:	MEDICAL RECORD #:
DATE:	TIME:	LOCATION: LEHIGH VALLEY HEART SPECIALISTS	

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 behalf 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*

COMPLETE & RETURN THIS FORM TO THE RECEPTIONIST

PATIENT INFORMATION **DATE** ____________________________

LAST NAME ____ FIRST NAME____

ADDRESS ____

CITY ____ST_________ ZIP ________________ CIRCLE: MALE FEMALE

HOME PHONE ______________________________________ CELL PHONE _____________________________________

DATE OF BIRTH _____________________________________ SSN____

PREFERRED PHARMACY_____________________________**PHONE NUMBER** _______________________

EMPLOYER INFORMATION

PATIENT EMPLOYER ____OCCUPATION____________________________

EMPLOYER ADDRESS ____ WORK PHONE __________________________

HOW DID YOU HEAR ABOUT OUR PRACTICE?

□ RELATIVE □ FRIEND □ WEBSITE □ PHYSICIAN (FILL OUT BELOW)

REFERRING DOCTOR INFORMATION

FAMILY DOCTOR ____ PHONE ______________________________

REFERRING DOCTOR ____ PHONE ______________________________

SPOUSE INFORMATION

LAST NAME ____ FIRST NAME ___________________________________

DATE OF BIRTH ____ SSN ____

EMPLOYER ____ WORK NUMBER ___________________________

EMPLOYER ADDRESS ____

EMERGENCY CONTACT

NAME ____ PHONE NUMBER ____________________________

RELATIONSHIP ____ NEXT OF KIN _________________________________

IF PATIENT IS A MINOR

MOTHER'S NAME _________________________________SSN______________________BIRTHDATE_________________

FATHER'S NAME__________________________________SSN______________________BIRTHDATE _________________

INSURANCE	**PRIMARY**	**SECONDARY**
NAME	____	____
ID#	____	____
SUBSCRIBER	____	____
EFFECTIVE DATE	_____________________________________	____

PLEASE BE SURE TO BRING YOUR INSURANCE CARDS WITH YOU TO THE OFFICE.

Lehigh Valley Health Network
A PASSION FOR BETTER MEDICINE.

Consent for Release of Information

MEDICAL RECORD NO.________________________________

PATIENT NAME	SOCIAL SECURITY NO.	DATE OF BIRTH
PATIENT ADDRESS		TELEPHONE NO.

I, ___________________________________do hereby consent to and authorize
____to disclose to:

NAME OF DOCTOR/HOSPITAL/INSURANCE COMPANY/OTHER AGENCY: **Lehigh Valley Heart Specialists** **FAX #: 610- 402-3225**
ATTENTION
ADDRESSEE **1250 S Cedar Crest Blvd, Suite 300, Allentown, PA. 18103**
FOR THE PURPOSE OF **TRANSITION/CONTINUITY OF CARDIAC MEDICAL MANAGEMENT**

Information from within the Practice's records relating to my identity, diagnosis, prognosis, or treatment. However, I do not give permission for any other use of redisclosure of this information.

ATTENTION PATIENT

Please be alerted that, if any one of the following three (3) boxes are checked, it is with the intention of making you aware that your record(s) contains "PROTECTED" information related to these categories. Therefore, your signature next to the identified category acknowledges your awareness of this fact. (This information has been disclosed to you from records whose confidentiality is protected by Federal Law and PA State Statutes.) The information will not be released unless you signature is obtained.

I further understand that there is specific documentation within my records which is protected under the

_______________________________________ ☐ Confidential Alcohol & Drug Abuse Patient Information, 42 C.F.R. Part II
SIGNATURE

_______________________________________ ☐ PA Mental Health Procedure Act.
SIGNATURE

_______________________________________ ☐ Confidentiality of HIV-Related Information Act, PA Law Act 148.
SIGNATURE

I also understand that my record may contain:

- Drug or alcohol information, if drug or alcohol tests were ordered or treatment provided by my physician;
- Psychiatric or psychological information, if psychiatric or psychological treatment was given by my physician;
- HIV-related information, if HIV-related tests were ordered by my physician.

The information to be released is:

	Related To		Related To	
☐ Progress Notes	__________________	☐ Consultation Report	__________________	☐ Date of Service of records requested____________________
☐ History & Physical	__________________	☐ X-Ray Report	__________________	
☐ Laboratory Results	__________________	☐ Entire Record	__________________	
☐ EKG, EEG, Stress	__________________	☐ Summary	__________________	

☐EXCEPTION: I do not give permission to release (please specify):____
____

I also understand that this consent may be revoked by me at any time by submitting a written revocation notice, except to the extent that action has been previously taken, and in that event, this consent will remain in force in order to effectuate the purposes for which it is given.

Dated this ____day of _______________________, 20______________

Consent expires the ____ day of _______________________, 20______________

PATIENT SIGNATURE
____WITNESS____

SIGNATURE OF PARENT/LEGAL GUARDIAN/
AUTHORIZED REPRESENTATIVE:
____

☐ Unable to sign because:
____

If you have any questions, please contact the Release of Information Specialist, at (610) 402-8380, 8:00am - 4:30pm, Monday – Friday, or by Mail at: Lehigh Valley Health Network, Attention - Release of Information, Cedar Crest & I-78, PO Box 689, Allentown, PA 18105-1556.

Rev 03/10

LVPG Medical Information Communication Preferences

Patient ___________________________________ MR#_________________________ DOB ____/___/____

As our patient, we may need to communicate with you when you are not in the practice. To assure your privacy, we would like you to indicate your preferred method for us to communicate medical information to you and/or to others involved in your care. Please note that an “appointment reminder” is not classified as medical information.

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 #, Extension
Home			
Answering Machine			
Work Phone			
Cell Phone			
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 (i.e. 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

_________________________ Date

____(Please Print Name)