WELCOME TO COLLEGE HEIGHTS OBGYN ASSOCIATES

We are pleased you have selected College Heights OBGYN Associates for your obstetrical / gynecological care.

Meeting a new medical provider can cause anxiety for a patient. As such, we ask that you complete the attached forms and bring them with you to your initial visit. This will help our entire staff handle your experience more effectively. **Please arrive 15 minutes prior to your appointment and be certain to bring your insurance card and co-payment, a photo ID, a list of your current medications including strength and dosage, and any required referral forms.**

In an effort to better serve our patients, our office has implemented an electronic medical record (EMR). This new system will make it easy for us to share information with you and members of your care team. Most importantly, this system will allow us to provide a safer, more efficient healthcare experience for you. Additionally, our office can accommodate those patients who utilize email for scheduling appointments, prescription refills, or non-urgent medical questions.

Please visit our website at **www.chobgyn.com** for additional information regarding our practice and providers.

Thank you for giving us the opportunity to participate in your medical care. Our staff will strive to maintain your confidence in providing you with the ideal patient experience.

Sincerely,

The Patient Care Team of College Heights OBGYN Associates

1245 S Cedar Crest Blvd STE 201
Allentown, PA 18103-6267
610-437-1931

1665 Valley Center Pkwy STE 130
Bethlehem, PA 18017
610-317-0208

2101 Emrick Blvd STE 201
Bethlehem, PA 18020
484-895-3230

333 Normal Avenue STE 202
Kutztown, PA 19530
610-683-5522

Health Center at Trexlertown
6900 Hamilton Blvd
Trexlertown, PA 18087
484-664-2970

Revised 11-21-2012

PLEASE COMPLETE ALL QUESTIONS - PLEASE PRINT

Today's Date ____________________________ Mark "X" if you are a previous patient __________ **MR#** ____________________

Patient ____ Birth date ______________________
Last Name First Name Middle Initial

Address ____
Street City State Zip Code

Home Phone ( )_________________________________ Work Phone ( )___________________________ Ext. _______

Cell Phone ( )_________________________________ Social Security # ____

Circle: Single / Married / Divorced / Separated / Widowed / Student

Spouse: Name ______________________________________ SS#____________________________ Birth date______________

IF MINOR OR FULL TIME STUDENT

Father's Name _________________________________ SS# ___________________________ Birth date ___________________

Mother's Name ________________________________ SS#____________________________ Birth date___________________

Patient's Employer (If minor or FT student, write Mother's)

Company ____

Address ____

____

Occupation _______________________________________

Phone ( )___________________________Ext.________

Spouse's Employer (If minor or FT student, write Father's)

Company ____

Address ____

____

Occupation ____

Phone ( )______________________________ Ext. _______

ALLERGIES – Medication ____

ALLERGIES - Other (Dust, pollen, pets, etc.)____

Family Doctor/PCP ____ Phone ( )___________________________

1. Primary Insurance CARD COPY.

2. Secondary Insurance CARD COPY.

AUTHORIZATION: I, the undersigned patient OR parent / legal guardian of a minor patient, authorize LVPG~College Heights OBGYN Associates to release any medical information necessary to process health insurance claim(s) for services rendered to me or to the minor patient. I hereby authorize direct payment by my health insurance plan(s) to LVPG-College Heights OBGYN Associates for all medical services provided to me or to my dependent.

____ (Signature of Patient or Parent / Legal Guardian)

Form: 11-02-2011

LVPG-COLLEGE HEIGHTS OBSTETRICAL & GYNECOLOGICAL ASSOCIATES

MEDICAL HISTORY FORM

Please take a moment to complete this form to the best of your ability. You may leave questions blank for anything that you cannot answer. Thank you!

Patient Name ____ **Date** ________________________________

Date of Birth ____ MR**#** ________________________________

PREGNANCY HISTORY:
# of miscarriages ______ # of ectopics ______ # of abortions ______ # of living children ______

Year	*Delivery*	*# Weeks Pregnant*	*Baby's Gender*	*Baby's Weight*	*Complications*
	☐ Vaginal ☐ C-section		☐ Male ☐ Female		
	☐ Vaginal ☐ C-section		☐ Male ☐ Female		
	☐ Vaginal ☐ C-section		☐ Male ☐ Female		
	☐ Vaginal ☐ C-section		☐ Male ☐ Female		

PAST GYNECOLOGIC HISTORY:
Age of first menses ________ Frequency ________________________ Duration ______________________
Age of menopause ________ ☐ Natural ☐ Surgical ☐ Induced by medication
Sexually active: ☐ Yes ☐ No Partners: ☐ Male ☐ Female ☐ Both
Age of first intercourse _______ Number of lifetime sexual partners ________

Current birth control method ____

Sexually transmitted infections (e.g. chlamydia, gonorrhea, trichomoniasis, herpes, syphilis, HIV, genital warts, HPV):

____

☐ Abnormal Pap(s) ☐ Endometriosis ☐ Colposcopy ☐ LEEP ☐ Cone biopsy ☐ Fibroids

MEDICAL HISTORY: List any significant medical problems you have now or have had in the past.
☐ High Blood Pressure
☐ Elevated Cholesterol
☐ Underactive thyroid
☐ Overactive thyroid
☐ Diabetes:
- ☐ Controlled w/ diet
- ☐ Controlled w/ meds
- ☐ Controlled w/ Insulin

☐ Osteoporosis
☐ Osteopenia
☐ Migraines
☐ Blood clots (now or previous)
Other: ____________________________________
____
____
____

PAST SURGICAL HISTORY:
Hysterectomy: ☐ Abdominal ☐ Vaginal ☐ Laparoscopic ☐ Supracervical
Reason*:* ☐ Fibroids ☐ Bleeding ☐ Prolapse ☐ Endometriosis
☐ Cancer: Type ______________________ ☐ Cervical dysplasia/precancer
☐Endometrial hyperplasia / precancer ☐ Other________________________________
Ovaries removed: ☐ Left ☐ Right ☐ Both
Breast Surgery: ☐ Biopsy ☐ Lumpectomy: ☐ Left ☐ Right ☐ Mastectomy: ☐ Left ☐ Right
Reason: ☐ Benign ☐ Precancer ☐ Cancer

PAST SURGICAL HISTORY CONTINUED:
List any other surgeries you have had. Please remember to include C-sections, tubal ligation, D&C or D&E, prolapse or incontinence surgery as well as non-gynecologic surgeries.

______________________________ ______________________________ ______________________________
______________________________ ______________________________ ______________________________
______________________________ ______________________________ ______________________________

MEDICATIONS:
List any current medications, doses and instructions. (Attach a list if you are on several.)

____ ____
____ ____
____ ____

ALLERGIES:

Medication / Food	*Reaction*

FAMILY HISTORY: List any medical problems that run in your family as well as the effected members.

Condition	*Family member(s)*	*Condition*	*Family member(s)*
☐ Breast cancer		☐ Diabetes	
☐ Uterine cancer		☐ High blood pressure	
☐ Colon cancer		☐ Heart disease / attack	
☐ Ovarian cancer		☐ Stroke	
Other:		Other	

SOCIAL HISTORY:
Tobacco use: ☐ Never ☐ Quit ☐ Current: Number of packs per day______________
Alcohol use: ☐ No ☐ Yes Average number of drinks per day ________________
Drug use: ☐ No ☐ Yes Substance____

VACCINATIONS: Please indicate if and when you received these vaccines:
☐ Gardasil (HPV vaccine): Date(s) ______________ ☐ Hepatitis B: Date(s) ________________________
☐ Pneumovax: Date __________________________ ☐ Tetanus: Date _____________________________
☐ Adacel/TDaP: Date _________________________ ☐ Herpes Zoster (shingles): Date _______________

PREVENTATIVE SERVICES: Please indicate if and when you have had the following tests:
☐ Pap smear: Date______________________________ ☐ Cholesterol blood work: Date ___________________
☐ Mammogram: Date ____________________________ ☐ DEXA scan (bone density): Date ________________
☐ Colonoscopy: Date ____________________________ ☐ Sahara (bone density): Date ____________________

Exciting new patient videos!

<u>Emmi Programs</u>: Interactive, online, <u>health care education</u> for our patients

What are Emmi programs?
They are a series of web-based, online, multimedia videos that educate patients and help them to take an active role in their care.

How do patients receive Emmi programs?
Your care provider will order an Emmi educational video that is specific to your gynecological or obstetrical care. You will receive secure emails to your home email address with the information you need to log into Emmi at your convenience, at any time, and view the educational programs ordered for you – just like watching an online video! You can even type questions to a qualified Emmi nurse who is standing by for an interactive chat session.

On the "**LVPG Medical Information Communication Preferences Form", please check the "YES" box** and write your email address on the line *"E-MAIL to receive provider-ordered online patient education programs"* so you can receive Emmi videos which your care provider feels are important to your care.

We hope you enjoy Emmi programs, and we look forward to your feedback on the videos and to finding out if they are beneficial to you.
Thank you.

01-31-2013

LVPG Medical Information Communication Preferences

Patient ________________________________ MR#________________________ DOB ____/___/____

As our patient, we may need to reach you when you are not in the practice. For 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 list your email address to receive online health care educational programs ordered by your care provider.

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			
E-MAIL for our Patient Portal secure email registration			
E-MAIL to receive provider-ordered online patient education programs			
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 of Patient or Patient's Legal Representative Date

____(Please Print Signer's Name)