Lehigh Valley Physician Group
LEHIGH VALLEY HEALTH NETWORK

Welcome to LVPG Obstetrics and Gynecology

We are pleased you have selected LVPG Obstetrics and Gynecology 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 **LVHN.org/obgyn** 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 LVPG Obstetrics and Gynecology

LVPG Obstetrics and Gynecology

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 Obstetrics and Gynecology 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 Obstetrics and Gynecology for all medical services provided to me or to my dependent.

_____ (Signature of Patient or Parent / Legal Guardian)

Form: 06-24-2015

LVPG Obstetrics and Gynecology

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 _____ M**R#** _____

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 _____

LVPG Obstetrics and Gynecology

Exciting new patient videos!

Emmi Programs: Interactive, online, health care education 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.

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)

Cancer Genetic Assessment **Name:** _____ **MR#** _____ **Date of Birth:** _____

This form will help us get a clear picture of your health history. Your doctor may send you for genetic testing based on this form if it shows you have a strong family history of certain cancers. For each entry, place an X in the "You had it" column if it applies to you. (For example, if you had breast cancer at or before age 45, you would place an X in the first entry under the "You had it" column.) Next, place an X in the "Family member had it" column if the entry applies to your blood relatives. (For example, if your aunt had breast cancer at or before age 45, you would place an X in the first entry under the "Family member had it" column.) It is very important to remember that your family history includes your parents, brothers, sisters, children, grandchildren, grandparents, aunts, uncles, nieces, nephews and first cousins. These are your blood relatives. Do not include people related to you by marriage. If you or your family have not had any cancers, place an X in the no history box.

This form may be hard to complete. If you have any trouble with any of the entries on this form, please ask a staff member to help you complete the form.

ONLY ONE REQUIRED FOR REFERRAL			
Diagnosis of:	**You had it**	**Family member(s) had it**	**No history**
Breast cancer at or before age 45			
Triple negative breast cancer at or before age 60			
Two primary breast cancers (first one at or before age 50)			
Breast cancer at any age **and** are of Ashkenazi Jewish descent			
Cancer of the ovary, fallopian tube or primary peritoneum at any age			
Blood relative with male breast cancer			
Blood relative with a BRCA gene mutation			
Three or more blood relatives on same side of family with breast cancer			
One family member with breast cancer AND two or more blood relatives on the same side of the family with pancreatic, prostate or ovarian/fallopian tube/primary peritoneal cancer			

TWO OR MORE REQUIRED FOR REFERRAL			
Diagnosis of:	**You had it**	**Family member(s) had it**	**No history**
Breast cancer at any age			
Two or more family members on same side of family with breast, pancreatic or prostate cancer at any age			
At least one blood relative with breast cancer at or before age 50			
At least one blood relative with ovarian/fallopian tube/primary peritoneal cancer at any age			

BOTH REQUIRED FOR REFERRAL			
Diagnosis of:	**You had it**	**Family member(s) had it**	**No history**
Pancreatic cancer at any age			
Two or more family members from same side of family with breast, ovarian/fallopian tube/primary peritoneal, pancreatic or prostate cancer			

ONLY ONE REQUIRED FOR REFERRAL			
Diagnosis of:	**You had it**	**Family member(s) had it**	**No history**
Colon cancer before age 50			
Uterine (endometrial) cancer before age 50			
Multiple colon or other cancers listed below in the same person			
Two or more family members from the same side of the family with any of the other cancers listed below (one must be diagnosed before age 50)			
Three or more family members from the same side of the family with any of the other cancers listed below			
Blood relative with a gene mutation linked to Lynch syndrome			

TWO OR MORE REQUIRED FOR REFERRAL			
Diagnosis of:	**You had it**	**Family member(s) had it**	**No history**
Any of the other cancers listed below before age 50			
Any of the other cancers listed below at or after age 50			
At least one blood relative with any of the other cancers listed below at or before age 50			
Two or more family members from the same side of the family with any of the other cancers listed below at any age			

Other Cancers : *Some of the questions above asked about other cancers. The list of other cancers*: Colon, Rectal, Ovarian, Small intestine, Uterine (endometrial), Pancreas, Ureter or renal pelvis, Stomach (gastric), Biliary tract, Brain (glioblastoma), Keratoacanthomas, Sebaceous gland adenomas or carcinomas

PATIENT NAME: (Please print) _____ SIGNATURE: _____ DATE: _____

OFFICE USE ONLY: ☐ Refer to Genetics ☐ Packet provided ☐ Referral not indicated ☐ Genetic referral declined by patient

Physician Signature: _____ **Date:** _____

10/2014