Welcome Kit

Switching to **AHN** is as easy as

1 2 3

Allegheny Health Network

AHN.org/welcomekit

Fill out your health history

Complete the Health History Form to get started on your switch to AHN.

Release your medical records

The Authorization for Release of Protected Health Information must be completed in order for AHN to collect your medical records from your previous medical care provider.

Find a doctor

Searching by specialty? Looking for a location? We make it easy to take the next step in joining the AHN network.

Allegheny Health Network

Welcome

Allegheny Health Network has more than 2,100 doctors, providing care at physician offices and more than 200 inpatient and outpatient sites across western Pennsylvania.

From sudden injury and illness to preventive screening and immunizations, our board-certified doctors are dedicated to providing you and your loved ones with the most innovative, compassionate care possible.

Choosing the right primary care provider (PCP) is one of the most important decisions you can make in life. That's why we are making it so simple to make the switch.

To find an Allegheny Health Network primary care provider or specialist near you, please call **844.AHN.APPT** or visit **AHN.org** on the web.

Contact the doctor you choose for an appointment. If you have any problem finding a doctor or getting an appointment, please call us at **844.AHN.APPT**.

Please fill in and sign the forms in this packet and take them to your first appointment with your Allegheny Health Network doctor.

We wish you the best of health!

Allegheny
Health Network

STEP 1

Health History

In order for your AHN physician to properly address each and every one of your medical concerns, we will need you to provide your complete health history. Six pages may seem lengthy, but it is important to the success of your well-being to be honest and comprehensive when it comes to disclosing your health history.

Health History Form located at back of document

STEP 2

Release Records

Authorization by the patient is required to release medical records in any case. Be sure to fill out this form in its entirety to avoid delays with your medical care. Please note in some cases your previous medical provider may associate a fee with releasing your records.

Records Release Form located at back of document

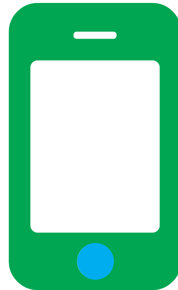
Allegheny Health Network

STEP 3

Find a doctor

WEB

Click “**Find A Doctor**” and filter by specialty, last name or location.



APP

On our AHN Health Finder app, click “**Seek Help**” then “**Find A Doctor**” to get started.

CALL

Connect with our appointment scheduling hotline at **844.AHN.APPT**.

OUTPATIENT

Review our Outpatient Care Services to find the right service and location for you. Visit our “**Locations**” tab at AHN.org to learn more.

DIAGNOSTIC TESTING

AHN has fully licensed testing facilities conveniently located throughout western PA. Start on our “**Locations**” page to learn more.

PRIMARY CARE

Find a Primary Care facility by visiting us online at AHN.org, then select “**Primary Care Offices**” from the “**Locations**” tab.

Let's get started!

	Fill out your health history
	Release your medical records
	Find a doctor

Needed Forms

Medical History

Records Release

Allegheny Health Network

Adult Health History

Allegheny Health Network

Patient Name: ______________________________

Date of Birth: ______________________ Age: __________

If you are not sure how to answer any of the questions on this form, please ask the nurse or doctor for help.

Medical History

Have you ever been told by a doctor that you had any of the following medical conditions? Check those that apply. If you do not have any past or present medical conditions, check "None".

- ❑ **None** – No Past or Present Medical Conditions

Cardiovascular — Heart Diseases / Conditions ❑ **None**

- ❑ Atrial Fibrillation
- ❑ Congestive Heart Failure (CHF)
- ❑ Coronary Artery Disease (CAD)
- ❑ Heart Attack — Prior Myocardial Infarction
- ❑ High Blood Pressure — Hypertension
- ❑ High Cholesterol — Hyperlipidemia
- ❑ Mitral Valve Prolapse
- ❑ Murmur
- ❑ Peripheral Vascular Disease (PVD)
- ❑ Other: ______________________

Cancer ❑ **None**

- ❑ Brain
- ❑ Breast
- ❑ Bone
- ❑ Colon
- ❑ Prostate (male)
- ❑ Leukemia (Blood)
- ❑ Lung
- ❑ Skin
- ❑ Throat
- ❑ Other: ______________________

Endocrine ❑ **None**

- ❑ High Blood Sugar — Diabetes
- ❑ Menopause/Hot Flashes
- ❑ Obesity (Overweight)
- ❑ Thyroid Disorder

Gastrointestinal — Digestive Diseases / Conditions ❑ **None**

- ❑ Acid Reflux — Esophageal Reflux
- ❑ Crohn's Disease
- ❑ Gallbladder Problems
- ❑ Gastrointestinal Bleeding
- ❑ Hemorrhoids or Rectal Disease
- ❑ Inflammation of Colon — Acute Colitis
- ❑ Inflammation of Liver — Hepatitis
- ❑ Irritable Bowel Syndrome
- ❑ Liver Damage — Cirrhosis
- ❑ Stomach Ulcers — Peptic Ulcer

Hematological — Blood Conditions ❑ **None**

- ❑ Blood Clots in Legs — DVT
- ❑ Blood Problems — Specify: ______________________
- ❑ Low Iron — Anemia

Immunological ❑ **None**

- ❑ Allergies

Infectious Disease ❑ **None**

- ❑ AIDS
- ❑ HIV
- ❑ TB (Tuberculosis)

Mental Health Conditions ❑ **None**

- ❑ Anxiety (nervousness)
- ❑ Bipolar
- ❑ Depression (sadness)
- ❑ Other: ______________________

Musculoskeletal — Bone Conditions ❑ **None**

- ❑ Aching Joints — Osteoarthritis
- ❑ Calcium Depletion — Osteoporosis
- ❑ Ruptured Disc — Intervertebral Disc Degeneration
- ❑ Other: ______________________

©2014 AHN • An equal opportunity employer • All rights reserved • 34492B 7/14 cd/sb

Medical History *(continued)*

Neurological

- ❑ Alzheimer's — Dementia
- ❑ Convulsions/Seizures
- ❑ Migraine Headache
- ❑ Stroke — CVA/TIA

Pulmonary – Lung Diseases / Conditions

- ❑ Asthma
- ❑ Chronic Obstructive Pulmonary Disease (COPD)
- ❑ Ear Infections — Otitis Media
- ❑ Emphysema (Lung Problem)
- ❑ Pneumonia
- ❑ Sinus Infections — Sinusitis
- ❑ Sleep Apnea (Stop breathing during sleep)
- ❑ Trouble with Anesthesia

Renal (Kidney) / Urinary Conditions

- ❑ Enlarged Prostate — BPH
- ❑ Kidney Stones — Nephrolithiasis
- ❑ Renal/Kidney Failure
- ❑ Renal/Kidney Disorder — Specify: ____________________
- ❑ Urinary Tract/Bladder Infection

Sensory

- ❑ Blindness
- ❑ Eye — Cataracts
- ❑ Eye — Glaucoma
- ❑ Hearing Loss

Please list any other medical conditions not indicated above:

____

____

Do you have an eye doctor? ❑ Yes ❑ No

If yes, please write the name of your eye doctor: ____

Please indicate the dates of your last tetanus, pneumonia and flu shots.

Tetanus	Pneumonia	Flu

Are all of your immunizations up to date? ❑ Yes ❑ No

Please indicate the dates and results of the testing listed below.

	Date	Abnormal	If yes, please explain
Colonoscopy		❑ Yes ❑ No	
Pap		❑ Yes ❑ No	
Mammogram		❑ Yes ❑ No	
Prostate Exam		❑ Yes ❑ No	

Surgical History

Have you ever had a surgical procedure or operation? ❑ Yes ❑ No

If yes, list the procedure/operation, the date of the procedure/operation and your age at the time.

Procedure/Operation	Date	Age
1.		
2.		
3.		
4.		
5.		

Medications

Are you currently taking any medications (prescription and/or over the counter)**?** ❑ Yes ❑ No

If yes, list the medication, dose and instructions

Name of Medication	Dose & Instructions
Example: Ibuprofen — Advil	800mg — 2 times a day
1.	
2.	
3.	
4.	
5.	
6.	

Allergies

Are you allergic to any of the following?

Latex ❑ Yes ❑ No X-ray dye ❑ Yes ❑ No Penicillin ❑ Yes ❑ No

Do you have any allergies? ❑ Yes ❑ No

If yes, list the allergy and reaction.

Allergy	Reaction
1.	
2.	
3.	
4.	
5.	

Family History

We realize that medical information on relatives is sometimes quite limited. Complete the questions below to the best of your knowledge. If you are unable to provide medical history information on your biological relatives, please check the box below and continue onto the next page.

❑ **Unable to Provide Family History Information**

Please check the appropriate box below to indicate family history of blood relatives. (GM = Grandmother, GF = Grandfather)

				(Mother's side)		(Father's side)	
	Mother	**Father**	**Siblings**	**GM**	**GF**	**GM**	**GF**
Coronary Artery Disease (Heart)	❑	❑	❑	❑	❑	❑	❑
Congestive Heart Failure	❑	❑	❑	❑	❑	❑	❑
Heart Attack	❑	❑	❑	❑	❑	❑	❑
High Blood Pressure — Hypertension	❑	❑	❑	❑	❑	❑	❑
Respiratory/Lung Disorder	❑	❑	❑	❑	❑	❑	❑
Asthma	❑	❑	❑	❑	❑	❑	❑
COPD	❑	❑	❑	❑	❑	❑	❑
Emphysema (Lung Problem)	❑	❑	❑	❑	❑	❑	❑
Crohn's Disease	❑	❑	❑	❑	❑	❑	❑

Family History *(continued)*

	Mother	Father	Siblings	(Mother's side) GM	(Mother's side) GF	(Father's side) GM	(Father's side) GF
Hepatic Problems (Liver Problems)	❑	❑	❑	❑	❑	❑	❑
Renal/Kidney Disease	❑	❑	❑	❑	❑	❑	❑
High Cholesterol — Hyperlipidemia	❑	❑	❑	❑	❑	❑	❑
Thyroid Problems	❑	❑	❑	❑	❑	❑	❑
Calcium Depletion — Osteoporosis	❑	❑	❑	❑	❑	❑	❑
High Blood Sugar — Diabetes	❑	❑	❑	❑	❑	❑	❑
Joint Problems — Arthritis	❑	❑	❑	❑	❑	❑	❑
Migraine Headaches	❑	❑	❑	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	❑	❑	❑
Mental Retardation	❑	❑	❑	❑	❑	❑	❑
Mental Health Conditions (Depression, Anxiety, etc.)	❑	❑	❑	❑	❑	❑	❑
Alcoholism	❑	❑	❑	❑	❑	❑	❑
Hematologic/Blood Problems (Sickle Cell, Bleeding Problems, etc.)	❑	❑	❑	❑	❑	❑	❑
Cancer — Specify type:______________________	❑	❑	❑	❑	❑	❑	❑
Colon Cancer — Malignant Neoplasm	❑	❑	❑	❑	❑	❑	❑
Lung Cancer	❑	❑	❑	❑	❑	❑	❑
Breast Cancer	❑	❑	❑	❑	❑	❑	❑
Ovarian Cancer	❑	❑	❑	❑	❑	❑	❑
Cervical Cancer	❑	❑	❑	❑	❑	❑	❑
Prostate Cancer	❑	❑	❑	❑	❑	❑	❑
Sudden Death — Explain:______________________	❑	❑	❑	❑	❑	❑	❑

Personal/Social History

Race: ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Hispanic
❑ Native Hawaiian or Other Pacific Islander ❑ Other ❑ White

Ethnicity: ❑ African American ❑ American ❑ Arabian ❑ Asian-Indian ❑ Australian ❑ Austrian ❑ Bavarian ❑ British
❑ Chinese ❑ Eastern European ❑ European ❑ Filipino ❑ French ❑ German ❑ Hispanic ❑ Irish ❑ Italian
❑ Japanese ❑ Jewish ❑ Korean ❑ Mexican ❑ Polish ❑ Puerto Rican ❑ Russian ❑ Scotch Irish ❑ Scottish
❑ Spanish ❑ Other

What is your primary language? ______________________________

Are you adopted? ❑ Yes ❑ No

Do you drink beverages that have caffeine? ❑ Yes ❑ No

If Yes: What do you drink? ❑ Co ee ❑ Soda ❑ Tea ❑ Other: ______________

How many cups per day do you drink? ______________________________

Do you use tobacco? ❑ Yes ❑ No

If Yes: What type of tobacco do you use? ❑ Cigarettes ❑ Cigar ❑ Pipe ❑ Chew

Have you smoked within the last twelve (12) months? ❑ Yes ❑ No

Personal / Social History (continued)

How many packs a day do you smoke? ____________________

How many years have you smoked? ____________________

If you have quit smoking, what year did you stop smoking? ____________________

Are you exposed to second hand smoke? ❑ Yes ❑ No

Do you drink alcoholic beverages? ❑ Yes ❑ No

If Yes: What do you drink? ❑ Beer ❑ Wine ❑ Hard Liquor ❑ Other: ____________________

How often do you drink? ❑ Daily ❑ Weekly ❑ Occasionally ❑ Other: ____________________

When was the last time you drank alcohol? ____________________

Do you use illegal drugs? ❑ Yes ❑ No

If Yes: What type of drugs do you use? ❑ Marijuana ❑ Cocaine ❑ Heroin ❑ Other: ____________________

How often do you use drugs? ❑ Daily ❑ Weekly ❑ Occasionally ❑ Other: ____________________

When was the last time you used drugs? ____________________

Do you use sunscreen? ❑ Yes ❑ No

Do you wear a seatbelt? ❑ Yes ❑ No

Do you exercise? ❑ Yes ❑ No

If Yes: How often do you exercise? ____________________

What type of exercise do you do? ____________________

What is your marital status? ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Who do you live with? ____________________

School History: Do you have a ❑ GED ❑ High School Diploma ❑ Trade School Degree ❑ College Degree

If you did not complete High School or get your GED, what is the last grade you completed? ____________________

Work History: Are you ❑ Unemployed ❑ Employed Part-time ❑ Employed Full-time ❑ Retired ❑ Disabled

If employed, what is your job/occupation? ____________________

If disabled, please explain. ____________________

Are you sexually active? ❑ Yes ❑ No

If Yes: Are you using birth control? ❑ Yes ❑ No

If Yes: What method of birth control do you use? ❑ Condoms ❑ Birth Control Pills ❑ Other: ____________________

Nutrition/Food

What is your average daily caloric intake? ❑ less than 1800 calories per day ❑ greater than 1800 calories per day

Do you currently take a multi-vitamin? ❑ Yes ❑ No If yes, what kind? ____________________

Do you currently take a calcium supplement? ❑ Yes ❑ No

How would you rate your current eating habits? ❑ Good ❑ Fair ❑ Poor

How many times per week on average do you eat out? ____________________

Are you currently following a special diet? ❑ Yes ❑ No Specify: ____________________

Living Will

Do you have a living will? ❑ Yes ❑ No

Adult Health History

Men Only

Loss of Sexual Activity ❑ Yes ❑ No

Discharge from Penis ❑ Yes ❑ No

Night Time Voiding ❑ Yes ❑ No

Hernia or Mass in Groin ❑ Yes ❑ No

Breast Pain/Mass ❑ Yes ❑ No

Vasectomy ❑ Yes ❑ No

Women Only

Age of Onset of Period__________ Last Menstrual Period__________

Menopause __________ Date of Last Pap Smear __________ ❑ Normal ❑ Abnormal

Pregnancies__________

Births__________ Miscarriages__________ Still Births__________ Age at First Pregnancy__________

Hormone Replacement ❑ Yes ❑ No

Miscellaneous

Is there anything you want us to know?

I authorize the following facility(s):

- ❑ Allegheny General Hospital
- ❑ Allegheny Valley Hospital
- ❑ Canonsburg Hospital
- ❑ West Penn Hospital
- ❑ Forbes Hospital
- ❑ Jefferson Hospital
- ❑ Saint Vincent Hospital
- ❑ Other Facility: ______________________
- ❑ Physician Office *(provider name)*: ______________________

to release information from the record of:

Patient Name: ______________________ Date of Birth: ______________________

Address: ______________________
Street City State Zip code

Patient Phone Number: ______________________

as described below, the information will be released to:

Facility/Person to Receive Records ______________________

Phone ______________________ Fax ______________________

Address: ______________________
Street City State Zip code

I have been a patient at your facility, or am the patient's authorized representative. I understand that the facility has legally protected health information about me or the person I represent. I understand that signing or not signing this form will not affect treatment I receive in any way. The facility cannot require me to sign the authorization in order to receive treatment.

The following information or copies of (place a check by types of records desired):

- ❑ Consultation Reports
- ❑ Discharge Summary
- ❑ Laboratory Reports/Tests
- ❑ EKG Report
- ❑ Nurses Notes
- ❑ Emergency Department Report
- ❑ Entire clinical record
- ❑ Other *(specify)*: ______________________
- ❑ History & Physical Exam
- ❑ Medication Administration Records
- ❑ Operative Report
- ❑ Rehabilitation Records
- ❑ Pathology Report
- ❑ Abstract *(history/physical, consults, labs, EKGs, ORs, D/C summaries, ER reports)*
- ❑ Billing or other business records *(specify)*: ______________________
- ❑ Physician Orders
- ❑ Physician Progress Reports
- ❑ Psychiatric/Psychological Evaluation
- ❑ Radiology Report

HIV, mental health, and drug/alcohol information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated. ***Do not release:***

- ❑ Drug/Alcohol
- ❑ HIV
- ❑ Mental Health (Psychiatric)

Reason for Request:

- ❑ Continuing treatment
- ❑ Legal
- ❑ Employer
- ❑ Disability
- ❑ Insurance
- ❑ Study/Research
- ❑ I do not wish to disclose the reason
- ❑ Other: ______________________

(over)...

Authorization for Release of Protected Health Information

Patient Identification

Dates of Service for record requests:____

This authorization will expire in six months or: ____

A disclosure statement, as required by law, will accompany all records released. Release of my records will be for the purpose stated on this form. Only those items checked off or listed will be released.

I understand that this authorization is subject to revocation at any time, except to the extent that Allegheny Health Network has already taken action in reliance upon it. A photocopy or facsimile of this authorization will be considered valid unless otherwise specified. I also understand and agree that this authorization will terminate as set forth above unless I revoke this authorization in writing and delivered to the Privacy Officer. My decision to revoke the authorization may result in my insurance company not being able to pay for my medical care, and I understand that I may be responsible for payment of the claim. I understand that recipients may redisclose information which I have authorized them to receive and the information will no longer be protected by federal privacy regulations. If I am physically unable to sign, I may provide oral authorization if witnessed by two (2) staff members.

Patient or Representative Signature ______________________________ Date____________Time____________

*If representative, give relationship and authority to act*____

If authority to act is a Power of Attorney, supporting documentation must be included with this request.

Witness Signature ______________________________ Date____________Time____________

Witness Signature ______________________________ Date____________Time____________

❑ Copy accepted ❑ Copy refused

All release of information requests must be sent directly to the corresponding facility or physician office. The provider's office should be contacted directly to obtain their fax number. Below is the contact information for each hospital.

Allegheny General Hospital
Attn: Medical Records Dept.
320 East North Avenue
Pittsburgh, PA 15212
Phone: 412-359-4282
Fax: 412-359-3260

Allegheny Valley Hospital
Attn: Medical Records Dept.
1301 Carlisle Street
Natrona Heights, PA 15065
Phone: 724-226-7095
Fax: 724-226-7494

Canonsburg Hospital
Attn: Medical Records Dept.
100 Medical Boulevard
Canonsburg, PA 15317
Phone: 724-745-6100, option 2
Fax: 724-873-5890

Forbes Hospital
Attn: Medical Records Dept.
2570 Haymaker Road
Monroeville, PA 15146
Phone: 412-858-3296
Fax: 412-858-2341

Jefferson Hospital
Attn: Medical Records Dept.
565 Coal Valley Road
Jefferson Hills, PA 15025
Phone: 412-469-5669
Fax: 412-469-5678

Saint Vincent Hospital
Attn: Medical Records Dept.
232 West 25th Street
Erie, PA 16544
Phone: 814-452-5070
Fax: 814-454-2348

West Penn Hospital
Attn: Medical Records Dept.
4800 Friendship Avenue
Pittsburgh, PA 15224
Phone: 412-578-1686
Fax: 412-578-1665

Patient Identification

Authorization for Release of Protected Health Information