Welcome Kit

Switching to AHN is as easy as

1 2 3

AHN.org/welcomekit
1 Fill out your health history
Complete the Health History Form to get started on your switch to AHN.

2 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.

3 Find a doctor
Searching by specialty? Looking for a location? We make it easy to take the next step in joining the AHN 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!
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

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
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!

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Fill out your health history</td>
</tr>
<tr>
<td></td>
<td>Release your medical records</td>
</tr>
<tr>
<td></td>
<td>Find a doctor</td>
</tr>
</tbody>
</table>

Needed Forms

- Medical History
- Records Release
### 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”.

- **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)
  - [ ] 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

- **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: ____________

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Medical History (continued)

Neurological
- Alzheimer’s — Dementia
- Convulsions/Seizures
- Migraine Headache
- Stroke — CVA/TIA

Renal (Kidney) / Urinary Conditions
- Enlarged Prostate — BPH
- Kidney Stones — Nephrolithiasis
- Renal/Kidney Failure
- Renal/Kidney Disorder — Specify: _______________________
- Urinary Tract/Bladder Infection

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

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.

<table>
<thead>
<tr>
<th>Date</th>
<th>Abnormal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus</td>
<td>□ Yes  □ No</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>□ Yes  □ No</td>
</tr>
<tr>
<td>Flu</td>
<td>□ Yes  □ No</td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>Date</th>
<th>Abnormal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colonoscopy</td>
<td>□ Yes  □ No</td>
</tr>
<tr>
<td>Pap</td>
<td>□ Yes  □ No</td>
</tr>
<tr>
<td>Mammogram</td>
<td>□ Yes  □ No</td>
</tr>
<tr>
<td>Prostate Exam</td>
<td>□ Yes  □ No</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Procedure/Operation</th>
<th>Date</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
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<tr>
<td>2.</td>
<td></td>
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<td>3.</td>
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<tr>
<td>4.</td>
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<tr>
<td>5.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Medications

Are you currently taking any medications (prescription and/or over the counter)?

- Yes  
- No

If yes, list the medication, dose and instructions:

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Dose &amp; Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: Ibuprofen  — Advil</td>
<td>800mg — 2 times a day</td>
</tr>
<tr>
<td>1.</td>
<td></td>
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<tr>
<td>2.</td>
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<tr>
<td>3.</td>
<td></td>
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<td>4.</td>
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<tr>
<td>5.</td>
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<tr>
<td>6.</td>
<td></td>
</tr>
</tbody>
</table>

## 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:

<table>
<thead>
<tr>
<th>Allergy</th>
<th>Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
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<tr>
<td>2.</td>
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<tr>
<td>3.</td>
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<td>4.</td>
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<td>5.</td>
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</tr>
</tbody>
</table>

## 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 on to 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)

<table>
<thead>
<tr>
<th>Coronary Artery Disease (Heart)</th>
<th>Mother</th>
<th>Father</th>
<th>Siblings</th>
<th>(Mother’s side) GM</th>
<th>GF</th>
<th>(Father’s side) GM</th>
<th>GF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Congestive Heart Failure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Attack</td>
<td></td>
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</tr>
<tr>
<td>High Blood Pressure — Hypertension</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Respiratory/Lung Disorder</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
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<tr>
<td>COPD</td>
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</tr>
<tr>
<td>Emphysema (Lung Problem)</td>
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<td></td>
</tr>
<tr>
<td>Crohn’s Disease</td>
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</tr>
</tbody>
</table>
### Family History (continued)

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

### 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:**
  - Coffee
  - Soda
  - Tea
  - Other: ______________________

  **How many cups per day do you drink?**

- **Do you use tobacco?**
  - Yes
  - No

  **If Yes:**
  - Cigarettes
  - Cigar
  - Pipe
  - Chew

  **Have you smoked within the last twelve (12) months?**
  - Yes
  - No
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
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): __________________________

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
- Employer
- Legal
- Disability
- Insurance
- Study/Research
- I do not wish to disclose the reason
- Other: __________________________

(over)...
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