Medical Diagnostics Associates

Carol G Simon Cancer Center at Overlook Hospital

99 Beauvoir Ave, Summit, NJ 07901

Phone: 908-608-0078 Fax: 908-608-1505

Dennis Lowenthal MD, Bonni Guerin MD, Neil Morganstein MD
Sophie Morse MD, Rujuta Saksena MD

Dear:_____

Your consultation with Dr_____

This appointment has been scheduled for_____

_____Arival Time (30 minutes prior to your appointment time)

_____Appointment time

Please read and complete this packet in its entirety. This time is used for administrative purposes to register you with our system and gather your new patient paperwork that is enclosed in this packet.

We must have all medical records pertaining to your appointment prior to the scheduled date of your appointment for the doctor to review, as needed. If your records originate from Overlook Hospital, we are able to obtain those medical records for your appointment. When gathering your medical records, please include the following if it applies to you:

Blood work: (we would like a three year history for your hematology appointment). Radiology reports: including CAT SCANS, PET SCANS, MRI REPORTS, X-RAYS AND BONE SCANS Mammography reports: any and all mammograms including the bilateral mammography and ultrasound prior to any diagnosis for breast cancer patients. Pathology: any and all biopsy and surgery pathology reports, operative reports/ and or doctor notes

You MUST bring your insurance cards and a photo ID. If your insurance requires a referral to see a specialist you must have it along with the completed new patient paperwork enclosed with this packet. Should you have any questions, please call our office at 908-608-0078.

Thank you for your cooperation.

Medical Diagnostic Associates
99 Beauvoir Avenue
Summit, NJ 07902
908-608-0078
908-608-1504 – Fax

Directions:

Route 24 West:
Take exit marked Millburn. Springfield. Summit. Bear right to Broad Street and follow blue hospital signs uphill to Hospital.

Route 24 East:
Take Summit Avenue Exit. Follow Summit Avenue through downtown Summit, over Railroad Bridge and through traffic light at Broad Street. Make second left at Walnut Street and follow blue Hospital signs.

From Due North or Northwest:
Take Kennedy Parkway to Short Hills Mall. Take either Route 24 East or Route 124 East (access road). Get off Summit Avenue Exit (1/2 mile). Take Summit Avenue through downtown Summit and follow blue Hospital signs.

Garden State Parkway South:
Take Exit 142 to I-78 West to Route 24 West. Then follow directions from Route 24 West (above).

Garden State Parkway North:
Take Exit 142. You must take the Exit immediately after the toll plaza (stay to the extreme right at the toll plaza). Proceed one mile East on I-78 before following signs to make U-turn to I-78 West. Take I-78 West to Route 24 West (stay in right lane). Then follow directions from Route 24 West (above).

I-78 East:
Take Exit 45, marked Summit-Glenside Avenue. Make a left at traffic light at end of ramp onto Glenside Avenue. Follow Glenside for two miles to blue Hospital sign. Then take a left onto Baltusrol Road and then a sharp left onto Morris Avenue at next blue Hospital sign.

I-78 West:
Take Exit 49 to route 24 West. Then follow directions from Route 24 West (above).

New Jersey Turnpike North or South:
Take Exit 14, marked Newark Airport to I-78 West. Follow nine miles to Route 24 West (stay in right lane). Then follow directions from Route 24 West (above).

Route 22:
You must be in the westbound lane for Summit Road Exit on Route 22 in Mountainside. Turn right at Getty stations for Summit Road, which becomes Baltusrol Road. Follow blue hospital signs, turning left up Morris Avenue. Pass Overlook Hospital and take next right at Beauvoir Place (just before traffic light). Bear right uphill to Hospital.

Park in the visitors parking garage. Come through the Cancer Center doors and make an immediate left through the sliding glass doors and the office will be on your right.

WELCOME TO OUR OFFICE
MEDICAL DIAGNOSTIC ASSOCIATES

NAME:_____ D.O.B:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

PRIMARY PHONE #_____ SECONDARY PHONE # _____

EMAIL ADDRESS:_____SOCIAL SECURITY # _____

RACE: _____ PRIMARY LANGUAGE: _____ ETHNICITY: _____

OCCUPATION: _____ EMPLOYER: _____

NAME OF SPOUSE: _____ D.O.B: _____

YOUR CARE TEAM:

	NAME	ADDRESS	PHONE #	FAX #
REFERRING MD				
OB/GYN				
PRIMARY CARE PHYSICIAN				
CARDIOLOGY				
OTHER				
OTHER				

PHARMACY

NAME:_____

ADDRESS: _____

PHONE NUMBER: _____

EMERGENCY CONTACTS:

NAME: _____

PHONE #: _____

RELATIONSHIP: _____

NAME: _____

PHONE #: _____

RELATIONSHIP: _____

Medical Diagnostic Associates, P.A.

Health History

(Confidential)

Name_____ **Birth date**_____ **Age**_____

Reason for Visit_____ **Date**_____

Symptoms: Check (√) symptoms you are currently experiencing

General:
- ☐ Chills
- ☐ Fever
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Sweats
- ☐ Fatigue

Eyes:
- ☐ Blurry Vision
- ☐ Double Vision
- ☐ Tearing
- ☐ Red Eyes

Ears/ Nose/ Throat:
- ☐ Hoarseness
- ☐ Mouth Sores
- ☐ Nosebleeds
- ☐ Sinus Problems
- ☐ Hearing Loss

Cardiovascular:
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Swelling of Legs

Respiratory:
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Coughing Blood

Gastrointestinal:
- ☐ Diarrhea
- ☐ Constipation
- ☐ Nausea
- ☐ Vomiting
- ☐ Bowel Changes
- ☐ Vomiting Blood
- ☐ Rectal Bleeding
- ☐ Bloating
- ☐ Hemorrhoids

Genitourinary:
- ☐ Blood in Urine
- ☐ Frequent Urine
- ☐ Painful Urination
- ☐ Incontinence
- ☐ Urinating at Night

Mental Health:
- ☐ Loss of Sleep
- ☐ Anxiety
- ☐ Depression
- ☐ Stress

Neurologic:
- ☐ Headaches
- ☐ Seizures
- ☐ Fainting
- ☐ Numbness
- ☐ Tremors

Musculoskeletal:
Pain in:
- ☐ Back
- ☐ Arms
- ☐ Legs
- ☐ Hands

Skin:
- ☐ Easy Bruising
- ☐ Itching
- ☐ Change in Moles
- ☐ Hives

Men Only:
- ☐ Breast Lump
- ☐ Erectile Difficulty
- ☐ Lump in Testicle
- ☐ Penis Discharge

Women Only:
- ☐ Abnormal Pap Smear
- ☐ Breast Lump
- ☐ Irregular Periods
- ☐ Hot Flashes
- ☐ Nipple Discharge
- ☐ Painful Intercourse
- ☐ Number of pregnancies ____

Health Maintenance:
Date of last colonoscopy_____
Date of last Pap Smear_____
Date of last mammogram ____
Date of last PSA ____

CONDITIONS: Check (√) conditions you have or have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Breast Lump
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Coronary Disease
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraines
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problem
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Other

FAMILY HISTORY: Fill in information about your family						
Relation	**Age**	**State of Health**	**Cause of Death**		**Check if your blood relatives had: Disease**	**Relationship**
Father					Cancer	
Mother					Diabetes	
Brothers					High Blood Pressure	
					Heart Attacks	
					Strokes	
Sisters					Kidney Disease	
					Blood Clots	

HOSPITALIZATIONS/ SERIOUS ILLNESS		
Year	**Hospital**	**Reason for Hospitalization/ Illness**

Have you ever had a blood transfusion? ☐ Yes ☐ No Did you have a reaction_____
If Yes give approximate dates: _____

SOCIAL HISTORY					**Pregnancy History**		
	Current	Packs/drinks	Past	Packs/drink	Year of Birth	Sex	Complications
Tobacco							
Alcohol							
If you have quit smoking/ drinking how many years has it been? _____							
Occupation:_____					Have you had a miscarriage? If yes, how many_____		

I certify that he above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

Signature: _____ Date: _____

Reviewed By: _____ Date: _____

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(P) 908-608-0078 (F) 908-608-1504

QD- Daily
BID- Twice
TID- Three
QOD- Every Other

DATE OF OFFICE VISIT

R	Vitamin/ Over the Counter/ Medication	MG	DOSE											

PATIENT_____ D.O.B _____ CHART # _____