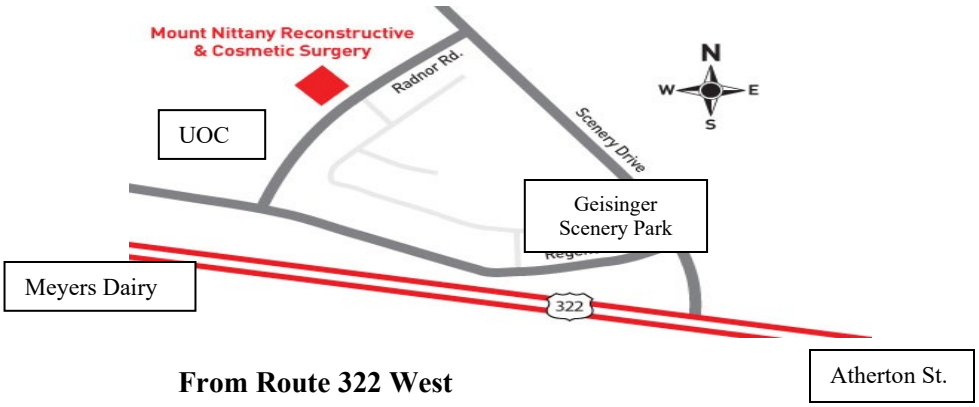
MOUNT NITTANY
PHYSICIAN GROUP



From Route 322 West

1. Go past the exit to the Medical Center.
2. Take the exit for Boalsburg/ Oak Hall. Turn RIGHT at the bottom of the exit ramp.
3. Turn RIGHT at the light onto Atherton Street.
4. Turn RIGHT at the light onto Scenery Drive.
5. Turn LEFT onto the second road, which is Radnor Rd. Follow to 100 Radnor Road.
6. Turn RIGHT into parking lot. Proceed to the back of the building to the lower level.

From Route 322 East

1. Take the exit for Boalsburg/ Oak Hall. Turn RIGHT at the bottom of the exit ramp.
2. Turn RIGHT at the light onto Atherton Street.
3. Turn RIGHT at the light onto Scenery Drive.
4. Turn LEFT onto the second road, which is Radnor Rd. Follow to 100 Radnor Road.
5. Turn RIGHT into parking lot. Proceed to the back of the building to the lower level.

From I-80

1. Take exit 161 (Bellefonte)
2. Follow Route 220 to State College
3. Take exit 73 toward State College/Lewistown
4. Take the exit for Boalsburg/ Oak Hall. Turn RIGHT at the bottom of the exit ramp.
5. Turn RIGHT at the light onto Atherton Street.
6. Turn RIGHT at the light onto Scenery Drive.
7. Turn LEFT onto the second road, which is Radnor Rd. Follow to 100 Radnor Road. Turn RIGHT into parking lot. Proceed to the back of the building to the lower level.

MOUNT NITTANY PHYSICIAN GROUP

Reconstructive and Cosmetic Surgery

Dr. Emily Peterson ~ 100 Radnor Road, Suite 101, State College, PA 16801
P: 814-231-7878 F: 814-237-1034

Name: _____ **DOB:** _____ **SSN:** _____

If Applicable – Preferred Name: _____ **Pronouns:** _____

Address: _____

Home Number: _____ Cell Number: _____

Email Address: _____

May leave messages on my Voicemail: Yes____ No_____ Pharmacy: _____

Occupation: _____ Employer: _____

Reason for Visit: _____

Please tell us how you heard of us/who referred you: _____

Please check all that apply to **you** and explain:

( ) None

( ) Arthritis _____
( ) Asthma _____
( ) Blood/bleeding disorder _____
( ) Depression/anxiety _____
( ) Diabetes _____
( ) Gastrointestinal problems _____
( ) Gynecological problems _____
( ) Heart disease _____
( ) Hepatitis _____
( ) High blood pressure _____
( ) High cholesterol _____
( ) HIV/AIDS _____
( ) Autoimmune Disease _____
( ) Liver disease _____
( ) Lung problems _____
( ) Prostate problems _____
( ) Stomach problems _____
( ) Seizures/epilepsy _____
( ) Skin disorder _____
( ) Shingles _____
( ) Stroke _____
( ) Thyroid problems _____
( ) Tuberculosis _____
( ) Ulcers _____
( ) Kidney/bladder problems _____
( ) Personal history of cancer _____

( ) Other: _____

Surgical History

( ) No Past Surgery

Type of Surgery	Date	Type of Surgery	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Current Height: _____ **Current Weight** _____

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Name: _____ **DOB:** _____

Allergies & Reactions

( ) No Known Allergies

( ) Latex _____
( ) Adhesive/Tape _____
( ) Penicillin_____
( ) CT Dye/Iodine _____
( ) Sulfa _____
( ) Other_____

Current Medications
Please list any prescription medications
you are currently taking (List Name, Dose and frequency)

_____
_____

Current Vitamins and Supplements
Please list any over-the-counter medications (for example, aspirin, vitamins, etc.), herbal medicine or alternate therapy.

_____
_____

If you need more room, please use another page or attach a typed copy of medications.

When was your last tetanus shot? _____ When was your last flu shot? _____

Do you use sunscreen? ( ) Yes ( ) No If yes, how often? _____ SPF _____

Have you ever smoked cigarettes or used chewing tobacco or other tobacco/nicotine products?
Currently using: ( ) Yes ( ) No Type/Amount_____
Previously used: ( ) Yes ( ) No Type/Amount_____
Month/Year Quit_____

Do you currently use:
Alcohol ( ) Yes ( ) No If yes, How often? _____
Illegal Drugs ( ) Yes ( ) No If yes, Type/Amount _____

Family History
Have any of your relatives had a chronic illness (for example, cancer, heart disease, diabetes)?

Relative	**List Specific Chronic Illness (es)**	Living	Deceased
Biological Mother	_____	( )	( )
Biological Father	_____	( )	( )
Maternal Grandmother	_____	( )	( )
Maternal Grandfather	_____	( )	( )
Paternal Grandmother	_____	( )	( )
Paternal Grandfather	_____	( )	( )
Siblings	_____	( )	( )
Aunt(s)	_____	( )	( )
Uncle(s)	_____	( )	( )

MOUNT NITTANY PHYSICIAN GROUP

AUTHORIZATION TO PHOTOGRAPH FOR TREATMENT, PAYMENT OR OPERATIONS

Patient Name: _____ **Department:** Reconstructive and Cosmetic Surgery
Date of Birth: _____ **Effective Date:** _____

Note: This authorization is valid for one year from the effective date unless rescinded by the patient or their healthcare representative.

I. Authorization to Photograph, Video (hereafter referred to as photographs or photography) and/or voice recording by patient for treatment, payment or operations:

I hereby authorize my attending physician and/or Mount Nittany Physician Group employees designated by him/her to photograph me. I understand that these photographs will be used 1) in the course of my treatment or 2) for operational purposes such as, but not limited to, quality reviews, risk management reviews or safety reviews or 3) for purposes of securing payment for services rendered. Additionally, I acknowledge that these photographs will be part of my medical record and securely maintained in electronic form or hard copy.

In the event that my photographs are requested for educational or illustrative purposes outside of Mount Nittany Physician Group, I will be required to authorize this use by completing a separate authorization form. I acknowledge that these photographs may be used for educational purposes within Mount Nittany Physician Group.

I acknowledge that I or my healthcare representative may withdraw this authorization at any time. However, any photographs previously obtained while this authorization was in force will remain part of my medical record. This authorization is effective for one year from the date above.

I acknowledge that I will receive no compensation in exchange for authorizing the taking of these photographs and I release Mount Nittany Physician Group, its employees and agents from any liability or other obligation arising from the taking of these photographs.

II. Patient Authorization:

Patient's signature: _____ Date: _____
(May be signed by patient's healthcare representative)

Witness's Signature: _____ Date: _____