



# TETON CANCER INSTITUTE

*trusted, for life.*

## Patient Information Form

DATE: \_\_\_\_\_

NAME: \_\_\_\_\_  
*Last First Middle Initial*

How would you like to be addressed? \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ AGE: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_ ☐ Male ☐ Female

MAILING ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ COUNTY: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

ACCIDENT OR INJURY: ☐ YES ☐ NO RELIGION: \_\_\_\_\_ ETHNICITY: \_\_\_\_\_ RACE: \_\_\_\_\_

Tobacco Use: Never ☐ Previous ☐ Current ☐ Type \_\_\_\_\_ Usage \_\_\_\_\_

### SPOUSE/GUARDIAN INFORMATION:

• NAME: \_\_\_\_\_ S/S \_\_\_\_\_

• Address (if different than above): \_\_\_\_\_

• RELATIONSHIP TO PATIENT: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

• EMPLOYER: \_\_\_\_\_

• TELEPHONE NUMBER: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

### PHYSICIAN/PHARMACY/EMERGENCY CONTACT INFORMATION:

Primary Care Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### INSURANCE INFORMATION:

Primary Insurance Company Name: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Policy Holder Employer: \_\_\_\_\_

ID: \_\_\_\_\_ Group #: \_\_\_\_\_

Pharmacy of Choice: \_\_\_\_\_ Prescription card info: \_\_\_\_\_ ☐ No Rx coverage  
*(Name & city) (ID, Group & BIN numbers)*

Secondary Insurance Company Name: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Policy Holder Employer: \_\_\_\_\_

ID: \_\_\_\_\_ Group #: \_\_\_\_\_





**TETON CANCER INSTITUTE**  
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## Records Request Form

Date of request: \_\_\_\_\_

Patient's full name: \_\_\_\_\_

Patient's date of birth: \_\_\_\_\_

Patient's signature: \_\_\_\_\_

The above listed patient has an appointment in our office on: \_\_\_\_\_

Date records are needed: \_\_\_\_\_

I, \_\_\_\_\_ by signing above give my permission to have my medical information sent to the following facility:

**Teton Cancer Institute**  
A Mountain View Hospital affiliate

☐ 1957 E. 17th St.  
Idaho Falls, ID 83404  
(phone) 208-523-1100  
(fax) 208-523-1317

☐ 380 Walker Dr.  
Rexburg, ID 83440  
(phone) 208-356-9559  
(fax) 208-356-6601

☐ Radiation Oncology  
1550 Hoopes Ave  
Idaho Falls, ID 83404  
(phone) 208-542-7220  
(fax) 208-522-7600



TETON CANCER INSTITUTE

## AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

ACCOUNT # \_\_\_\_\_

Patient's Name at Time of Visit: \_\_\_\_\_

Attending Physician: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date(s) of Treatment: \_\_\_\_\_

Please Initial:

\_\_\_\_\_ I hereby authorize Mountain View Hospital to furnish the named individual or company below with all medical data and information they may request, as listed below, concerning my illness or injury.

\_\_\_\_\_ This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance hereon, and if not earlier revoked, it shall terminate **six months** from the date of consent without express revocation.

\_\_\_\_\_ I hereby consent to the release of any and all records containing alcohol and/or drug medication abuse and/or psychiatric diagnosis under the same consideration as outline above. I understand that such information cannot be released without my specific consent, except in accordance with a court order.

\_\_\_\_\_ I further understand that I have a right to receive a copy of this authorization upon request.

Medical Information to be released to: \_\_\_\_\_

Address: \_\_\_\_\_  
City State Zip Code Telephone Number

Reason for Release: \_\_\_\_\_

☐ I hereby authorize the above named individual access to my medical records.

☐ I do not require a copy for myself at this time.

Medical Information Requested: **A copy fee of \$1.00 per report will be charged as applicable.**

- |                                            |                                              |                                           |                                            |
|--------------------------------------------|----------------------------------------------|-------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> History & Physical  | <input type="checkbox"/> Operative Report | <input type="checkbox"/> X-ray             |
| <input type="checkbox"/> Consultation      | <input type="checkbox"/> Clinical Laboratory | <input type="checkbox"/> EKG, EEG         | <input type="checkbox"/> Outpatient Clinic |
| <input type="checkbox"/> Other: _____      | <input type="checkbox"/>                     |                                           |                                            |

I hereby authorize the above named individual access to my medical records. I do/ don't require a copy for myself at this time.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Patient, Parent/Legal Guardian

Witness: \_\_\_\_\_ Date: \_\_\_\_\_  
MVH Employee

☐ Verified ID: \_\_\_\_\_ ☐ Records issued: Initial \_\_\_\_\_ Date: \_\_\_\_\_

**\*\*\* I understand this request may take up to 2 weeks to process. \*\*\***



TETON CANCER INSTITUTE

## AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

The individuals listed in the chart below will be allowed to obtain medical information concerning you, the patient:

| Name | Relationship |
|------|--------------|
|      |              |
|      |              |
|      |              |
|      |              |
|      |              |
|      |              |
|      |              |
|      |              |
|      |              |
|      |              |
|      |              |

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient, Parent or Legal Guardian

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

MVH Employee

*(for office use only)*

The following questions are to improve patient care. They help us in clarifying your medical history. Please use short but complete answers.

*Office use only:*

Who referred you to our practice? \_\_\_\_\_

Primary care physician: \_\_\_\_\_

What brings you in to see us today?

When did this problem start?

What symptoms were you having?

Is there anything that makes it worse? Or better?

Is the problem constant, or does it come and go?

If you had surgery for this problem, date of surgery, surgeon, and where was it performed?

What has happened since?

What symptoms are you having now?

**PAST MEDICAL PROBLEMS**

| Yes/No<br>(Y/N) | Problem                                   | Date of onset | Active (A) | Resolved (R) |
|-----------------|-------------------------------------------|---------------|------------|--------------|
|                 | Angina                                    |               |            |              |
|                 | High blood pressure                       |               |            |              |
|                 | Heart Attack / MI                         |               |            |              |
|                 | Congestive heart failure/pulmonary edema  |               |            |              |
|                 | Asthma                                    |               |            |              |
|                 | Emphysema/COPD                            |               |            |              |
|                 | Pneumonia                                 |               |            |              |
|                 | Diabetes                                  |               |            |              |
|                 | Thyroid disease                           |               |            |              |
|                 | Kidney disease                            |               |            |              |
|                 | Hepatitis/Cirrhosis                       |               |            |              |
|                 | Inflammatory bowel disease                |               |            |              |
|                 | Osteoporosis                              |               |            |              |
|                 | Rheumatoid arthritis                      |               |            |              |
|                 | Degenerative joint disease/osteoarthritis |               |            |              |
|                 | Stroke                                    |               |            |              |
|                 | Epilepsy/seizure disorder                 |               |            |              |
|                 | Parkinson's                               |               |            |              |
|                 | Phlebitis                                 |               |            |              |
|                 | Other:                                    |               |            |              |
|                 | Other:                                    |               |            |              |



(for office use only)

**PAST SURGICAL HISTORY**

Please list your past surgeries including why &amp; where it was done:

| Approx. Date | Age | Procedure | Why Surgery Was done | Surgeon/Hospital |
|--------------|-----|-----------|----------------------|------------------|
|              |     |           |                      |                  |
|              |     |           |                      |                  |
|              |     |           |                      |                  |
|              |     |           |                      |                  |
|              |     |           |                      |                  |
|              |     |           |                      |                  |
|              |     |           |                      |                  |

**MALIGNANCY HISTORY:**

| Site of Cancer | Date on Onset | Active/Resolved |
|----------------|---------------|-----------------|
| _____          | _____         | _____           |
| _____          | _____         | _____           |
| _____          | _____         | _____           |

**Hematologic (Blood) disorders:**

\_\_\_\_\_ Anemia  
\_\_\_\_\_ Abnormal clotting  
\_\_\_\_\_ Abnormal bleeding  
Ever had a blood transfusion? Y / N

**HEALTH MAINTENANCE:**

Have you ever received a flu vaccine? Y / N  
Have you ever received the pneumonia vaccine? Y / N  
Have you ever had sigmoidoscopy/colonoscopy? Y / N

Date of last vaccination: \_\_\_\_\_  
Date of last vaccination: \_\_\_\_\_  
Date of last exam: \_\_\_\_\_

**Women:**

Have you ever had a screening mammogram? Y / N  
When was your last routine gynecologic exam?

Date of last exam: \_\_\_\_\_  
Date of last exam: \_\_\_\_\_

**Men:**

Have you had a digital rectal exam to screen for prostate cancer? Y / N Date of last exam \_\_\_\_\_  
Have you had a PSA test done? Y / N Date of last exam \_\_\_\_\_ Result \_\_\_\_\_

**HABITS:**

Tobacco use: Never: \_\_\_\_\_ Current: \_\_\_\_\_ Previous: \_\_\_\_\_ Quit when? \_\_\_\_\_  
Cigarettes \_\_\_\_\_ Cigars \_\_\_\_\_ Pipe \_\_\_\_\_ Snuff \_\_\_\_\_ Chewing tob \_\_\_\_\_  
Average use = # \_\_\_\_\_ pks per day x \_\_\_\_\_ years

Alcohol use: Never: \_\_\_\_\_ Current: \_\_\_\_\_ Previous: \_\_\_\_\_ Quit when? \_\_\_\_\_  
Beer: \_\_\_\_\_ Wine: \_\_\_\_\_ Liquor: \_\_\_\_\_  
Average use = # \_\_\_\_\_ drinks per \_\_\_\_\_ day, \_\_\_\_\_ week, \_\_\_\_\_ month

Drug use: Never: \_\_\_\_\_ Current: \_\_\_\_\_ Former user: \_\_\_\_\_ Quit when? \_\_\_\_\_  
Marijuana \_\_\_\_\_ Cocaine \_\_\_\_\_ Heroin \_\_\_\_\_ Amphetamines \_\_\_\_\_



(for office use only)

**SOCIAL HISTORY:**Occupation: \_\_\_\_\_ full time: ☐ part-time: ☐ unemployed: ☐ retired ☐

Have you had a significant exposure to toxic chemicals such as industrial solvents or PCB/s? Y / N

Aside from medical or dental x-rays, have you been exposed to ionizing radiation? Y / N

Have you ever been exposed to asbestos fibers? Y / N

Education: Last grade of school completed: \_\_\_\_\_ Type of degree: \_\_\_\_\_

Religion: Religious Affiliation: \_\_\_\_\_ Parish/ward/congregation: \_\_\_\_\_

**FAMILY HISTORY:**

How many siblings do you have? (brothers) \_\_\_\_\_ (sisters) \_\_\_\_\_

How many living siblings do you have? \_\_\_\_\_ How many live in this area? \_\_\_\_\_

How many children do you have? (boys) \_\_\_\_\_ (girls) \_\_\_\_\_

How many living children do you have? \_\_\_\_\_ How many live in this area? \_\_\_\_\_

Has anyone in your family ever had cancer, blood disorders, etc. If so fill out the details:

| Health Problem | Cancer | Blood disorder | Relationship | Alive/Deceased | Age |
|----------------|--------|----------------|--------------|----------------|-----|
|                |        |                |              |                |     |
|                |        |                |              |                |     |
|                |        |                |              |                |     |
|                |        |                |              |                |     |
|                |        |                |              |                |     |
|                |        |                |              |                |     |
|                |        |                |              |                |     |

Are there any OTHER significant illnesses in your family? (heart disease, high blood pressure, diabetes, stroke)

| Relationship | Health Problem | Alive/deceased | Age |
|--------------|----------------|----------------|-----|
|              |                |                |     |
|              |                |                |     |
|              |                |                |     |
|              |                |                |     |
|              |                |                |     |

**REPRODUCTIVE HISTORY (Women) :**Age at 1<sup>st</sup> period \_\_\_\_\_ Age at 1<sup>st</sup> pregnancy \_\_\_\_\_ # of pregnancies \_\_\_\_\_ # of live births \_\_\_\_\_

Did you breast feed? Y / N

Date of last menstrual period \_\_\_\_\_, Age when periods stopped \_\_\_\_\_ (menopause)

Have you ever used contraceptive pills (birth control pills)? Y / N

If so, how long? \_\_\_\_\_ yrs

Have you ever used estrogen replacement therapy? Y / N

If so, how long? \_\_\_\_\_ yrs

Are you still taking your hormone pills? Y / N

If not, when did you stop? \_\_\_\_\_



Allergies to medications and reaction:

| Medication | Type of Reaction |
|------------|------------------|
|            |                  |
|            |                  |
|            |                  |
|            |                  |

**LIST OF MEDICATIONS/SUPPLEMENTS**

Please List Current Medications and Supplements including any injections that you get on a routine basis:

| Name of medication | Dose | What is it for? | Date prescribed | Prescribing doctor | Directions for taking | Any side effects |
|--------------------|------|-----------------|-----------------|--------------------|-----------------------|------------------|
|                    |      |                 |                 |                    |                       |                  |
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(for office use only)

|                                 | Current                  | Past                     | Negative                 | Comments |
|---------------------------------|--------------------------|--------------------------|--------------------------|----------|
| <b>General</b>                  |                          |                          |                          |          |
| Weight loss                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          |
| Weight gain                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          |
| Fever                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          |
| Fatigue                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          |
| <b>Eyes</b>                     |                          |                          |                          |          |
| Double vision                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          |
| Spots before eyes               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          |
| Vision changes                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          |
| <b>ENT/MOUTH</b>                |                          |                          |                          |          |
| Earaches                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          |
| Ringing in ears                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          |
| Sinus problems                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          |
| Sore throat                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          |
| Mouth sores                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          |
| Dental problems                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          |
| <b>Endocrine</b>                |                          |                          |                          |          |
| Dry skin                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          |
| Abnormal thirst                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          |
| Hot flashes                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          |
| <b>Hematologic/Lymphatic</b>    |                          |                          |                          |          |
| Bruises, frequent               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          |
| Cuts don't stop bleeding        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          |
| Enlarged lymph nodes            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          |
| <b>Respiratory</b>              |                          |                          |                          |          |
| Wheezing                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          |
| Spitting up blood               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          |
| Shortness of breath             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          |
| Cough, chronic                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          |
| <b>Cardiovascular</b>           |                          |                          |                          |          |
| Painful breathing               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          |
| Chest pain                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          |
| Difficult breathing on exertion | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          |
| Swelling of legs                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          |
| Palpitations of heart           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          |
| <b>Gastrointestinal</b>         |                          |                          |                          |          |
| Diarrhea, frequent              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          |
| Bloody stool                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          |
| Nausea/vomiting                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          |
| Constipation                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          |
| <b>Genitourinary</b>            |                          |                          |                          |          |
| Blood in urine                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          |
| Pain w/urination                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          |
| Incomplete emptying             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          |
| Stress incontinence             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          |
| Vaginal bleeding/discharge      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          |
| Vaginal lesions                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          |
| <b>Musculoskeletal</b>          |                          |                          |                          |          |
| Muscle weakness                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          |
| <b>Skin (Integumentary)</b>     |                          |                          |                          |          |
| Pain in breast                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          |
| Discharge                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          |
| Masses/lumps                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          |
| Rash                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          |
| Ulcers                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          |
| <b>Neurological</b>             |                          |                          |                          |          |
| Dizziness                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          |
| Seizures                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          |
| Numbness                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          |
| Trouble walking                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          |
| <b>Psychiatric</b>              |                          |                          |                          |          |
| Depression                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          |
| Crying, frequent                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          |
| Cuts don't stop bleeding        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          |