Dr. Karen Zempolich

General Information

Name: ______________________ Date of Birth: ______________ Age: __________

Marital Status: ______________________ Social Security #: ______________________

Mailing address: ____

City: ______________ State: __________ Zip: __________ County: ______________

Home Phone: ______________________ Cell Phone: ______________________

Employer: ______________________________ Work Phone: ______________________

Spouse/Guardian Information

- Name: ______________________________ phone #: ______________________
- Relationship to Patient: ____

Emergency Contact: ______________________ Relationship: ____________ Phone: ____________

Primary Care Provider: ____

OB/GYN History

Number of Pregnancies: ________ Number of Children: ________ Number of Miscarriages: ________

Number of Vaginal Deliveries: ________ Number of Cesarean deliveries: ________ Number of Adopted children: ________

Age Period Started ________ Number of day's period lasts: ________ Days between periods: ________

Age of Menopause: __________ Date of last Pap smear: __________

Have you ever been treated for an abnormal PAP? YES or NO. If yes, please explain: ______________

____

____

____

Hormone use: YES or NO If yes # of years used: ______________________

Contraceptive use: YES or NO If yes # of years used: ______________________

CIRCLE ANY THAT APPLY

Irregular Bleeding   Vaginal Discharge   Hysterectomy   IUD   HPV Vaccine

Endometrial Ablation   Depo-Provera   Hormone Replacement

Date of last Mammogram: __________ Results: ______________________

Date of last Colonoscopy: __________ Results: ____

Surgical History

____
____
____
____
____
____
____
____
____
____

Medical history/Medical problems such as thyroid disorders, blood clots, sleep apnea, heart disease, hypertension, etc.

____
____
____
____
____
____
____
____
____
____

Have you ever had problems with general anesthesia? Yes / No

Social History	Yes	No	Frequency	Family Cancer History: Type of Cancer	Family relation
Alcohol:	_____	_____	_________	______________________________	_______________
Smoking:	_____	_____	_________	______________________________	_______________
Other: ________________			_________	______________________________	_______________
				______________________________	_______________

Current Medications	Dose/Strength	Frequency	What is it used for

Allergies	Reaction

Pharmacy:

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trusted, for life

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.***

☐ **Discharge Summary**	☐ **History & Physical**	☐ **Operative Report**	☐ **X-ray**
☐ **Consultation**	☐ **Clinical Laboratory**	☐ **EKG, EEG**	☐ **Outpatient Clinic**
☐ **Other:** _________	☐		

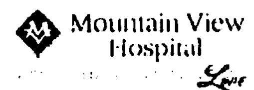
I hereby authorize the above named individual access to my medical records. I do/ don't require a copy for myself at this time.

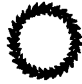
Signature: ______________________________ Date: ___________
Patient, Parent/Legal Guardian

Witness: ______________________________ Date: ___________
MVH Employee

☐ Verified ID: _______________ ☐ Records issued: Initial _____ Date: ______

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





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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

Mountain View Hospital

Malnutrition Screening Tool (MST)

STEP 1: Screen with the MST

1. Have you recently lost weight without trying?

No	0
Unsure	2

If yes, how much weight have you lost?

2-13 lb	1
14-23 lb	2
24-33 lb	3
34 lb or more	4
Unsure	2

Weight loss score:

2. Have you been eating poorly because of a decreased appetite?

No	0
Yes	1

Appetite score:

Add weight loss and appetite scores

MST SCORE:

STEP 2: Score to determine risk

MST = 0 OR 1
NOT AT RISK
Eating well with little or no weight loss

If length of stay exceeds 7 days, then rescreen, repeating weekly as needed.

MST = 2 OR MORE
AT RISK
Eating poorly and/or recent weight loss

Rapidly implement nutrition interventions. Perform nutrition consult within 24-72 hrs, depending on risk.

STEP 3: Intervene with nutritional support for your patients at risk of malnutrition.

Notes

Ferguson, M et al. *Nutrition* 1999 15 458-464

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PATIENT HEALTH QUESTIONNAIRE-2 (PHQ-2)

Patient Name: ____________________ Date: ____________________

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(Please circle to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things:	0	1	2	3
2. Feeling down, depressed, or hopeless:	0	1	2	3

____0____+__________+__________+__________

= Total Score____________