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 INFORMATON:

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 #: _____

1957 East 17th St., Idaho Falls, ID 83404
Office: (208) 523-1100 Fax: 523-1317

380 Walker Dr., Rexburg, ID 83440
Office: (208) 356-9559 Fax: 356-6601

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.***

❑ **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. *****

Mountain View Hospital

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

Mountain View Hospital

TETON CANCER INSTITUTE
Mountain View Hospital Affiliate
New Patient Health Questionnaire

Patient Name:_____

Date:_____

(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 (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 & 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 — Date of last vaccination:_____
Have you ever received the pneumonia vaccine? Y / N — Date of last vaccination:_____
Have you ever had sigmoidoscopy/colonoscopy? Y / N — Date of last exam:_____

Women:

Have you ever had a screening mammogram? Y / N — Date of last exam:_____
When was your last routine gynecologic 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 1st period____ Age at 1st 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

Patient Name: _____

Date: _____

(for office use only)

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

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: _____

_____

Are you currently receiving mental health services for a diagnosed condition? Yes/No (Circle one)

If yes, please provide reason for mental health services and where you are being seen: _____

Have you ever been diagnosed with bipolar disorder? Yes/No (Circle one)

If yes, please provide date of diagnosis and no further questions required: _____

If no, please answer the following questions:

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_____

If the "Total Score" is 3 or greater, a referral to a Licensed Clinical Social Worker will be made for further evaluation. Are you interested in a referral today? Yes/No (Circle One)

CMS eCQM ID CMS2v13 Quality Measure Guideline