Welcome!

We are honored that you have chosen us to help with your healthcare needs. We look forward to meeting you at your upcoming office visit! We are an affiliate of Mountain View Hospital in Idaho Falls.

Please plan to arrive 1 hour before your scheduled appointment time to complete necessary paperwork. This helps us to correctly establish your patient chart. Your first appointment with us will likely last between 1-1 ½ hours.

We make every attempt to remain on schedule. However, due to the nature of our work, some of our patients need extra time and care from our staff and there are times that we may run behind. We ask that you please be patient if this happens. We are doing our best to ensure that each patient gets the care and attention that they need. Due to our high number of patients, we ask that you bring no more than 2 other people to your appointment.

With this letter, you will find a new patient packet. It includes a lot of detailed questions to ensure that our doctors are able to view as much of your medical history as possible. We understand that you may not have all of the information, but please fill it out to the best of your ability and sign the appropriate forms. Please bring the completed packet to your appointment with your insurance card and photo ID. Also bring any medical records that you have related to the problem we are seeing you for unless arrangements have made for them to be sent to us. These include doctor’s notes, lab work, radiology reports, and pathology reports.

**Insurance information:** We will bill your insurance as a courtesy. If you have medical insurance, your insurance company will be billed after deductibles and copayment requirements have been met. *We are required to collect all co-pays at the time of your visit.* You are responsible for prompt payments of any amounts not covered or paid by your insurance carrier, including deductible amounts. If you do not have insurance or only have a primary carrier, or need more assistance with payment options, we are pleased to offer a patient financial coordinator to assist you.

If there is an outstanding balance, we will mail a monthly statement to you at the address you have given us. Regular monthly payments are necessary in order to keep your account in good standing. If you have any concerns about this, please contact Mountain View Hospital billing department at (208) 557-2709.

Thank you for taking the time to review and complete this packet. We will see you soon. If you have any questions or concerns, please contact our office and ask to speak to one of our new patient coordinators for assistance.

Sincerely,

The Staff of Teton Cancer Institute



***Patient Information***

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_**

 **Last First MI**

**Birthday:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender:\_\_\_\_\_\_\_\_\_\_\_\_**

 **Mailing Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_ ZIP:\_\_\_\_\_\_\_\_\_**

**Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Accident or Injury: Yes NO Religion:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ethnicity:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Race:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Spouse/Guardian Information: Marital Status:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Address (If different than Patient’s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Birthday:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact Information**

 **Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**Pharmacy of Choice:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insurance Information**

**Primary Insurance Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder’s Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Policy Holder:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthday:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Secondary Insurance Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder’s Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Policy Holder:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthday:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please tell us about the condition we are seeing you for today.**

|  |  |
| --- | --- |
| What problem(s) are you having? |  |
|  |  |
| When did it start? |  |
| What symptoms have you had? |  |
|  |  |
| Are you still having these symptoms? |  |
| Does anything make it better or worse? |  |
|  |  |
| Does it come and go or is it constant? |  |
|  |  |
| Have you had surgery for this? (date, surgeon, facility) |  |
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| *Office use only* |  |

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| --- | --- |
| **Have you had any of these conditions?** |  |
|  **Date of Onset**  |  **Date of Onset**  |
| **□** Angina |  |  **□**Ongoing **□**Resolved | **□** High blood pressure |  |  **□**Ongoing **□**Resolved |
| **□** Asthma |  |  **□**Ongoing **□** Resolved | **□** Inflammatory bowel disease |  |  **□**Ongoing **□** Resolved |
| **□** Congestive heart failure/pulmonary edema |  |  **□**Ongoing **□** Resolved | **□** Kidney disease |  |  **□**Ongoing **□** Resolved |
| **□** Degenerative joint disease/osteoarthritis  |  |  **□**Ongoing **□** Resolved | **□** Osteoporosis |  |  **□**Ongoing **□** Resolved |
| **□** Diabetes **□** *Type 1* **□** *Type 2* |  |  **□**Ongoing **□** Resolved | **□** Parkinson's disorder |  |  **□**Ongoing **□** Resolved |
| **□** Emphysema/COPD |  |  **□**Ongoing **□** Resolved | **□** Phlebitis |  |  **□**Ongoing **□** Resolved |
| **□** Epilepsy/seizure disorder |  |  **□**Ongoing **□** Resolved | **□** Pneumonia |  |  **□**Ongoing **□** Resolved |
| **□** Heart attack *I* myocardial infarction (MI) |  |  **□**Ongoing **□** Resolved | **□** Rheumatoid arthritis Where? |  |  **□**Ongoing **□** Resolved |
| **□** Hepatitis/Cirrhosis |  |  **□**Ongoing **□** Resolved | **□** Stroke |  |  **□**Ongoing **□** Resolved |
| **□** High blood pressure |  |  **□**Ongoing **□** Resolved | **□** Thyroid disease |  |  **□**Ongoing **□** Resolved |
| **□** Inflammatory bowel disease |  |  **□**Ongoing **□**Resolved |  **Comments :** |
| **□** Kidney disease |  |  **□**Ongoing **□** Resolved |
| ***Other Medical Problems*** |
| Problem | Treating Physician | Comments |
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| *Office use only* |

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| --- | --- |
| ***Malignancy History***  |  |
| Type of Cancer & Where | Date of Onset |  | Comments |
|  |  | **□**Ongoing **□**Resolved |  |
|  |  | **□**Ongoing **□** Resolved |  |
|  |  | **□**Ongoing **□** Resolved |  |
|  |  | **□**Ongoing **□** Resolved |  |
| ***Hematological History*** (includes anemia, hemochromatosis, deep vein thrombosis, and any other blood disorders) |
| **Have you ever had:**  Blood transfusion: Yes**□** No**□** Abnormal clotting: Yes**□** No**□** Abnormal bleeding: Yes**□** No**□** |
| Problem | Date of Onset |  | Comments |
|  |  | **□**Ongoing **□** Resolved |  |
|  |  | **□**Ongoing **□** Resolved |  |
|  |  | **□**Ongoing **□** Resolved |  |
|  |  | **□**Ongoing **□** Resolved |  |
| *Office use only* |

**Surgical History**

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| --- | --- | --- | --- |
| Type of Surgery/Part of Body | Date | What was it for? | Surgeon/Facility |
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| *Office use only* |

**Family History** (please include whether the family member is on your mother or father’s side. We are especially interested in family members with a history of cancer or blood disorder.)

***□*** *I am adopted and unsure of my biological family’s medical history*

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| --- | --- | --- | --- |
| Relationship to you | Problem | Age of onset  | Comments (alive/deceased) |
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| *Office use only* |

**Health Maintenance**

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| Date of last flu vaccine: | **□** I’ve never had this vaccine |
| Date of last pneumonia vaccine: | **□** I’ve never had this vaccine |
| Date of last sigmoidoscopy/colonoscopy: | **□** I’ve never had this procedure |
| ***Women*** |  |  |  |
| Gynecologist: | Facility: |
| Date of last mammogram: | Date of last gynecologic exam: |
| Age at first period: | Age at menopause: Reason: |
| Age at first birth: | Total # of pregnancies: |
| # of live births: | # of interrupted pregnancies: |
| Did you breastfeed? |  |
| Have you ever used hormonal contraceptives (pills, patch, injection, vaginal ring)? Yes **□** No **□** Are you currently using them? Yes **□** No **□** If yes, for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Have you ever had hormone replacement therapy (HRT)? Yes **□** No **□** Are you currently using it? Yes **□** No **□** If yes, for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Have you had any of the following problems? **□** Heavy menstrual flow **□** Miscarriage **□** Uterine fibroids |
| ***Men*** |
| Date of last digital rectal exam: |  | **□** I’ve never had this procedure |
| Date of last PSA test: |  | **□** I’ve never had this test |
| *Office use only* |

**Social History**

|  |
| --- |
| Occupation: **□**  Full time **□** Part time **□** Unemployed **□** Retired |
| **□**  I cannot receive blood products for religious reasons **□**  I cannot receive blood products for other reasons |
| Have you been exposed to: **□** Asbestos **□** Ionizing radiation (does not include X-rays) **□** Toxic chemicals such as industrial solvents or PCBs  |
| ***Tobacco/Nicotine*** | Are you currently using tobacco/nicotine? Yes**□** No**□** | **□** I’ve never used tobacco/nicotine |
| **□** Cigarettes | **□** Cigars/Pipe | **□** Snuff/Chew | **□** Electronic cigarettes/Vape |
| Packs per day:  | How often? \_\_\_\_\_\_\_\_\_\_ | How often? \_\_\_\_\_\_\_\_\_\_\_\_\_ | How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| When did you start? |  | If you quit, when? |  |
| ***Alcohol*** | Are you currently using alcohol? Yes**□** No**□** | **□** I’ve never used alcohol |
| **□** Beer | **□** Wine | **□** Liquor | If you quit, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| On average, how many drinks do you have: | Per day: | Per week: | Per month: | **□** Less than 1 drink monthly |
| ***Recreational drugs*** | Are you currently using recreational drugs? Yes**□** No**□** | **□** I’ve never used recreational drugs |
| **□** Marijuana | **□** Cocaine | **□** Heroin | **□** Amphetamines |
| **□** Narcotics | **□** Other:  | **□** Other: | If you quit, when? |
| *Office use only* |

**Allergies**

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| --- | --- |
| **Medications** | **Type of Reactions** |
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**Medication and Supplement List**

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| --- | --- | --- | --- | --- |
| **Name of Medication** | **Dose**  | **Directions for Taking** | **What is this for?** | **Prescribing Physician** |
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**Have you had any of these symptoms?**

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| --- | --- | --- | --- |
| **General** |  | **Gastrointestinal** |  |
| Weight loss (unexpected) | **□**Ongoing **□** Resolved | Frequent diarrhea | **□**Ongoing **□** Resolved |
| Weight gain (unexpected) | **□**Ongoing **□** Resolved | Frequent constipation | **□**Ongoing **□** Resolved |
| Fever | **□**Ongoing **□** Resolved | Bloody/tarry stool | **□**Ongoing **□** Resolved |
| Fatigue | **□**Ongoing **□** Resolved | Nausea/vomiting | **□**Ongoing **□** Resolved |
| Headache | **□**Ongoing **□** Resolved | **Genitourinary** |  |
| **Eyes** |  | Blood in urine | **□**Ongoing **□** Resolved |
| Double vision | **□**Ongoing **□** Resolved | Painful urination | **□**Ongoing **□** Resolved |
| Spots in vision | **□**Ongoing **□** Resolved | Unable to empty bladder | **□**Ongoing **□** Resolved |
| Vision changes | **□**Ongoing **□** Resolved | Stress incontinence | **□**Ongoing **□** Resolved |
| **ENT/Mouth** |  | Vaginal bleeding/discharge | **□**Ongoing **□** Resolved |
| Earaches | **□**Ongoing **□** Resolved | Vaginal lesions | **□**Ongoing **□** Resolved |
| Ringing in ears (tinnitus) | **□**Ongoing **□** Resolved | **Musculoskeletal** |  |
| Sinus problems | **□**Ongoing **□** Resolved | Muscle weakness | **□**Ongoing **□** Resolved |
| Sore throat | **□**Ongoing **□** Resolved | Joint/muscle pain | **□**Ongoing **□** Resolved |
| Sores in mouth | **□**Ongoing **□** Resolved | **Integumentary** |  |
| Dental problems  | **□**Ongoing **□** Resolved | Breast pain | **□**Ongoing **□** Resolved |
| **Endocrine** |  | Rash | **□**Ongoing **□** Resolved |
| Dry skin | **□**Ongoing **□** Resolved | Masses/lumps | **□**Ongoing **□** Resolved |
| Hot flashes | **□**Ongoing **□** Resolved | Ulcers/open sores | **□**Ongoing **□** Resolved |
| Abnormal thirst | **□**Ongoing **□** Resolved | Discharge | **□**Ongoing **□** Resolved |
| Excessive/frequent urination | **□**Ongoing **□** Resolved | **Neurological** |  |
| **Hematologic/Lymphatic** |  | Dizziness | **□**Ongoing **□** Resolved |
| Frequent/severe bruising | **□**Ongoing **□** Resolved | Uncontrolled shaking | **□**Ongoing **□** Resolved |
| Swollen lymph nodes | **□**Ongoing **□** Resolved | Fainting | **□**Ongoing **□** Resolved |
| **Respiratory** |  | Numbness | **□**Ongoing **□** Resolved |
| Chronic cough | **□**Ongoing **□** Resolved | Seizures | **□**Ongoing **□** Resolved |
| Shortness of breath | **□**Ongoing **□** Resolved | Difficulty walking | **□**Ongoing **□** Resolved |
| Coughing up blood | **□**Ongoing **□** Resolved | **Psychiatric** |  |
| Wheezing | **□**Ongoing **□** Resolved | Depression | **□**Ongoing **□** Resolved |
| **Cardiovascular** |  | Frequent crying | **□**Ongoing **□** Resolved |
| Painful breathing | **□**Ongoing **□** Resolved | Excessive aggression | **□**Ongoing **□** Resolved |
| Chest pain/pressure | **□**Ongoing **□** Resolved | Anxiety | **□**Ongoing **□** Resolved |
| Difficulty breathing on exertion | **□**Ongoing **□** Resolved |
| Swelling in legs | **□**Ongoing **□** Resolved |
| Heart palpitations | **□**Ongoing **□** Resolved |
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