



Welcome to the Mountain States Tumor Institute,

MSTI is dedicated to providing the best quality care for our patients. We provide a wide range of services including care for cancer and blood disorders. Please provide us with the information requested below to help us effectively manage your care in a timely manner.

Together you will be covering the following information below:

- Reviewing your health history form for accuracy. Please complete this form prior to your visit.
- **It is especially important to provide us with a list of medications, vitamins, minerals, and other supplements you are currently taking on the health history form.**
- Parents of pediatric patients should remember to bring a copy of the child's immunization record.
- Please bring any records or x-ray films that pertain to your referral to MSTI.
- We will verify your insurance coverage and make copies of your insurance cards so please be sure to bring your cards.
- There are consent forms for treatment and records release that will be reviewed and signed.
- A brief overview of the services at MSTI will also be covered.
- Your picture may be taken for your medical record.

Following your meeting with the Patient Representative, you will be taken to the waiting area and then will see your physician and other health care providers.

Please let us know if there is anything we can do for you while you are at MSTI. Our staff is very friendly and knowledgeable and is here to make things as comfortable for you as possible.

Sincerely,

Mark D. Parkinson, Administrator  
Mountain States Tumor Institute

100 E. Idaho Street  
Boise, Idaho 83712  
P (208) 381-2711 F (208) 381-4675  
(800) 845-4624

1118 NW 16th Street, Suite D  
Fruitland, Idaho 83619  
P (208) 452-7677 F (208) 452-8681  
(800) 473-9618

520 S. Eagle Road  
Meridian, Idaho 83642  
P (208) 706-5651 F (208) 706-5344  
(800) 473-0331

308 E. Hawaii Avenue  
Nampa, Idaho 83686  
P (208) 467-6700 F (208) 463-6001  
(800) 553-6415

656 Addison Avenue W  
Twin Falls, Idaho 83301  
P (208) 737-2441 F (208) 737-2864  
(800) 947-4852

**Thomas M. Beck, MD**  
Medical Director

**Mark Parkinson**  
Administrator

***Medical Hematology/Oncology***

Thomas M. Beck, MD  
Norman Zuckerman, MD  
Paul G. Montgomery, MD  
William H. Kresle, MD  
Larry Fiorentino, MD  
Theodore A. Walters, MD  
Jonathan N. Swerdloff, MD  
Banu E. Symington, MD  
Lisa Y. Law, MD  
Dan Zuckerman, MD  
Benjamin Bridges, MD  
Silvana Z. Bucur, MD  
Kathleen Clifford, FNP  
Cheryl Mills, FNP  
Linda Ertandson, FNP  
Dorene Boydston, FNP  
Brittany Linn, NP-C  
Jed Bartschi, PA  
Mallori Hooker, NP-C

***Pediatric Hematology/Oncology***

Eugenia Chang, MD  
Nicolas A. Camilo, MD  
Matthew D. Hansen, MD  
Nathan Mesker, MD  
Marni Allen, FNP

***Radiation Oncology***

Charles E. Smith, MD  
Ronald V. Dorn, III, MD  
Sarah L. Bolender, MD  
Stephen C. Smith, MD  
Tonya L. Kuhn, MD  
Colleen Lambertz, FNP  
Jerrimi Helmick, FNP

***Surgical Oncology***

Gynecological Oncology  
Jerry Perez, MD  
Amy Cooper, MD  
Thoracic Oncology  
Matthew Schoolfield, MD  
Pancreatic Disease  
William Traverso, MD

Service provided by St. Luke's Boise  
stlukesonline.org





# INITIAL CLINICAL DATA - ADULT BASELINE HEALTH HISTORY - MSTI

Patient Name: \_\_\_\_\_

S.S.#: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_

PAST MEDICAL HISTORY (CHECK ALL THAT APPLY)					
<input type="checkbox"/> COPD	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Angina	<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Seizures	<input type="checkbox"/> Autoimmune Disorder
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Gastrointestinal Problems	<input type="checkbox"/> Reflux	<input type="checkbox"/> Crohns	<input type="checkbox"/> Kidney	
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Stroke	<input type="checkbox"/> Migraine Headaches	
<input type="checkbox"/> Other: _____					
If you marked any of the above, please explain briefly:					

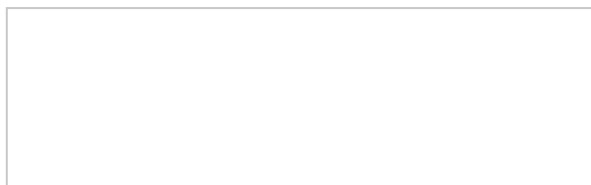
List any previous surgeries or procedures and approximate dates. Please include implanted devices such as joint replacements, artificial heart valves, plates, stents, screws, prosthesis, pacemaker, etc.

Surgery/Procedure	Date

## FAMILY HISTORY of CANCER (Please check all that apply to your immediate family)

Relative / Relationship	Sex	Age at Diagnosis	Type Of Cancer	Are They Deceased?	Age at Death
	M F			Y N U	
	M F			Y N U	
	M F			Y N U	
	M F			Y N U	
	M F			Y N U	
	M F			Y N U	

**LEGEND:** M=Male F=Female Y=Yes N=No U=Unknown



## INITIAL CLINICAL DATA - ADULT BASELINE HEALTH HISTORY – MSTI

<b>Please list all allergies or intolerances below. Include allergies to medications, environment (e.g., pets, pollen, dust), food, contrast media, or latex.</b>				
<input type="checkbox"/> <b>No Medication Allergies</b>	<i>For RN Use Only</i>		<i>For RN Use Only</i> <b>REACTION CODES</b> 1) Anaphylactic 2) Breathing problems 3) ENT swelling 4) Mental changes 5) GI disturbances 6) Skin reactions 7) Cardiac 8) Renal disturbances 9) Neurological changes 10) Unknown  <b>SEVERITY CODES</b> (M) = Mild (MO) = Moderate (S) = Severe	<i>For RN Use Only</i> <b>TREAT AS LATEX ALLERGY</b> Type 1 known latex allergy  OR Anyone with neural tube defect  OR Food allergy to: <ul style="list-style-type: none"> <li>• Avocado</li> <li>• Banana</li> <li>• Chestnuts</li> <li>• Kiwi</li> </ul>
	Reaction	Severity		

List all medications used at home including all prescribed, over-the-counter, research drugs, vitamins / minerals, supplements, nutraceuticals, patches, inhalers, eye drops, and herbals.				
Medication	Drug Dose	Frequency	Route (eg: oral, injection)	Who Prescribed

Local Pharmacy: \_\_\_\_\_ Location: \_\_\_\_\_ Phone \_\_\_\_\_

Mail Order Pharmacy: \_\_\_\_\_ Member # \_\_\_\_\_ Phone \_\_\_\_\_



INITIAL CLINICAL DATA - ADULT BASELINE HEALTH HISTORY - MSTI

CURRENT REVIEW OF SYSTEMS (CHECK ALL THAT APPLY)

GENERAL
Weight loss, Decrease in appetite, Fever / Chills, Fatigue, Problems Sleeping

EYES
Glasses or Contacts, Seeing Double, Recent Vision Changes

EARS / NOSE / THROAT
Difficulty Hearing / Ringing in Ears, Hoarse Voice, Problems with Teeth / Gums, Stuffy Nose without a Cold

INTEGUMENTARY (SKIN)
New, Enlarging, Color Changing or Bleeding Moles, New Skin Rash

ENDOCRINE
Hot or Cold Intolerance, Excessive Thirst or Urination

GASTROINTESTINAL
Nausea, Vomiting, Difficulty Swallowing, Stomach Pain / Bloating, Diarrhea / Constipation, Bleeding from Rectum / Black Stools

RESPIRATORY
Shortness of Breath, Wheezing, Cough with Blood, Cough with Phlegm, Chest Cold more Than 1 per Month
Tobacco Use: Never Smoked, Cigarettes, Cigars, Smokeless, Pipes
How many packs per day? # of years?
Smoking History: Previous packs per day? years?
At what age did you begin smoking?
Quit Smoking? (year) Quit at what age?
Exposed to second-hand smoke? Explain

ALCOHOL/OTHER DRUGS
Alcohol: Never, Monthly or less, 3-4X Month, 2-3X week, 4 or more times week, Daily
How many drinks do you have on a typical day when you are drinking?
Drugs for recreational use: None

MUSCULOSKELETAL
Stiff Muscles, Swollen Joints, Bone Pain

CARDIOVASCULAR
Thumping Heart, Racing Heart, Pains / Tightness in Chest, Swollen Ankles / Feet

URINARY
Frequent Urination, Pain with Urination, Difficulty Starting Urine Flow, Blood in the Urine

NEUROLOGICAL
Numbness, Convulsion, Trembling / Shaking, Seizure, Headache (More than 1 per week.), Weakness

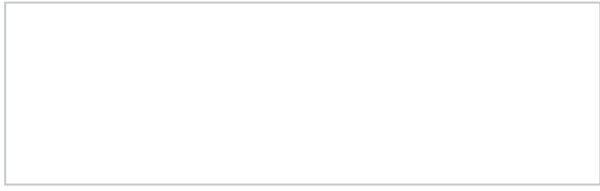
HEMATOLOGY
History of Excess Bruising, History of Bleeding, History of Blood Transfusions

LYMPHATIC
History of Immune Deficiency/Recurrent Infections, History of Chronic Infections, History of Swollen Glands

GYNECOLOGICAL
Age at First Pregnancy: Total #
Age at First Period: Menopause:
Duration of Birth Control:
Date/type:
Duration of Hormone Therapy:
Date/type:
Previous mammogram (date)

SEXUALITY (MALE AND FEMALE)
Planning pregnancy?
Are you experiencing sexual difficulty?

Pain Assessment
Focused Pain Assessment
Date/time:
I am in pain now. (where?):
My pain level is: (0-10)
An acceptable goal for my pain level is: (0-10)
Pain Scale: 0 to 10 0=No Pain 10 = Worst possible pain.
Other / Explain:





# INITIAL CLINICAL DATA - ADULT BASELINE HEALTH HISTORY - MSTI

## Referrals

(CHECK ALL THAT APPLY)

### Infection Control Infection Control Referral Date/Time \_\_\_\_\_

- I have been exposed to an infectious disease in the past 30 days. Describe: \_\_\_\_\_
  - I have had an infection that was resistant to antibiotics ®  
Organism, if known: \_\_\_\_\_
  - I **did not** have a flu shot this season (between September 1st through February 28th).
  - I am over 65 years of age and have **not** received a pneumococcal shot  **Yes**  **No**  
 Unknown
  - I have traveled outside the U.S. in the past 12 months.  
If yes, where? \_\_\_\_\_
- Other / Explain: \_\_\_\_\_

### Nutritional / Metabolic Nutrition Referral Date/Time \_\_\_\_\_

- Have you lost weight  **Yes**  **No**  
If Yes, how much? \_\_\_\_\_
- Do you receive tube feeding or IV nutrition (TPN)?  
 **Yes**  **No**

### Social / Emotional MSW Referral Date/Time \_\_\_\_\_

- I feel unsafe in my current relationship ®  
Who gives you support or help when needed? \_\_\_\_\_
  - In the last 6 months, I have experienced:**  
 Depression  Mood swings  **Anxiety**
  - Are you or have you taken medication for these conditions?  
Explain \_\_\_\_\_
  - Thoughts of hurting myself or others ®
  - I would like some help with these symptoms ®
  - I have problems sleeping.
- Other / Explain: \_\_\_\_\_
- I have no social/emotional needs at this time**

### Integrative Medicine ® IMC\* Date/Time \_\_\_\_\_

- I am interested in learning more about complementary therapies (such as yoga, acupuncture, massage) for
- Managing symptoms  Help with relaxation/tension
  - Improving quality of life  Gentle movement/exercise
  - Other \_\_\_\_\_

### Managing Symptoms ® SCC\* Date/Time \_\_\_\_\_

- I have a concern about managing my care and symptoms Related to my condition and/or treatment

### Spiritual / Cultural Spiritual Care Referral Date/Time \_\_\_\_\_

- I anticipate experiencing religious, sacramental, or spiritual needs during my care ®
  - My personal beliefs will not allow me to receive the following:  
 Blood products (list) \_\_\_\_\_
  - Medications (list) \_\_\_\_\_
  - Treatments (list) \_\_\_\_\_
  - I have cultural practices that need to be accommodated during my care. ® Please describe: \_\_\_\_\_
- Other/Explain: \_\_\_\_\_

### Patient Advocate Consult Date/Time \_\_\_\_\_

- I would like to speak to someone about financial arrangements for my medical care. ®

### Caregiver/Community Resources MSW Referral Date/Time \_\_\_\_\_

- I take care of someone who will need caregiving help during my treatment. ® (who?): \_\_\_\_\_
  - I use these agencies: (Please provide name of agency)**
  - Home health service: \_\_\_\_\_
  - Hospice: \_\_\_\_\_
  - Medical equipment supplier / IVs: \_\_\_\_\_
  - Private attendant: \_\_\_\_\_
  - Housekeeping service  Meals on Wheels
  - Other: \_\_\_\_\_  None of the above
  - I live in:**
  - Apartment  Mobile home  House
  - Shelter home  Homeless ®  Other \_\_\_\_\_
  - Assisted living facility: \_\_\_\_\_
  - Skilled nursing facility: \_\_\_\_\_
  - I have environmental barriers in my home (stairs, narrow doorways, lack of running water, or other utilities, etc.)  
Explain: \_\_\_\_\_
  - I need assistance now with these necessities: ®**
  - Food  Shelter  Utilities
  - Medication  Transportation
  - Please describe assistance needs: \_\_\_\_\_
  - I use a:**  Walker  Crutches
  - Cane  Wheelchair
- Other / Explain: \_\_\_\_\_

\*IMC=Integrative Medicine Coordinator

\*SCC=Supportive Care Clinic





INITIAL CLINICAL DATA - ADULT BASELINE HEALTH HISTORY - MSTI
(CHECK ALL THAT APPLY)

Patient / Family Education

- Please teach the following individuals about my condition and care:
Myself, Family, Guardian, Significant Other, Other: Relationship:
I learn best by:
Listening / Discussion, Visual / Written, Repetition, Demonstration / Hands-on, No Preference
Please consider the following when giving me (us) information:
Language, Culture, Memory, Finance, Physical ability, Spiritual needs, Emotional state, Age / Development, Literacy, Other

What are you most concerned about with your current condition?

Who provided this information? Patient Other

Signature (person responsible for providing information)

Relationship to patient:

RN / MD Signature:

Date: Time:

Legend: ® Referral Required

Home Phone Number: Work Phone Number: Cell / Other Phone Number:

Date of Birth: Birth State Marital Status Spouse/S.O. name/phone

I live alone I live with: Relationship:

Emergency Contact Name/phone Religious Preference

Past/current Occupation Employer

If retired, date and primary occupation Highest grade/level of education completed

Primary Care Physician: Referring Physician:

Name and Address of Insurance Provider

ID Group #

Name and Address of Insurance Provider (secondary)

ID Group #

Primary Subscriber: Name DOB SS#

Employer (for insurance) and effective date

Medicare Part D? No Yes Name Address

ID Group#

Do you need an interpreter? No Yes Primary Language (if other than English):

Hispanic or Latino? Yes No Which group describes you best (circle one): White, Black or African American, Asian, American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander.

Do you have a Living Will / Advance Directive? Yes No

If you answered, "Yes", does St. Luke's MSTI have it on file? Yes No

If you answered "No", would you like some information about Living Wills/Advanced Directives? Yes No

Empty rectangular box for additional information.

## AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> 100 E. Idaho St.<br>Boise, ID 83712<br>Fax: (208) 381-4675                             | <input type="checkbox"/> 520 S. Eagle Rd.<br>Meridian, ID 83642<br>Fax: (208) 706-5243      | <input type="checkbox"/> 308 E. Hawaii Ave.<br>Nampa, ID 83686<br>Fax: (208) 463-6001   |
| <input type="checkbox"/> 1118 NW 16 <sup>th</sup> Street, Suite D<br>Fruitland, ID 83619<br>Fax: (208) 452-8643 | <input type="checkbox"/> 656 Addison Ave. W.<br>Twin Falls, ID 83301<br>Fax: (208) 737-2864 | <input type="checkbox"/> BCS Film Library (Original Imaging Studies/Films)<br>100 E. Idaho St.<br>Fax: (208) 381-2840<br><br><input type="checkbox"/> Permanent or <input type="checkbox"/> Temporary |

Patient: \_\_\_\_\_ Medical Record No: \_\_\_\_\_  
 Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 \_\_\_\_\_ Telephone: \_\_\_\_\_

Other names under which patient has been treated: \_\_\_\_\_

I hereby authorize St. Luke's and any of their affiliated entities, employees, agents, or associated health care practitioners to use or disclose the patient's protected health information as described below.

1. St. Luke's may use or disclose information relating to the patient's care during the following relevant time period:
  - At any time.
  - From (date) \_\_\_\_\_ to (date) \_\_\_\_\_.
  
2. St. Luke's may use or disclose the following type(s) of information per this authorization:
  - Any information concerning the patient's health, health care, or payment during the relevant time.
 

<input type="checkbox"/> Discharge summaries <input type="checkbox"/> History and physicals <input type="checkbox"/> Consultation reports <input type="checkbox"/> Procedure reports <input type="checkbox"/> Emergency service reports <input type="checkbox"/> Pathology reports <input type="checkbox"/> Laboratory reports	<input type="checkbox"/> Diagnostic test reports <input type="checkbox"/> Diagnostic imaging studies and reports <input type="checkbox"/> X-ray films <input type="checkbox"/> Psychotherapy notes <input type="checkbox"/> HIV/Aids <input type="checkbox"/> Other: _____
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  - Billing and payment records for care rendered during the relevant time.
  - Other: \_\_\_\_\_

## AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

3. St. Luke's may disclose the information to the following person(s) or entity(ies) per this authorization:

Name or description: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

4. St. Luke's may use or disclose the information per this authorization for the following purpose(s):

The disclosure is made at my request.

For a potential or pending legal proceeding.

For marketing. St. Luke's:  will  will not receive remuneration from a third party for the use or disclosure of the information.

Other: \_\_\_\_\_

I understand that I have the right to revoke this authorization at anytime except to the extent that St. Luke's has taken action in reliance on this authorization. To revoke this authorization, I must submit a written revocation to **Director of Health Information Services (Medical Records)**.

I understand that St. Luke's may not condition the patient's health care on this authorization unless (1) the purpose for St. Luke's evaluation and treatment is to obtain and disclose information to entities consistent with this authorization, or (2) the patient is involved in research-related treatment and the use or disclosure is for such research.

I understand that information disclosed by St. Luke's pursuant to this authorization may be re-disclosed by the entity that receives this information and may no longer be protected by privacy regulations.

This authorization will expire on the following date or event: \_\_\_\_\_. If no specific date or event is stated, this authorization will expire one (1) year from the date of this authorization.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date/Time**

\_\_\_\_\_  
**Authority or Relationship to the Patient**