The GW Transplant Institute

The GW Liver and Pancreas Institute for Quality (LPIQ)

Initial Patient Assessment / History

Patient Name ____ **Date** _______________________

Age _________ **Sex** ________ **Race** ________ **Referred by** ___________________________(MD)

Primary Care / Family Physician ____ (MD)

History of Present Illness

Main reason for Visit ____

1. **When were you first diagnosed with liver problems?** ____
2. **What type of liver problems were you diagnosed with?** ____
3. **Have you ever been treated for your liver problems (Circle One)** **Yes** **No**

   If so, what were you treated with? (Modifying Factors) (Check All that Apply)

☐ **Pegylated Interferon** ☐ **Ribavirin** ☐ **Interferon** ☐ **Steroids** ☐ **Phlebotomy** ☐ **Other** _____________

4. **How did/does this treatment make you feel?** **Worse or Better**

Date Treatment Started _________________________ **Date Ended/Stopped** _____________________________

Date Treatment Started _________________________ **Date Ended/Stopped** _____________________________

Date Treatment Started _________________________ **Date Ended/Stopped** _____________________________

Side effects experienced while on treatment ____

____

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5. **Have you ever had a liver biopsy?** **(Circle One)** **Yes / No**

   If so, When? _________________________ **Where? (Hospital)** ___________________________

6. **Have you ever had any of the following tests?**

			Date	Comment (Physician/Staff only)
Liver Ultrasound	**Yes**	**No**	____________	___________________________________
Abdominal CAT Scan	**Yes**	**No**	____________	___________________________________
MRI of the Liver	**Yes**	**No**	____________	___________________________________
Upper Endoscopy (EGD)	**Yes**	**No**	____________	___________________________________

Colonoscopy **Yes** **No** ______________ ____

Comment (Physician/Staff only) ____

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Risk Factors for Liver Disease **Date** **Comments**

1. **Have you ever used IV drugs?** **Yes** **No** ____________ ________________________________
2. **Have you ever gotten a tattoo?** **Yes** **No** ____________ ________________________________
3. **Have you had a blood transfusion?** **Yes** **No** ____________ ________________________________
4. **Have you ever snorted cocaine?** **Yes** **No** ____________ ________________________________
5. **Have you had any body-piercings?** **Yes** **No** ____________ ________________________________
6. **Have you had multiple sex partners?** **Yes** **No** ____________ ________________________________
7. **Have you ever been stuck by a dirty or infected needle?** **Yes / No** **When?** __________________________
8. **Do you drink alcohol or have you drank alcohol in the past?** **Yes / No**

   Amount: ___________________ **Type:** _______________________ **How often?** _______________________

   When did you start? ___________________ **When did you stop?** __________________________

9. **Do you have any family history of liver disease?** **Yes / No**

   If so, relationship? ______________________________ **Type:** ___________________________________

Current Symptoms of Liver Disease

Do you currently **have any of the following symptoms?**

Yes	No		Date	Comment (Physician/Staff only)
☐	☐	**Fatigue/Tiredness**	________________	____
☐	☐	**Rash**	________________	____
☐	☐	**Abdominal Pain**	________________	____
☐	☐	**Joint Swelling**	________________	____
☐	☐	**Joint Pain**	________________	____

10. Rate your pain/other symptom from 1-10 scale **1, 2, 3, 4, 5, 6, 7, 8, 9, 10**

11. What is the quality of pain/other symptoms? (Mild / sharp / radiating / throbbing / cramping / tingling)

Symptoms of Severe Liver Disease

Have you ever had any of the following symptoms?

Yes	No		Date	Comment (Physician/Staff only)
☐	☐	**Itching**	__________	________________________________
☐	☐	**Ascites (fluid in abdomen)**	__________	________________________________
☐	☐	**Swelling of feet / ankles**	__________	________________________________
☐	☐	**Variceal Bleed (vomiting blood)**	__________	________________________________
☐	☐	**Jaundice (yellow skin/eyes)**	__________	________________________________
☐	☐	**Encephalopathy (mental confusion Forgetfulness / drowsiness)**	__________	________________________________

12. When do you feel these symptoms? **Day / Night** **Constantly / Occasionally**

Past Medical History **Comments**

Yes	No		Comments
☐	☐	**Diabetes**	______________________________________
☐	☐	**Diabetic Complications**	______________________________________

☐	☐	**High Blood Pressure**	________________
☐	☐	**Heart Disease**	________________
☐	☐	**Kidney Disease**	________________
☐	☐	**Auto-Immune Disease**	________________
☐	☐	**Lung Disease (COPD, Asthma, Emphysema)**	________________
☐	☐	**Cancer**	________________
☐	☐	**HIV**	________________
☐	☐	**Seizure Disorder**	________________
☐	☐	**Thyroid Disease**	________________
☐	☐	**Chronic Low-back Pain**	________________
☐	☐	**Weight Loss**	________________
☐	☐	**High Cholesterol, High Lipids**	________________
☐	☐	**Other** ______________	________________

Past Surgical History

Previous Surgery (Circle One) Yes No If yes, type of surgery and date performed.

Date/Procedure: ________________________________

Date/Procedure: ________________________________

Date/Procedure: ________________________________

Past Family History

Has anyone in your family (blood relative) had the following?

Yes	No		
☐	☐	**Liver Disease**	________________
☐	☐	**Cancer**	________________
☐	☐	**Heart Disease**	________________
☐	☐	**Diabetes**	________________

Has your partner been tested for Hepatitis C? (Circle One) Yes No N/A

Has your partner been tested for Hepatitis B? (Circle One) Yes No N/A

Social History

Marital Status (circle one) Single Married Separated Divorced Widowed

Number of children ______________

Are you currently employed? (Circle One) Yes / No If so, do you work full time? (Circle One) Yes / No

What type of work do you do? ________________________________

Do you smoke? (Circle One) Yes / No

If yes, how much? ________________ **How long have you smoked?** ______________

Have you ever been in AA (Alcoholics Anonymous) or any other type of rehab program?

(Circle One) Yes / No If yes, when? ________________________________

Psychiatric History

Do you suffer from depression and/or anxiety? **(Circle One)** **Yes / No**

Are you currently under the care of a psychiatrist? **(Circle One)** **Yes / No**

Do you currently have suicidal ideation? **(Circle One)** **Yes / No**

Have you ever been admitted to a hospital or institution for psychiatric reasons?

(Circle One) **Yes / No** **If yes, when?** ____

Medications:
Please list all medications you are currently taking, including all over-the-counter medications.

Medication Name / Dosage / How often

1) ____ **7)** ____

2) ____ **8)** ____

3) ____ **9)** ____

4) ____ **10)** ____

5) ____ **11)** ____

6) ____ **12)** ____

Allergies

Are you allergic to any medications? **(Circle One)** **Yes** **No** **Unknown**

Do you have environmental or food allergies? **(Circle One)** **Yes** **No** **Unknown**

Allergy	Type of Reaction
____	____
____	____
____	____
____	____
____	____

Review of Symptoms (check all that apply)

Constitutional

- ☐ **Fever or Chills**
- ☐ **Weight Loss**
- ☐ **Weight Gain**
- ☐ **Trouble Sleeping**
- ☐ **Fatigue**
- ☐ **Decreased Appetite**
- ☐ **Increased Appetite**

Comments

____

____

____

EYES

- ☐ Redness ☐ Yellowness ____________________________________
- ☐ Visual Changes ____________________________________

NOSE/THROAT

- ☐ Sore Throat ☐ Mouth Sores ____________________________________
- ☐ Nasal or Sinus Inflammation / Infection ____________________________________

Respiratory

- ☐ Cough ☐ Difficulty Breathing ____________________________________
- ☐ Shortness of Breath (without exertion) ____________________________________

Heart/Cardiac

- ☐ Chest Pain ☐ Heart Palpitations ____________________________________
- ☐ Shortness of Breath (with exertion) ____________________________________

Gastrointestinal

- ☐ Abdominal Pain ☐ Abdominal Swelling ____________________________________
- ☐ Nausea ☐ Vomiting ____________________________________
- ☐ Diarrhea ☐ Constipation ____________________________________
- ☐ Vomiting Blood ☐ Rectal Bleeding ____________________________________
- ☐ Black or Pale Stool ☐ Heartburn ____________________________________

Reproductive / Urinary

- ☐ Blood in Urine ☐ Frequent Urination ____________________________________
- ☐ Burning with Urination ☐ Dark Urine ____________________________________

Skin/Integumentary

- ☐ Rash ☐ Itching ____________________________________
- ☐ Injection Site Reaction ☐ Hair Loss ____________________________________

Musculoskeletal

- ☐ Joint Pain ☐ Back Pain ____________________________________
- ☐ Swelling in Extremities ____________________________________

Neurological

- ☐ Headache ☐ Dizziness ____________________________________
- ☐ Weakness ____________________________________
- ☐ Tingling / Numbness in Extremities ____________________________________

☐ **ALL SYSTEMS NEGATIVE EXCEPT NOTED IN HPI**