The GW Transplant Institute – Liver Transplantation

The GW Liver and Pancreas Institute for Quality (LPIQ)

Initial Patient Assessment / History

Patient Name _____ **DOB**_____ **Age** _____ **Date**_____ **Sex** _____

Race _____ **Ht**_____ **Wt**_____ **Phone**_____ **E-mail**_____

Referred by _____ **Phone**_____

Primary Care / Family Physician _____ **Phone**_____

Preferred Pharmacy _____ **Phone**_____

History of Present Illness

Main reason for Visit _____

1. When were you first diagnosed with liver/pancreas problems? _____

2. What type of liver/pancreas problems were you diagnosed with? _____

3. Have you ever been treated for your liver/pancreas 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**_____

Side effects experienced while on treatment _____

_____

5. Have you ever had a liver/pancreas 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/Pancreas Ultrasound	**Yes**	**No**	_____	_____
Abdominal CAT Scan	**Yes**	**No**	_____	_____
MRI of the Liver/Pancreas	**Yes**	**No**	_____	_____
Upper Endoscopy (EGD)	**Yes**	**No**	_____	_____
Colonoscopy	**Yes**	**No**	_____	_____

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/pancreas 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**

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
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Past Medical History **Comments**

Yes	No		
☐	☐	**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? _____

Review of Symptoms (check all that apply)

Constitutional — **Comments**

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

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**