



# 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 \_\_\_\_\_

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?

	Yes	No	Date	Comment (Physician/Staff only)
Liver Ultrasound	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Abdominal CAT Scan	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
MRI of the Liver	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Upper Endoscopy (EGD)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

**Colonoscopy**

Yes

No

\_\_\_\_\_

\_\_\_\_\_

Comment (Physician/Staff only)

\_\_\_\_\_

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)
<input type="checkbox"/>	<input type="checkbox"/>	Fatigue/Tiredness	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Rash	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Joint Swelling	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	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)
<input type="checkbox"/>	<input type="checkbox"/>	Itching	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Ascites (fluid in abdomen)	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Swelling of feet / ankles	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Variceal Bleed (vomiting blood)	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Jaundice (yellow skin/eyes)	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Encephalopathy (mental confusion Forgetfulness / drowsiness)	_____	_____

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

Past Medical History

Comments

Yes	No		
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	_____
<input type="checkbox"/>	<input type="checkbox"/>	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                       |               |       |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer        | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 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
- Visual Changes

- Yellowness

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**NOSE/THROAT**

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

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**Respiratory**

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

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**Heart/Cardiac**

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

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**Gastrointestinal**

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

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**Reproductive / Urinary**

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

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**Skin/Integumentary**

- Rash
- Injection Site Reaction
- Itching
- Hair Loss

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**Musculoskeletal**

- Joint Pain
- Swelling in Extremities
- Back Pain

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**Neurological**

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

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- ALL SYSTEMS NEGATIVE EXCEPT NOTED IN HPI