LIVER CENTER | THE QUEEN'S MEDICAL CENTER

Name _____ **DOB**: _____ **PCP:** _____

Please complete this form to the best of your knowledge. This information will help the Liver Center take better care of you. All information is confidential and cannot be released without your written consent.

Reason for your visit: _____ ***Who Referred you:*** _____

Medical History

☐ **IN EPIC**

Do you currently have, or have you been told you have a history of or problems with the following?

Blood/Lymph System:	☐ Easy Bruising	☐ Blood Clotting	☐ Iron Overload
☐ NONE	☐ Other:		
Endocrine System:	☐ Hypothyroid	☐ Hyperthyroid	☐ Diabetes
☐ NONE	☐ Other:		
Gastroenterology:	☐ Blood in Stool	☐ Black Tarry Stool	☐ Vomiting Blood
☐ NONE	☐ Jaundice (Yellow Skin)	☐ Swollen Abdomen	☐ GERD/Acid Reflux
	☐ Other:		
Heart/Cardiovascular:	☐ Hypertension	☐ Hyperlipidemia	☐ Swelling (Feet/Legs)
☐ NONE	☐ Heart Attack	☐ Stroke	☐ Pace Maker/ AICD
	☐ Other:		
Lungs/Pulmonary:	☐ Asthma	☐ COPD	☐ Sleep Apnea
☐ NONE	☐ Other:		
Urinary System:	☐ Prostate Enlargement	☐ UTI	☐ Painful Urination
☐ NONE	☐ Other:		
Muscles/Joints:	☐ Arthritis	☐ Gout	☐ Fibromyalgia
☐ NONE	☐ Other:		
Neurological System:	☐ Migraines	☐ Seizures	☐ Neuropathy
☐ NONE	☐ Other:		
Psychiatric System:	☐ Anxiety	☐ Depression	☐ Bipolar
☐ NONE	☐ Other:		
Cancer:	☐ Liver Cancer	☐ Bile Duct Cancer	☐ Colon Cancer
☐ NONE	☐ Other:		

Surgical History:

What Surgery and when? _____

Family History:

☐ Unknown Family History

Are you adopted? ☐ Yes ☐ No

Birth Place _____ Ethnicity: _____

Liver *Cancer* in any of your 1st Degree Relatives (Parents, Siblings, Children) ☐ Yes ☐ No

Liver *Disease* in any of your 1st Degree Relatives (Parents, Siblings, Children) ☐ Yes ☐ No

Father:	☐ Deceased	☐ Alive } Problems:	_____
Mother:	☐ Deceased	☐ Alive } Problems:	_____
Sisters:	☐ Deceased	☐ Alive } Problems:	_____
Brothers:	☐ Deceased	☐ Alive } Problems:	_____

Social History:

Occupation: _____

Who do you live with: ☐ Alone ☐ Spouse ☐ Children ☐ Homeless ☐ Other: _____

Alcohol: ☐ Never ☐ Quit: _____ ☐Currently } ☐Beers ☐Liquor ☐Wine

How many: _____ ☐ a day ☐ a week ☐ a month

Smoking: ☐Never ☐Quit: _____ ☐Currently } ☐ Cigarettes ☐ E-Cigs ☐Cigars

How many: _____ ☐ a day ☐ a week ☐ a month

Illicit Drugs ☐Never ☐Quit: _____ ☐Currently } Type of Drug: _____

How many: _____ ☐ a day ☐ a week ☐ a month

Do you follow a special Diet? ☐ Yes ☐ No

If Yes: _____

Do you exercise? ☐ Yes ☐ No

If Yes: How long? _____ How often? _____

Current Conditions:

Do you currently have the following?			Comments
Fever or chills	☐Yes	☐No	
Unexplained tiredness	☐Yes	☐No	
Unexplained sweating at night	☐Yes	☐No	
Allergies/immune System	☐Yes	☐No	
Ever had blood transfusion	☐Yes	☐No	
Tattoo/Body Piercing	☐Yes	☐No	
Any changes in your weight?	☐Yes	☐No	

Medications:

Preferred PHARMACY : ☐ **IN EPIC**

	Name of Medication	Dose	How Often
1.			☐Daily ☐ Twice a Day ☐ Other:
2.			☐Daily ☐ Twice a Day ☐ Other:
3.			☐Daily ☐ Twice a Day ☐ Other:
4.			☐Daily ☐ Twice a Day ☐ Other:
5.			☐Daily ☐ Twice a Day ☐ Other:
6.			☐Daily ☐ Twice a Day ☐ Other:
7.			☐Daily ☐ Twice a Day ☐ Other:
8.			☐Daily ☐ Twice a Day ☐ Other:
9.			☐Daily ☐ Twice a Day ☐ Other:
10.			☐Daily ☐ Twice a Day ☐ Other:

	Allergies:	**Reaction:**
1.		
2.		
3.		
4.		
5.		

☐ NO KNOWN ALLERGY