THE QUEEN'S MEDICAL CENTER

Queens Liver Center
550 S. Beretania St. #501
Honolulu, Hi 96813
Ph: 808-691-8838 Fx: 808-691-8839

Patient 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.

What is your 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:	☐ Rheumatoid Arthritis	☐ Osteoarthritis	☐ 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:

(Type/When): _____

Family History:

☐ Unknown Family History

Are you adopted? ☐ Yes ☐ No ☐ Unknown

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	☐ Living } Problems:	_____
Mother:	☐ Deceased	☐ Living } Problems:	_____
Sisters:	☐ Deceased	☐ Living } Problems:	_____
Brothers:	☐ Deceased	☐ Living } Problems:	_____

Social History: Occupation: _____

Living Situation: ☐Alone ☐Spouse ☐Children ☐Homeless ☐Other: _____

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

How many per a week? _____

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

How many per a week? _____

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

How many per a week? _____

Do you follow a special Diet? ☐ No ☐ Yes

If Yes: _____

Do you exercise? ☐ No ☐ Yes

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	
Have you 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	Dosage	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:
11.			☐Daily ☐ Twice a Day ☐ Other:
13.			☐Daily ☐ Twice a Day ☐ Other:
14.			☐Daily ☐ Twice a Day ☐ Other:

☐ None **Allergies:** **Reactions** **Allergies** **Reactions**

1.			**2.**		
3.			**4.**		