Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

Clinic Location:_____ Physician's Name:_____

Please complete this questionnaire and return as soon as possible to allow your provider at Stanford to spend more time with you in making clinical decisions and to help with your education process. Although some of the information is personal, this history is standard for medical providers and necessary for a thorough evaluation of your liver disease, to determine risk factors for your disease and help establish a prognosis. If you feel uncomfortable answering any question on this form, do not fill in that question, move on to complete the rest of the questionnaire. Once you submit a complete questionnaire, your practitioner will have more time to communicate and educate you about your disease and enhance your disease management and treatment.

Name: Last First Middle

Address: Street, Apt # City State Zip Code

Home Phone Work Phone Cell/Pager Fax #

Email Address Birthdate (MM/DD/YYYY) Age ❑ Male ❑ Female Gender

Status: ❑ Single ❑ Divorced ❑ Widowed

Emergency Contact (Telephone # and Name) English Speaking Contact (Telephone # and Name)

Employer's Name Address Occupation

1. **Background** Today's date: _____ Date/Time of your appointment:_____
   What is your current Height? _____ Weight? _____
   What was your weight at age 18? _____ What is your waist size in inches? _____
   What liver disease or diagnosis have you been given by your provider?_____
   What is your main reason for your visit here? What questions do you have?_____

2. **Primary Care Info**

PRIMARY CARE PHYSICIAN/OTHER MD (This information must be complete and current)	**SPECIALIST** (This information must be complete and current)
Name:_____	Name:_____
Address:_____	Address:_____
Phone:_____	Phone:_____

Please list any other providers, MDs, PAs, or NPs who contribute to your medical care:

Provider Name	Address & Phone Number	Reason seen	Approximate Dates

3. Current Review of Systems

Have you suffered from any of the following in the last three (3) months? Please check Yes or No and fill in intensity and duration. Please comment on what makes these symptoms worse or better.

Condition	**Yes**	**No**	**Intensity Mild, Moderate, Severe**	**Duration (in Days or Months)**
Abdominal pain	☐	☐		
Blood in bowel movements	☐	☐		
Chest pains	☐	☐		
Constipation	☐	☐		
Diarrhea	☐	☐		
Dry mouth or eyes	☐	☐		
Falls – have you had any in the last 6 months? If yes, how many? _____	☐	☐		
Fatigue	☐	☐		
Fevers, chills or sweats	☐	☐		
Itching	☐	☐		
Joint aches	☐	☐		
Leg swelling	☐	☐		
Loss of sexual interest	☐	☐		
Memory problems	☐	☐		
Muscle aches	☐	☐		
Muscle loss	☐	☐		
Night blindness	☐	☐		
Sexual difficulties	☐	☐		
Shortness of breath	☐	☐		
Sleeping problems	☐	☐		
Sores on your skin	☐	☐		
Trouble concentrating	☐	☐		
Urine symptoms	☐	☐		
Weight loss	☐	☐		
If yes, how much weight have you lost in the last year?_____			Reason for weight loss?_____	

4. Medical History

List all of your medical problems (diagnoses) including all reasons you've ever seen a doctor (eg. diabetes, hypotension, COPD, asthma, depression, etc) and date of onset:

List your surgical procedures and dates:

Have you had or do you have any of the following: Please check Yes or No. If Yes, please answer the questions listed in the details column.

Condition	Yes	No	Details, Date of Onset or Diagnosis
Ascites (fluid in abdomen)	☐	☐	
Asthma or emphysema	☐	☐	
Bleeding disorder	☐	☐	
Blood clots: in legs or other	☐	☐	
Cancer	☐	☐	
Chest pain/angina	☐	☐	
Depression	☐	☐	
Diabetes	☐	☐	
Encephalopathy (mental confusion)	☐	☐	
Epilepsy or seizures	☐	☐	
Heart attack	☐	☐	
High cholesterol	☐	☐	
Icterus (eyes turning yellow)	☐	☐	
Insomnia	☐	☐	
Intestinal bleeding	☐	☐	
Jaundice (skin turning yellow)	☐	☐	
Positive TB skin test	☐	☐	

Condition	Yes	No	Details, Date of Onset or Diagnosis
Rheumatologic or Autoimmune disease	☐	☐	
Sickle cell disease or other anemia	☐	☐	
Stroke	☐	☐	
Thyroid problems	☐	☐	
Tuberculosis/Quantiferon Blood Screen	☐	☐	

Have you ever been vaccinated for the following: Please check Yes or No.

Disease	Yes	No	Not Sure
Hepatitis A	☐	☐	☐
Hepatitis B	☐	☐	☐
Pneumovax (pneumonia vaccine)	☐	☐	☐

Have you ever had a liver biopsy: ☐ Yes ☐ No

If yes, give date(s): _____

If yes, what did your provider tell you that your liver biopsy showed (score, description /fibrosis, damage, etc.)?_____

_____

Women:

Number of pregnancies_____ Number of births _____

Last menstrual period _____ Are you using a birth control pill? ☐ Yes ☐ No

Last PAP smear_____ Last mammogram _____

Have you had your "tubes tied" or a hysterectomy? ☐ Yes ☐ No

5. Allergies and Reactions

Do you have any reactions/allergies to medicines? ☐ Yes ☐ No

If yes, please complete the following:

Medication	List the Specific Allergies or Reactions you have had to each Medication

6. Medication History

Have you ever taken any of the following? Please check Yes or No.

Medication	Yes	No	Comment
Birth Control pills	☐	☐	
Body building drugs	☐	☐	
Steroids (prednisone)	☐	☐	
Interferon (injection)	☐	☐	Type of interferon by brand name: Approximate dates:
Ribavirin	☐	☐	Dose: Dates:
For HCV – list any oral therapies:	☐	☐	Please list:
Lamivudine (Epivir)	☐	☐	
Adefovir (Hepsera)	☐	☐	
Entecavir (Baraclude)	☐	☐	
Tenofovir (Viread)	☐	☐	
Telbivudine (Tyzeka)	☐	☐	
Other Meds for Hepatitis B or C treatment? Please list:			
Experimental/Research Medications Please list:			

List all medications you are currently taking and the doses (include complementary medications, herbs, vitamins, supplements, injected medications, over the counter medications and alternate medications.)

Medication	Amount/Size and Frequency (eg 6 mg, 2 x a day)	Why are you taking this Medication	Is it working List side effects

Medication	Amount/Size and Frequency (eg 6 mg, 2 x a day)	Why are you taking this Medication	Is it working List side effects

7. Family History

Has any blood relative ever had any of the following problems. Please check Yes or No, and if yes please indicate relationship.

Condition	Yes	No	Relationship (who in your family?
Alcoholism	☐	☐	
Breast cancer	☐	☐	
Colon cancer	☐	☐	
Depression/Psychiatric disease	☐	☐	
Diabetes	☐	☐	
Emphysema	☐	☐	
Heart attacks before the age of 60	☐	☐	
Hip fracture or osteoporosis (*circle*)	☐	☐	
Liver cancer (hepatocellular carcinoma)	☐	☐	
Liver disease (hepatitis, cirrhosis)	☐	☐	
Lupus or rheumatoid arthritis (*circle*)	☐	☐	
List any other medical problems here that have occurred in your family:_____			

8. Personal and Social History

What is your ethnic/race background?_____

Where (in what country) were you born?_____

Where were your parents born?_____

Number of children you have had as natural birth or adopted, if any:_____

List all foreign countries where you have traveled?_____

Number of sexual partners in your lifetime: ☐ <10 ☐ 10-20 ☐ 20-50 ☐ >50

Sexual preference: ☐ Male ☐ Female ☐ Both

If you get sick, who would help take care of you?_____

Please provide the following information (Check Yes or No and provide details):

Personal History	Yes	No
Work		
Are you working? If yes, what do you do?_____	☐	☐
Are you on disability? If yes, for what diagnosis?_____	☐	☐
Is your disability: State: ☐ Yes ☐ No SSI: ☐ Yes ☐ No Social Security: ☐ Yes ☐ No		
Tobacco		
Have you ever any tobacco products If yes, for how many years? _____ Number of packs per day?_____ If yes, do you still smoke? If no, when did you quit? Date: _____	☐ ☐	☐ ☐
Blood Products		
Have you had blood, blood products or globulin exposure/transfusions? If yes, when? _____Type of product: _____ List number of units:_____ If yes, reason for transfusion_____	☐	☐
Have you ever been stuck by a needle in the work setting?	☐	☐
Do you have any tattoos/body piercings? If yes, where?_____	☐	☐
Alcohol		
Do you currently drink alcohol? If yes, number of drinks per day_____ If yes, number of days per week_____ What type?_____	☐	☐
If no, when was your last drink? Date: _____		
Have you ever had alcohol negatively influence your work or personal life?	☐	☐
Have you ever had a DUI (driving under the influence) ticket? When? _____ How many? _____	☐	☐
Have you ever tried to cut down on the amount that you were drinking?	☐	☐
Have you ever felt annoyed when people asked about your drinking?	☐	☐
Have you ever felt guilty about your drinking?	☐	☐
Have you ever had an "eye-opener" drink, first thing in the morning?	☐	☐

Personal History	Yes	No
Street Drugs		
Have you ever used drugs? (cocaine, marijuana, uppers, downers, LSD, etc)	☐	☐
Have you ever snorted drugs?	☐	☐
Have you ever used IV needles? (non-medical injections) If yes, what was the first date used?_____ If yes, what was the last date used?_____	☐	☐
When was your last experience with any drugs? Date: _____		
Have you ever been in jail or prison?	☐	☐
Have you ever attended Alcoholics or Narcotics Anonymous? If yes, why did you go to NA or AA?_____	☐	☐

Alcohol Use

This segment is about your use of alcohol. Please answer yes or not to all questions, even if you do not drink alcohol or if it was in the past. Include any necessary comments in the "details" section.

Question	Yes	No	Details
Do you feel you are a normal drinker? (normal means 0-2 drinks per day)	☐	☐	
Have you awakened in the morning after drinking the night before and could not remember part of the night before?	☐	☐	
Do friends/loved ones think you drink too much?	☐	☐	
Can you stop drinking easily after one or two drinks?	☐	☐	
Are you always able to stop drinking when you want to?	☐	☐	
Have you ever been to an Alcoholics Anonymous meeting?	☐	☐	
Have you ever gotten into fights while drinking?	☐	☐	
Has drinking ever created problems with your spouse/partner?	☐	☐	
Has your spouse/partner ever sought help because of your drinking?	☐	☐	
Have you ever lost a job because of drinking?	☐	☐	
Have you ever gotten into trouble at work because of drinking?	☐	☐	
Have you ever lost friends because of drinking?	☐	☐	
Have you ever neglected family, work or obligations for two days in a row because of drinking?	☐	☐	
Do you drink before noon?	☐	☐	
Have you ever been told you have liver problems or cirrhosis?	☐	☐	
Have you ever gone to anyone for help about your drinking?	☐	☐	
Have you ever been in a hospital because of drinking?	☐	☐	

Question	Yes	No	Details
Have you ever been a patient in a psychiatric hospital or regular hospital where drinking was part of the problem?	☐	☐	
Have you ever been seen at a psychiatric hospital or mental health clinic or gone to a doctor, social worker or clergyman for help with an emotional problem in which drinking played a part?	☐	☐	
Have you ever been arrested for drunken behavior?	☐	☐	
Have you ever been arrested for drunken driving?	☐	☐	
Have you ever been diagnosed as depressed?	☐	☐	
Do you feel depressed?	☐	☐	
Are you an alcoholic?	☐	☐	
When was your last drink of alcohol? (give date) _____			
How many glasses of alcohol do you drink each week? _____			

9. Psychiatric History

Condition	Yes	No
Have you ever been diagnosis with depression?	☐	☐
Have you ever been treated for depression?	☐	☐
Have you ever been hospitalized for psychiatric illness?	☐	☐
Have you ever attempted suicide?	☐	☐
Do you feel suicidal now?	☐	☐
Do you have a feeling of hopelessness	☐	☐
Do you describe yourself as anxious? (at times or consistently)	☐	☐
Have you ever been diagnosed with any other psychiatric disease? Details:_____	☐	☐
Please write any other additional comments about how you are feeling:		

For the following questions, please enter your number response in the Rank column as to how you feel:

Question	Description	Rank
Compared to one week ago, how would you rate your general health now	1 = Much better 2 = Somewhat better 3 = About the same 4 = Somewhat worse 5 = Much worse	

Question	Description	Rank
How much pain have you had during the past week?	1 = None 2 = Very mild 3 = Mild 4 = Moderate 5 = Severe 6 = Very severe	
During the past week, to what extent has your physical health or emotional problems interfered with your normal activities with family, friends, neighbors or groups?	1 = Not at all 2 = Slightly 3 = Moderately 4 = Quite a bit 5 = Extremely	
How much did this pain interfere with your normal work (in and out of the house)?	1 = Not at all 2 = Slightly 3 = Moderately 4 = Quite a bit 5 = Extremely	
During the past week, how often has your physical health or emotional problems interfered with your social activities (like visiting friends and relatives)?	1 = All of the time 2 = Most of the time 3 = Some of the time 4 = A little of the time 5 = None of the time	

During this past week, have you had any of the following problems with work or other regular daily activities as a result of ***emotional problems*** (such as depression or anxiety)? Please check Yes or No.

Question	Yes	No
Have you cut down on the amount of time spent on work or other activities?	☐	☐
Have you accomplished less than you would like?	☐	☐
Have you been unable to do work or other activities as carefully as usual?	☐	☐
Have you been diagnosed with PTSD (Post Traumatic Stress Disorder)?	☐	☐
Have you ever attempted suicide?	☐	☐
Do you feel suicidal now?	☐	☐
Do you have a feeling of hopelessness?	☐	☐
How many hours do you sleep at night? _____		
How often to you awake at night? _____		
Do you take naps during the day?	☐	☐
Do you take sleeping medications, over the counter or from a medical practitioner?	☐	☐
Do you describe yourself as anxious (at times or consistently)	☐	☐

During the past week, have you had any of the following problems with your work or other regular daily activities as a result of your ***physical health***?

Have you…	**Yes**	**No**
Cut down on the amount of time spent on work or other activities?	☐	☐
Accomplished less than you would like?	☐	☐
Been limited in the kind of work or other activities you like to do?	☐	☐
Had difficulty performing work or other activities (found it took more effort?)	☐	☐

How true or false are the following statements for you? Please circle the number that corresponds to how you feel after each statement:

Do you….	**Definitely True**	**Mostly True**	**Don't Know**	**Mostly False**	**Definitely False**
Seem to get sick easier than others?	1	2	3	4	5
Feel just as healthy as anyone you know?	1	2	3	4	5
Expect your health to get worse?	1	2	3	4	5

The following questions refer to how your health may limit daily activities. Please read the activity and circle the number that corresponds to how much your health limits you.

Activity	**Yes, Limited a lot**	**Yes, Limited a little**	**No, Not limited at all**
Vigorous activities such as running, lifting heavy objects, laying strenuous sports	1	2	3
Moderate activities such as moving a table, pushing a vacuum, bowling or playing golf	1	2	3
Lifting or carrying groceries	1	2	3
Climbing several flights of stairs	1	2	3
Climbing one flight of stairs	1	2	3
Bending, kneeling or stooping	1	2	3
Walking more than one mile	1	2	3
Walking several blocks	1	2	3
Walking one block	1	2	3
Bathing or dressing yourself	1	2	3

These next questions are about how you feel and how things have been during this past week. Please circle the number that corresponds most closely to how you have felt.

In the past week, how much of the time	Always	Most of the time	A good bit of the time	Some of the time	A little of the time	Never
Did you feel full of pep?	1	2	3	4	5	6
Have you been very nervous?	1	2	3	4	5	6
Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
Have you felt calm and peaceful?	1	2	3	4	5	6
Did you have a lot of energy?	1	2	3	4	5	6
Have you felt downhearted and blue?	1	2	3	4	5	6
Did you feel worn out?	1	2	3	4	5	6
Have you been a happy person?	1	2	3	4	5	6
Did you feel sick?	1	2	3	4	5	6

What one number or definition best fits your current medical condition? Circle the **percentage** (*only one*) in the table that best corresponds with the characteristic in the "criteria" column.

Definition	Criteria	Percentage
Able to carry on normal activity and work; no special care needed	Normal; no complaints or evidence of disease	100%
	Able to carry on normal activity; minor signs/symptoms of disease	90%
	Normal activity with effort; some (more than minor) signs/symptoms of disease	80%
Unable to work. Able to live at home and care for most personal needs. Varying amount of assistance needed.	Care for self. Unable to carry on normal activity or to do active work	70%
	Requires occasional assistance, but am able to care for most of my needs	60%
	Requires considerable assistance and frequent medical care	50%
Unable to care for self. Requires equivalent of institutional care. Disease may be progressing rapidly.	Disabled; requires special care/assistance	40%
	Severely disabled; hospitalization is needed; although death not imminent	30%

Center for Epidemiologic Studies Depression Scale (CESD-R)*

Circle the number for each statement that best describes how often you felt or behaved this way during the past week. Your provider will enter the "Score".

During the past Week.....	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	All of the time (5-7 days)	Score (Entry by provider)
1. I was bothered by things that usually don't bother me	0	1	2	3	
2. I did not feel like eating; my appetite was poor	0	1	2	3	
3. I felt that I could not shake off the blues even with the help from my family or friends	0	1	2	3	
4. I felt that I was just as good as other people	0	1	2	3	
5. I had trouble keeping my mind on what I was doing	0	1	2	3	
6. I felt depressed	0	1	2	3	
7. I felt that everything I did was an effort	0	1	2	3	
8. I felt hopeful about the future	0	1	2	3	
9. I thought my life had been a failure	0	1	2	3	
10. I felt fearful	0	1	2	3	
11. My sleep was restless	0	1	2	3	
12. I was happy	0	1	2	3	
13. I talked less than usual	0	1	2	3	
14. I felt lonely	0	1	2	3	
15. People were unfriendly	0	1	2	3	
16. I enjoyed life	0	1	2	3	
17. I had crying spells	0	1	2	3	
18. I felt sad	0	1	2	3	
19. I felt that people dislike me	0	1	2	3	
20. I could not get "going"	0	1	2	3	

* Public Domain

Signature (Patient, or Properly Designated Representative) Print Name

Relationship to Patient MM/DD/YYYY Time

Thank you for completing this questionnaire. This will help your doctor understand your health better. Please return this questionnaire to us at:

Instructions to Physician:

Your signature below indicates that you have reviewed the information contained in the entire questionnaire and you have reviewed the pertinent or key finding(s) with the patient and/or family.

Key findings must be summarized in our progress note; however, the questionnaire may be referenced for additional details.

PHYSICIAN SIGNATURE PRINT NAME MM/DD/YYYY TIME PAGER #