UnityPoint Health
Des Moines

CENTER FOR LIVER DISEASE

Name: _____ Date of Birth: _____/_____/_____

Date of Visit: _____/_____/_____

Pre Visit Questionnaire

What is your liver disease? _____ What was the cause if known? _____

Please list your medication allergies: _____
_____

Please list your medications or attach a separate list: _____
_____
_____

Have you ever had a blood transfusion? YES NO UNKNOWN If yes, when? _____

Have you ever used IV drugs or Nasal Cocaine? YES NO UNKNOWN

Do you currently use recreational drugs? YES NO

Did you use recreational drugs in the past? YES NO If yes, last use? _____

Have you ever had Acupuncture? YES NO UNKNOWN

Have you ever had Piercings? YES NO UNKNOWN

If yes, professional or home, prior to 1990? YES NO

Have you ever had Tattoos? YES NO UNKNOWN

If yes, professional or home or prison, prior to 1990? YES NO

Have you ever had more than 3 sexual partners in a 6 month period? YES NO UNKNOWN

Have you ever been or used a prostitute? YES NO UNKNOWN

Have you had exposure to chemical or toxins? YES NO UNKNOWN

Do you have a family history of liver disease or liver cancer? YES NO UNKNOWN

If yes, please list family member and disease _____

Have you ever been told you have hypertension (high blood pressure)? YES NO UNKNOWN

Have you ever been told you have Diabetes? YES NO UNKNOWN

*********PLEASE COMPLETE BACK SIDE*********

Have you ever been told you have Dyslipidemia (high cholesterol)? YES NO UNKNOWN

Have you used over the counter supplements, herbs, or vitamins?

If yes, please list _____

Do you currently drink Alcohol? YES NO If yes, beer wine liquor How many per week? ___

If no, did you drink alcohol heavily in the past?_____ When did you stop?_____

Do you currently smoke cigarettes or e-cigarettes? YES NO

If yes, more than ½ pack/day or less than ½ pack/day, and how many years?_____

If no, did you smoke cigarettes in the past? YES NO When did you quit?_____

Do you currently use nasal snuff or chewing tobacco? YES NO

If no, did you use smokeless tobacco in the past? YES NO When did you quit?_____

Have you been to ER or had any hospital stays recently/since your last office visit? YES NO

If yes, please explain when, where, and what for? _____

Who is your primary care doctor? _____

Who referred you to our office? _____

Please list any other specialists that you see: _____

_____

Have you had a liver biopsy? YES NO If yes, when and where? _____

Have you had an Upper Endoscopy or Colonoscopy? YES NO When and Where?_____

_____

Have you had an ultrasound, CT scan, or MRI of the abdomen/liver? YES NO

When and where? _____

*********PLEASE GIVE COMPLETED FORM TO THE NURSE*********

Name:_____ DOB:_____

Have you had any of the following?

- ☐ Varices on endoscopy
- ☐ Encephalopathy
- ☐ Ascites
- ☐ Sleepiness
- ☐ Bleeding varices
- ☐ Black tarry stool
- ☐ Vomiting blood
- ☐ Blood in stools
- ☐ Confusion
- ☐ Itching
- ☐ Fatigue
- ☐ Easy bruising
- ☐ Gallstones
- ☐ Yellow skin or eyes

Have you had any of the following infections?

- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Tuberculosis
- ☐ HIV

Do you have a Thyroid Disorder? YES NO

Details_____

Do you have Diabetes? YES NO

Date Diagnosed_____

Do you take insulin? YES NO

Do you have?

- ☐ Hypertension (high blood pressure)
- ☐ Chest pain/angina
- ☐ Shortness of breath
- ☐ Heart murmur
- ☐ Swelling of legs
- ☐ Heart attack (MI)
- ☐ High Cholesterol
- ☐ Difficulty breathing when sleeping or exercising

Have you had?

- ☐ COPD (Chronic Obstructive Pulmonary Disease
- ☐ Pneumonia
- ☐ Sinusitis
- ☐ Asthma
- ☐ Emphysema

Do you have any of these GI issues?

- ☐ Constipation
- ☐ Flatulence
- ☐ Rectal Bleeding
- ☐ Stomach Ulcers
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Abdominal Pain
- ☐ Loss of Appetite
- ☐ Weight Loss/gain

Dental History:

- ☐ Last Dental Exam: _____
- ☐ Do you wear Dentures? YES NO

Have you received a vaccine for Hepatitis A?
YES NO

Have you received a vaccine for Hepatitis B?
YES NO

Hepatitis B and C patients only:

- ☐ Are you currently taking any antiviral medications? YES NO
- ☐ Have you been treated with antiviral medication in the past? YES NO
  What and When?_____
  _____
  How Long?_____
  _____

*********PLEASE GIVE COMPLETED FORM TO THE NURSE*********