Rush Health System
Division of Hepatology

Date:______________

New Patient Data Base

Name: ______________________	Primary Care Doctor: ____________________
Address: ______________________	Address: ______________________________
Home Phone: ______________________	Phone #: ______________________________
Work Phone: ______________________	Fax #: ________________________________

Sex: M ___ F ___ Height _______ Age _______ Date of Birth ____/_____/_____

Current Problem

What is the main reason for your visit to the Hepatology/liver clinic?

____

____

Is English your primary language? ___Yes ___No My first language is__________________

What is your preferred Learning Method? ___Discussion ___Visual ___Reading ___Hands-on

Do you have any special learning needs? (Hearing/visual impairment, religious, etc.) ___Yes ___No

Have you had the following diseases or conditions?: (If yes which one and when did it start)

	No	Yes	When		No	Yes	When
Heart Disease (heart attacks, Failure,murmurs, or irregular heart beats)	___	___	_____	Bleeding problems	___	___	_____
				Pancreatitis	___	___	_____
Rheumatic Fever	___	___	_____	Diabetes	___	___	_____
High Blood Pressure	___	___	_____	Thyroid Disease	___	___	_____
High Blood Cholesterol	___	___	_____	Stomach Problems	___	___	_____
Anemia or blood problems	___	___	_____	Gall Bladder Disease	___	___	_____
Lung Disease (Asthma, Emphysema, tuberculosis)	___	___	_____	Seizures(Epilepsy)	___	___	_____
Kidney or Bladder Disease (infection, stones etc)	___	___	_____	Strokes or Paralysis	___	___	_____
Liver Disease(cirrhosis, hepatitis, Yellow jaundice)	___	___	_____	Psychiatric Problems (depression, suicide attempts, inpatient treatment)	___	___	_____
Cancer	___	___	_____	Skin Problems (changing moles, eczema, psoriasis)	___	___	_____
Arthritis	___	___	_____	Pain	___	___	_____

Other medical problems____

Previous Hospitalizations/Surgeries/Endoscopy or Xray Procedures

(Year) (Procedure)

____

____

____

____

____

____

Medication or Food Allergies (Are you allergic to any medication or food?)

Medication/Food Allergies Problems Experienced

____

____

____

____

Current Medications

(Include over-the-counter medication, antacids, laxatives, birth control pills, vitamins, herbs)

NAME	DOSE	HOW MANY TIMES PER DAY	LENGTH OF TIME TAKEN

Have you ever taken any of the following medicines? (circle)

Oral Diabetic Medications (Glucophage, Rezulin, DiaBeta) Insulin
Milk Thistle Vitamin E
Iron Steroids (prednisone, androgens, testosterone, DHEA)

Preventative Health Maintenance

	Date		Date
Mammogram	____________	Yearly Stool Occult Blood Test	____________
Pap Smear	____________	Flexible Sigmoidoscopy/Colonoscopy	____________
Digital Prostate Exam	____________	Fasting Cholesterol Profile	____________
Blood PSA level	____________	Hepatitis B Immunization	____________
		Hepatitis A Immunization	____________
Annual flue shot	____________	Pneumonia Immunization	____________

Review of Symptoms

		No	Yes
General	In the past six months have you lost or gained over 5 lbs?	____	____
	Do you have recurrent unexplained fevers?	____	____
	Do you have fatigue you consider significant?	____	____
Eyes	Do you have intermittent loss of vision or double vision?	____	____
ENT	Do you have problems with hearing?	____	____
	Do you have problems with speech?	____	____
Heart	Do you have chest pain that concerns you?	____	____
	Do you have episodes of irregular heartbeats?	____	____
	Are you bothered by dizzy spells?	____	____
Respiratory	Do you have a persistent cough?	____	____
	Do you get short of breath easily or wheeze?	____	____
	Have you ever coughed up blood?	____	____
GI	Do you have difficulty swallowing food or liquids?	____	____
	Have you noted a recent change in appetite?	____	____
	Have you ever vomited blood or been told you had varices?	____	____
	Do you have abdominal pain that concerns you?	____	____
	Have you noted black or tarry bowel movements?	____	____
	Have you noted any change in your bowel habits?	____	____
	Have you ever had ascites or fluid in your belly that was drained?	____	____
Genitourinary	Do you have discomfort when you urinate?	____	____
	Do you get up at night to urinate?	____	____
	[females]		
	Do you have any pain, lumps, or discharge in your breasts?	____	____
	Do you have any problems with your menstrual periods?	____	____
Skeletal	Do you have any pain or swelling in your joints?	____	____
Skin	Do you have any unexplained skin rashes?	____	____
	Do you have uncontrollable itching?	____	____
	Have you ever turned yellow or had jaundice?	____	____
Neurologic	Have you had a serious head injury or been knocked unconscious?	____	____
	Do you have any weakness or numbness in your arms or legs?	____	____
	Have you had episode of confusion or been lost in a familiar place?	____	____
Psychiatric	Are you bothered by depression?	____	____
	Do you have any personal problems you would like to discuss?	____	____
Endocrine	Have you become unusually thirsty recently?	____	____
	Do you sense room temperature differently from others?	____	____
Hematologic	Do you tend to bruise or bleed easily?	____	____
Immunologic	Do you get recurrent infections requiring antibiotics?	____	____

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Family History [Does anyone in your family have/had the following?]

	No	Yes	Who
Asthma	___	___	___
Heart Disease	___	___	___
Hypertension	___	___	___
Stroke	___	___	___
Cancer	___	___	___
Colon Polyps	___	___	___
High Cholesterol	___	___	___
Ulcerative Colitis/Crohn's	___	___	___
Diabetes	___	___	___
Liver disease	___	___	___

Social History

Marital status: Married___ Single___ Widowed___ Divorced___ No. of Children___

Occupation (Current or Previous):______________________________

Retired? ___ Disability? ____ Unemployed? ____

Have you traveled outside the U.S. in the last year? ______________________________

Cigarettes? No___ Yes___ Packs/day___ Years___

Do you use alcohol? No___ Yes___ How many drinks per week?___ Month? ____
Date of last drink________

Do you exercise? No___ Yes___ What kind?_________ How often?________

Have you ever had a blood transfusion? No___ Yes___ When?____________

What was your weight at age 20? ___________ age 40?___________

______________________________ ____________________
Patient Signature Date

Reviewed by: _______________ MD

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