Patient Name:

MRN:

DOB:

# Liver Transplant & Hepatobiliary Surgery

## Registration & Patient/Family History Questionnaire Form

| Demographics: | | |
|---|---|---|
| Name: | | Date of Birth: |
| Address: | | Social Security No.: |
| City: | | Marital Status: |
| State: Zip: | | ☐Single ☐Married ☐Divorced ☐Widowed |
| Home Phone #: | | Maiden Name: |
| Cell Phone # | | Mother's Maiden Name: |
| Work Phone # | | Father's Name: |
| Email: | | Emergency Contact (Name, Address, Phone & DOB) |
| Nearest Relative/Next of Kin (Name, Address, Phone, DOB) | | |
| Ethnicity / Race: | Gender: | Are you a US Citizen or Legal Resident? ☐ Yes ☐ No ☐ Other, _______________ |
| Are you currently Employed __ Yes __ No? If Yes, Name / Address / Phone of Employer _______________________________________________ Hire Date ___________. If no, what is the reason for unemployment, and what was your last occupation________________________ ______________________________________________________________________________ | | |
| Referring Physician: | | Phone #: |
| Primary Care Physician/Family Doctor: | | Phone #: |

**This questionnaire has seven (7) pages. Please read it all carefully and answer all of the questions. By filling it out you will provide us with significant information related to your health that may have an impact on the decisions we will make to help you get better. In addition, it will help us to make your visit shorter. We hold your information to strict levels of confidentiality. Attached is your notice of Privacy Practices of the University of Kentucky.**

**What is your current medical problem or reason for today's visit?**

____________________________________________________________________________

**Review of Systems**: please check ✓ the square of each symptom if you have experienced it in the past 2 to 4 weeks. Check "**NONE**" at the end of the list if you **HAVE NOT** experienced any of the listed symptoms. **In the last two to four weeks, have you had?**

| | | |
|---|---|---|
| ☐ Fever | ☐ Unexplained weight gain | ☐ Joint problems |
| ☐ Enlarged glands (lymph nodes) | ☐ Unexplained weight loss | ☐ Back problems |
| ☐ Headache | ☐ Difficulty swallowing | ☐ Problems with circulation of legs |
| ☐ Problems with your vision | ☐ Heartburn | ☐ Swelling in legs/feet |
| ☐ Eye pain or redness | ☐ Nausea or Vomiting | ☐ Bruise/bleed easily |
| ☐ Hearing Loss | ☐ Persistent Abdominal Pain | ☐ Chills |
| ☐ Dizziness | ☐ Diarrhea | ☐ Night sweats |
| ☐ Sinus problems | ☐ Constipation | ☐ Skin rashes or skin changes |
| ☐ Nose bleeds | ☐ Blood in your stools or dark stools | ☐ Changes in moles |
| ☐ Bleeding gums | ☐ Change in appetite | ☐ Itching |
| ☐ Mouth sores | ☐ Excessive thirst | ☐ Frequent headaches |
| ☐ Sore throat | ☐ Burning or pain with urination | ☐ Slurred speech |
| ☐ Hoarseness | ☐ Difficulty starting urinary stream | ☐ Personality changes |
| ☐ Breast lump | ☐ Difficulty emptying your bladder | ☐ Feeling depressed |
| ☐ Abnormal nipple discharge | ☐ Excessive urination | ☐ Memory disturbance |
| ☐ Persistent cough | ☐ Difficulty with leaking urine | ☐ Problems falling/staying asleep |
| ☐ Coughing up blood | ☐ Blood in your urine | ☐ Fatigue |
| ☐ Shortness of breath | ☐ Passing out | ☐ Dizziness or loss of balance |
| ☐ Wheezing | ☐ Changes in sexual drive or function | ☐ Difficulty moving an arm or a leg |
| ☐ Chest pain or chest pressure | ☐ Passing out | ☐ Seizures |
| ☐ Palpitations or fast heart beat | ☐ Involuntary tremors or shakes | ☐ Shortness of breath when walking or climbing stairs |
| ☐ Pain in the calves of your legs when walking | ☐ Muscle pain or weakness | ☐ **NONE** |
| ☐ Loss of consciousness | ☐ Numbness or tingling | |

**Only for WOMEN:**

| | |
|---|---|
| **Number of previous pregnancies** | |
| **Current birth control method** | |
| **Date of last OB/GYN visit** | |
| **Date of last menstrual period** | |
| **Date of last mammogram** | |
| **Date of last PAP smear** | |
| **Miscarriages** | |

**Have you ever had a reaction or allergy to any medication, dye or food:** ☐ YES ☐ NO.
If **YES** explain below: ____________________________________________________

List **ALL** current medications you are taking, including over-the-counter, or any other not prescribed by a health professional (vitamins, herbal supplements, etc.):

| Name of Medication | Dose (Strength) | How often taken | | Name of Medication | Dose (Strength) | How often taken |
|---|---|---|---|---|---|---|
| | | | | | | |
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Check ✓below **ANY** medical problems that run in your family and indicate family member to whom these condition(s) apply (**if not mentioned please fill in the blanks available at the end**):

| Family Conditions | Mother | Father | Grandparent | Siblings | Child |
|---|---|---|---|---|---|
| ☐ Colon cancer / Colon polyps | | | | | |
| ☐ Liver diseases, including cirrhosis | | | | | |
| ☐ Hepatitis | | | | | |
| ☐ Heart disease | | | | | |
| ☐ Alcoholism/Drug addiction | | | | | |
| ☐ Diabetes/High Blood Sugar | | | | | |
| ☐ Hypertension/High Blood Pressure | | | | | |
| ☐ Lung disease | | | | | |
| ☐ Kidney disease | | | | | |
| ☐ Cancer of any type | | | | | |
| ☐ Depression | | | | | |
| ☐ Bleeding Disorder | | | | | |
| ☐ Strokes | | | | | |
| ☐ | | | | | |
| ☐ | | | | | |
| ☐ | | | | | |
| ☐ | | | | | |
| ☐ | | | | | |
| ☐ | | | | | |

**Social History (Please check and fill in the blanks)**

Current marital status: ☐ Single; ☐ Married; ☐ Divorced; ☐ Separated; ☐ Widow(er).

Who do you live with? ____________________________________________________________

Who will help take care of you after you have had your transplant? ___________________________

How many years of education do you have? __________________________________________

Check ✓ **ONLY** the highest level of education that you have achieved**.**

| | COMPLETE | INCOMPLETE |
|---|---|---|
| Primary School | | |
| Middle School | | |
| High School | | |
| College (undergraduate) | | |
| Graduate studies | | |

**Please check ✓ all those that apply to you**.

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Do you have tattoos? | | | Have you spent time in jail? | | |
| Do you have body piercing? | | | Have you lived abroad? | | |
| Have you spent time in the military? | | | Have you had sexual transmitted diseases such as gonorrhea, syphilis, or similar. | | |
| Have you traveled abroad? | | | | | |

**Please list any additional Physicians or Healthcare Professionals that you may see:**

| Name | Phone | Provider type (Cardiologist, Endocrinologist, Etc.) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
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| | | |
| | | |
| | | |

**1)** Have you ever used nicotine (cigarettes, chewing tobacco, electronic cigarette)? ☐ **YES** ☐ **NO**

If **YES**: For how long? _____ years. How old were you when you started using nicotine? ______ years

How much? _____ per day. I continue nicotine ☐ **YES** ☐ **NO**.

If **NO** when did you stop using nicotine? ___________

**2)** Do you currently drink alcohol or have you ever drunk alcohol? ☐ **YES** ☐ **NO**

If **YES**: For how long? _____ years.How old were you when you started drinking? _______ years

How often? ____________ How much? _____________ What kind of alcohol?_________________

I continue drinking ☐ **YES** ☐ **NO**. If **NO** when did you stop drinking? _______________________

Have you participated in any kind of rehabilitation program such as AA?_____________________

**3)** Do you currently use drugs (cocaine, marijuana or alike) or have you ever used drugs?

☐ **YES** ☐ **NO** If **YES**: For how long? _____ years. How old were you when you started using drugs? _______ years

What kind of drugs? ___________________________________ How often?__________________

I continue using ☐ **YES** ☐ **NO**. If **NO**, when did you stop using it? _________________________

Have you participated in any kind of rehabilitation program? ☐ **YES** ☐ **NO**

**4)** Have you ever received blood transfusions or similar? ☐ **YES** or ☐ **NO**. If **YES**, what was the year you received it (them) and why: ________________________________________________

**Have you had ANY kind of operation/surgery in the past? ☐ YES or ☐ NO. If YES please explain (Please mention ALL of them).**

| Type of Operation/Surgery | Date of Operation |
|---|---|
| | |
| | |
| | |
| | |

**Have you ever had any of the following procedures done? If you have had the same procedure done several times, please mention the LAST time it was done. If not mentioned, please use blank cells available at the end.**

| PROCEDURE | DATE | WHY? | WHERE? |
|---|---|---|---|
| Upper endoscopy | | | |
| Colonoscopy or similar | | | |
| Ultrasound | | | |
| Scanner, CT scan or MRI | | | |
| Bone density scan | | | |
| Chest X-Ray | | | |
| Echocardiogram | | | |
| Cardiac cath | | | |
| Last eye exam | | | |

**Do you HAVE or HAVE HAD any of the following health problems and/or diseases? Please check ✓ all those that apply to you. If not you've had a health problem that is not listed, please write it at the bottom of this page.**

| **Health Problem and/or Disease** | ✓ | **Explain** |
|---|---|---|
| Any kind of Cancer | ☐ | |
| Diabetes mellitus (high blood sugar) | ☐ | |
| Arterial Hypertension (high blood pressure) | ☐ | |
| High cholesterol | ☐ | |
| Heart attack | ☐ | |
| Congestive Heart failure or any other heart problems (irregular heart beats, chest pain, etc) | ☐ | |
| Emphysema/Black lung | ☐ | |
| Pneumonia | ☐ | |
| Asthma or COPD | ☐ | |
| Stomach/duodenal ulcers | ☐ | |
| Crohn's Disease/Ulcerative colitis | ☐ | |
| Hepatitis of any type | ☐ | |
| Other problems with your liver (jaundice, yellow skin/eye color, etc) | ☐ | |
| Gallstones | ☐ | |
| Urinary Tract Infection | ☐ | |
| Kidney stones | ☐ | |
| Any other kind of kidney diseases | ☐ | |
| Thyroid problems | ☐ | |
| Epilepsy/Seizures | ☐ | |
| Glaucoma or other kind of eye problems | ☐ | |
| Tuberculosis or positive TB skin test | ☐ | |
| Ear infections or other kind of ear problems | ☐ | |
| Dental problems | ☐ | |
| Bone fractures | ☐ | |
| Herpes zoster | ☐ | |
| Meningitis | ☐ | |
| Blood cloating/bleeding problems | ☐ | |
| Anemia | ☐ | |
| Stroke or cerebral hemorrhage or bleeding | ☐ | |
| Problems with your pancreas | ☐ | |
| Any kind of trauma or accident | ☐ | |
| Problems with your joints or bones (arthritis, gout, spine problems, osteoporosis, etc) | ☐ | |
| Physical or sexual abuse | ☐ | |
| Depression or any other kind of psychological, emotional or psychiatric problem | ☐ | |
| Low blood pressure | ☐ | |
| Low blood sugar | ☐ | |
| Ulcers | ☐ | |
| | ☐ | |

**PLEASE WRITE ANY COMMENTS OR PROVIDE US WITH ANY ADDITIONAL INFORMATION THAT YOU THINK MAY BE RELEVANT OR IMPORTANT FOR US TO KNOW:**