[Patient Label]

Ronald Reagan UCLA Medical Center
Asian Liver Program

PATIENT HEALTH HISTORY

(Confidential)

NOTE: This is a confidential record and will be kept in your doctor's office. This information will not be released without your authorization.

Today's Date: _____/_____/_____ Age _____ Birthdate: ____/____/____ SSN# _____

Last Name: _____ First Name: _____ MI: _____

Address: _____City_____State_____Zip_____

Referring Physician: _____MD Phone: ( )_____

Address_____City_____State_____Zip_____

Oncologist: _____MD Phone: ( )_____

Address: _____City_____State_____Zip_____

Primary Care Physician: _____ Phone: ( )_____

Chief Complaint: (What is the main reason for your visit today?) _____

Medical History

Surgeries: Please list type of surgery and date of operation.

1. Type_____ Date_____ 2. Type _____ Date_____

Medical Illnesses: Have you ever had any of the following?

Disease	Yes	No	Date	Disease	Yes	No	Date
Hepatitis A				Heart murmur			
Hepatitis B				Rheumatic fever			
Hepatitis C				Stroke or mini-stroke			
Jaundice				Kidney disease			
Diabetes				Dialysis			
Angina				Ulcer			
Heart Attack				Gallstones			
High blood pressure				Seizure disorder			
Asthma				Psychiatric disorder			
Emphysema				Blood transfusion			
Liver Cancer				Other Cancer			
TIPPS							

Screenings: What is the most recent date and results of the following, if applicable?

Test	Yes	No	Date	Result
Colonoscopy				
Mammogram				
Pelvic Exam/ Pap Smear				
Digital rectal exam				
EKG (electrocardiogram)				
Chest CT scan				
Abdominal CT scan				
Bone scan				
PET scan				
MRI				

Adjuvant Therapy: If you have or had liver cancer, please state which treatment(s) you have received. Please list your most recent treatments.

1. Chemotherapy:

Date _____ Hospital _____ Date _____ Hospital _____

2. Radiation Therapy:

Date _____ Hospital _____ Date _____ Hospital _____

3. Chemoembolization:

Date _____ Hospital _____ Date _____ Hospital _____

4. Alcohol Injection:

Date _____ Hospital _____ Date _____ Hospital _____

5. Radiofrequency Ablation:

Date _____ Hospital _____ Date _____ Hospital _____

Medications: List the medications your are presently taking.

Medication	Strength	Frequency	Date started
1.			
2.			
3.			
4.			
5.			

Allergies: Please list any medications or foods you are allergic to.

_____

Family History: Do you have any family history of the following problems?

1. Liver Disease Yes / No If yes, who? _____ 6. Kidney Disease Yes / No If yes, who?_____

2. Heart Disease Yes / No If yes, who? _____ 7. Anesthesia Difficulty Yes / No If yes, who? _____

3. Cancer Yes / No If yes, who? _____ 8. Diabetes Yes / No If yes, who? _____

4. Ulcerative Colitis Yes / No If yes, who? _____ 9. Stroke Yes / No If yes, who? _____

5. Alcoholism Yes / No If yes, who? _____

Family Profile:

Relative	Living	Dead	Age	Cause of death
Mother				
Father				
Brothers				
Sisters				
Maternal Grandmother				

Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				

Race:

Caucasian _____ African American _____ Asian _____ Hispanic _____ Other (please specify) _____

Marital Status: o Single o Married o Divorced o Widow **Children:** o Yes o No If yes, how many? _____

Social History:

Are you currently working? Yes / No If yes, what type if work do you do? _____

Are you exposed to any chemicals, toxins, fumes, or asbestos in your workplace? Yes / No If yes, please specify_____

_____ How many years have you been working? _____

Habits:

Do you smoke cigarettes / tobacco Yes / No If yes, how long? _____ If you quit smoking, please specify when _____

Do you drink alcohol Yes / No If yes, how much daily? _____ If you quit drinking, please specify when _____

Have you ever done intravenous drugs? Yes / No If you have but you have quit, please specify when _____

Have you ever had acupuncture? Yes / No Do you have any tattoos? Yes / No

Do you exercise regularly? Yes / No If yes, how many times a week? _____

Review of Systems

Please explain any yes answers in the space provided.

Constitutions Symptoms: Fever Yes No Chills Yes No Headache Yes No Other: _____		**Integumentary:** Skin Rash Yes No Boils Yes No Persistent Itch Yes No Other: _____	
Eyes: Blurred vision Yes No Double vision Yes No Pain Yes No Other: _____		**Musculoskeletal:** Joint pain Yes No Neck pain Yes No Back pain Yes No Other: _____	
Allergic / Immunologic: Hay fever Yes No Drug allergies Yes No Other: _____		**Ear/ Nose/ Throat/ Mouth:** Ear infection Yes No Sore throat Yes No Sinus problems Yes No Other: _____	
Neurological: Termers Yes No Dizzy spells Yes No Numbness Yes No Other: _____		**Genitourinary:** Urinary retention Yes No Painful Urination Yes No Urinary frequency Yes No Other: _____	
Gastrointestinal Abdominal pain Yes No Nausea/vomiting Yes No Heartburn Yes No Other: _____		**Respitory:** Wheezing Yes No Frequent cough Yes No Shortness of breath Yes No Other: _____	
Cardiovascular: Chest pain Yes No Vericose veins Yes No High blood pressure Yes No Other: _____		**Hemotalogic/Lymphatic:** Swollen glands Yes No Blood clotting Yes No Other: _____	

Physician Use Only

Physical Exam

Vitals: P _____ T _____ BP _____ Resp _____ Hydration Asses _____ Wt _____

General Appearance: _____

		(-)	Positive Findings	GI	Abdomen/Bowel sounds	(-)	Positive Findings
Eyes	Conjunctival/Lids				Liver and Spleen		
	Pupils/Irises				Hernia		
	Optic discs				Anus,perineum, rectum		
					Hemocult (occult blood)		
ENMT	External				Umbilicus		
	Otoscopic						
	Hearing			**GU**	Scrotal contents		
	Nasal mucosa				Penis		
	Lips/teeth/gums				Kidneys		
	Oropharynx				External genitalia		
					Urethra		
Neck	Appearance/masses				Bladder		
	Thyroid				Cervix		
	Nuchal rigity				Uterus		
					Adnexa / patametria		
Resp	Respitory effort						
	Chest percussion			**MS**	Gait and station		
	Chest palpation				Digits and nails		
	Lung ascultation				Hip		
					Joints/bone/muscles		
CV	Heart palpation				Inspection/ palpation		
	Heart ascultation				Range of motion		
	Carotid arteries				Stability		
	Abdominal aorta				Muscle, strength, tone		
	Heart bruit						
	Pedal pulses			**Skin**	Inspection		
	Edema				Palpation		
	Capillary refill						
				Neuro	Cranial nerves		
Breast	Breast inspection				Deep tendon reflexes		
	Breast palpation				Neonatal reflexes		
	Developmental Asses				Sensation		
				Developmental	Gross motor		
Lymphatic	Neck				Fine motor		
	Axillae						
	Groin						
	Other						

Assessment /
Plan:_____

_____
_____
_____
_____
_____
_____
_____
_____

Print Name_____ Signature _____ Beeper #_____ Date _____