Name: _____ Date of Visit: _____

Date of Birth: _____ Referred by: _____

Med Record Number _____ Preferred lab: □ Labcorp □ Quest □ Inova □ Other

Reason for visit: Phone No: _____

Email:

DRUG ALLERGIES

□ No known drug allergies

□ YES (please list, along with type of reaction) _____

MEDICATIONS (list dosage and frequency)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

YOUR MEDICAL HISTORY	YES	NO
Anxiety		
Arthritis		
Ascites / Fluid in the Abdomen		
Asthma or COPD		
Benign Liver Lesions		
Cancer		
Cirrhosis		
Coronary Artery Dis / Heart Attack		
Heart Surgery, Bypass, Stents		
Crohn's Disease / Ulcerative Colitis		
Borderline diabetes / IFG		
Diabetes type I		
Diabetes type 2		
Depression		
GERD / Acid Reflux		
Hemochromatosis		
Hepatitis		
Hepatic Encephalopathy		

	YES	NO
High Cholesterol		
High Blood Pressure		
Infertility		
Kidney Disease		
Liver Cancer		
Psychiatric Disease		
NAFLD		
NASH		
Obesity		
Pancreatitis		
Peripheral Artery Disease / PVD		
PCOS (polycystic ovary syndrome)		
Sleep Apnea		
Stroke		
Thyroid Disorder		
Ulcers		
Variceal (Upper GI) Bleeding		

YOUR SURGICAL HISTORY	YES	NO
Appendectomy		
- Lap band		
- Roux-en-y gastric bypass		
- Vertical banded gastroplasty		
- Duodenal switch		
- Other bariatric surgery		
Cholecystectomy (gallbladder)		
EGD (upper endoscopy)		
Hysterectomy		
Liver Biopsy		
Other		

FAMILY HISTORY	YES	NO
If yes, **which family member?**		
Cirrhosis or liver failure		
Coronary artery disease		
Heart attack		
Open heart surgery		
Coronary artery stents		
Diabetes		
Hepatitis		
Liver cancer		
Obesity		
Stroke		

HEPATITIS C HISTORY	YES	NO
Prior blood transfusion		
If you have hepatitis C, have you been treated before?		

If yes, when and where?

Name: _____ Date of Birth: _____

ALCOHOL USE	Never	If yes, how many servings per week
Glasses of wine		
Cans of beer		
Shots of liquor		
Drinks containing 0.5 oz of alcohol		
During the last 6 months, how many days did you have more than 5 drinks in a single day?		□ never □ less than 10 days □ more than 10 days
Years of drinking?		
Years of abstinence?		□ less than 5 years □ 5 - 10 years □ over 10 years

TOBACCO USE

Have you ever smoked?	□ YES	□ NO
If yes, how many packs per day?		
_____packs per day		
For how many years? _____ years		
If you've quit, when did you quit? _____		
Ready to quit?	□ YES	□ NO
Smokeless tobacco, snuff or chew?	□ YES	□ NO

DIET & EXERCISE

Do you exercise for at least 30 minutes, 3 times a week?	□ YES	□ NO
Structured active diet program?	□ YES	□ NO
Previous weight loss attempt?	□ YES	□ NO

What type of work do you do?

With whom do you live?

HAVE YOU EVER HAD	YES	NO	If yes, when?
fatigue			
itching			
unexplained weight loss			
weight gain			
significant night sweats			
difficulty sleeping			
blood disorders / problems clotting			
vomiting blood			
bloody stool			
black tarry stool			
vision changes			
thyroid issues			
chest pain			
difficulty breathing			
palpitations / irregular heart beats			
fainting / dizziness			
nausea / vomiting			
jaundice			
fluid in abdomen (ascites)			
encephalopathy (severe confusion)			
fluid retention in the legs (edema)			
change in appetite			
abdominal pain			
change in bowel habits			
muscle aches			
arthritis			
infertility			
confusion / memory problems			
depression			
anxiety			
rash			

Dear Patient,

Please fill out the attached Patient Medical History Form. Please remember to have your referring physician fax your medical records to us at (703) 776-4386 prior to your appointment. Please also bring or fax an insurance referral from your primary care physician if your insurance requires a referral. Otherwise, you will be responsible for all charges associated with your visit.

The Center for Liver Diseases is part of Inova Fairfax Hospital and is considered an outpatient hospital practice. For many insurance companies, the billing procedures and payment policies are different for private practice and outpatient hospital settings. In the case of outpatient hospital settings like ours, two separate bills are created for a single visit. One bill is for the clinic visit (the “facility” services) and the other for the direct physician services.

If you have any questions regarding the hospital setting fee, please contact Inova Health System’s patient accounts department at 571-423-5750. Or if you have any questions regarding the physician fee, please contact 703-776-2080. We look forward to meeting you.