LIVER SPECIALISTS of TEXAS

PATIENT INTAKE FORM

Reset Form | Save Form | Print Form | Submit Form

PATIENT INFORMATION

COMPLETE NAME (*Last Name, First Name Middle Name*)	GENDER	DATE OF BIRTH	TODAY'S DATE
	☐ Male ☐ Female		

MATICAL STATUS	NO. OF CHILDREN
☐ Single ☐ Married ☐ Divorced ☐ Separate ☐ Widowed ☐ Civil Union	

HOME NUMBER	MOBILE NUMBER	EMAIL

I would like to receive preventive care and follow up care reminders ☐ Yes ☐ No

ALLERGIES

☐ No known allergies	☐ Penicillin	☐ Sulfa
☐ No known drug allergies	☐ Propofol	☐ Fentanyl
☐ Latex	☐ Versed	☐ Eggs
☐ Iodine	☐ Demerol	☐ Other:

PAST OR PRESENT MEDICAL CONDITIONS

☐ None (*Please proceed to next section*)

Neurology

- ☐ Stroke
- ☐ Seizures / Epilepsy
- ☐ Dementia
- ☐ Parkinson's

Endocrine

- ☐ Thyroid Disorder
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Elevated Cholesterol

Lungs

- ☐ Asthma
- ☐ Pulmonary Fibrosis
- ☐ Sleep Apnea
- ☐ COPD

Urinary

- ☐ Enlarged Prostate
- ☐ Prostate Cancer
- ☐ Kidney Failure
- ☐ Kidney Stones

Rheumatology

- ☐ Fibromyalgia
- ☐ Rheumatoid Arthritis
- ☐ Autoimmune Disease
- ☐ Lupus

Psychiatric

- ☐ Anxiety Disorder
- ☐ Bipolar Disorder
- ☐ Schizophrenia
- ☐ Depression

Liver Specialists of Texas
6560 Fannin Street, Suite 2050
Houston, TX 77030
Phone: 713-794-0700
Fax: 713-794-0610
www.texasliver.com

Date of Birth:
Today's Date:

PATIENT INTAKE FORM

Cardiac

- ☐ Heart Attack
- ☐ Atrial Fibrillation
- ☐ Congestive Heart Failure
- ☐ High Blood Pressure
- ☐ Pulmonary Hypertension

Liver

- ☐ Fatty Liver
- ☐ Hemochromatosis (Iron overload)
- ☐ Elevated Liver Tests
- ☐ Cirrhosis
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Autoimmune Hepatitis

Blood

- ☐ Anemia
- ☐ Lymphoma
- ☐ Bleeding Disorder
- ☐ Leukemia

Cancer (please provide details below)

Gastrointestinal

- ☐ Barrett's Esophagus
- ☐ Colon Cancer
- ☐ Colon Polyps
- ☐ Irritable Bowel Syndrome
- ☐ GERD
- ☐ Ulcerative Colitis
- ☐ Lactose Intolerance
- ☐ Stomach Ulcer
- ☐ Crohn's Disease
- ☐ Celiac Disease
- ☐ H. Pylori
- ☐ Diverticulosis

Circulation

- ☐ Deep Vein Thrombosis
- ☐ Peripheral Vascular Disease
- ☐ Carotid Artery Disease
- ☐ Pulmonary Embolus

Other:

Any conditions not listed (please specify below)

Date of Birth:
Today's Date:

PATIENT INTAKE FORM

SOCIAL HISTORY

ALCOHOL

☐ None (*Please proceed to next section*)

Type	Number / Week	How Long (Years)
☐ Beer		
☐ Wine		
☐ Hard Liquor		

TOBACCO

Smoking Status

☐ Never Smoked (*Please proceed to next section*)

☐ Current, Every Day Smoker ☐ Current, Some Day Smoker ☐ Former Smoker

DRUG USE

☐ None (*Please proceed to next section*)

Type	Drug	Duration / Year	Date Last Used
☐ IV Drug			
☐ Nasal / Inhaled			
☐ Other			

DIAGNOSTIC STUDIES / TESTS

☐ None (*Please proceed to next section*)

Diagnostic	When	Diagnostic	When	Diagnostic	When
☐ Colonoscopy		☐ Upper Endoscopy		☐ ERCP	
☐ EUS		☐ Ultrasound		☐ MRI	
☐ CT Scan		☐ Liver Biopsy		☐ Recent Abs	
☐ DEXA Scan					

PREVIOUS PROCEDURES & SURGERIES

☐ None (*Please proceed to next section*)

☐ Cataract Surgery	☐ Pacemaker	☐ Defibrillator
☐ Heart Valve	☐ Gallbladder Removed	☐ Abdominal Aneurysm
☐ Appendectomy	☐ C-Section	☐ Hysterectomy
☐ Carotid Artery	☐ Breast Surgery	☐ Prostate Surgery
☐ Tubal Ligation	☐ Bowel Surgery	☐ Hemorrhoids
☐ Joint Surgery	☐ Coronary Artery Stent	☐ Lung transplant

Date of Birth:
Today's Date:

PATIENT INTAKE FORM

PREVIOUS PROCEDURES & SURGERIES (continued)

- ☐ Coronary Bypass
- ☐ Kidney Transplant
- ☐ Colon Resection
- ☐ Liver Transplant
- ☐ Thyroid Surgery
- ☐ Other:
- ☐ Tonsillectomy

IMMUNIZATION

☐ None (*Please proceed to next section*)

Type	When	Type	When	Type	When
☐ Flu Shot		☐ Pneumonia Vaccine		☐ Singles	
☐ HPV					

COLONOSCOPY

- ☐ Normal
- ☐ Diverticulosis
- ☐ Colitis
- ☐ Polyps

UPPER ENDOSCOPY

- ☐ Normal
- ☐ Gastritis
- ☐ Varices
- ☐ Barret's Esophagus
- ☐ Ulcers
- ☐ Esophagitis

FAMILY MEDICAN HISTORY

☐ No knowledge of family medical history

No family history of ☐ Colon Cancer ☐ Polyps

Diagnoses	Mother	Father	Sister	Brother	Daughter	Son	Grandmother	Grandfather	Aunt	Uncle
Colon Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Colon Polyps	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Celiac Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ulcerative Colitis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Crohn's Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Others:										
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Date of Birth:
Today's Date:

PATIENT INTAKE FORM

CURRENT MEDICATIONS

☐ None (*Please proceed to next section*)

Name of Medication	Dose	Frequency	Prescribed By	
			PCP	Specialist
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

PHARMACY

NAME		CONTACT NUMBER	
ADDRESS:NUMBER & STREET	CITY	STATE	ZIP

CONSENT TO IMPORT MEDICATION HISTORY

I consent to obtaining a history of my medications purchased at pharmacies. ☐ Yes ☐ No

REVIEW OF SYSTEMS

Please select all recent symptoms)

Symptoms	Yes	No
Cardiovascular		
Chest pain	☐	☐
Shortness of breath with exercise	☐	☐
Palpitations	☐	☐

Symptoms	Yes	No
Genitourinary		
Dark urine	☐	☐
Painful urination	☐	☐
Blood in urine	☐	☐

Date of Birth:
Today's Date:

PATIENT INTAKE FORM

REVIEW OF SYSTEMS (continued)

Symptoms	Yes	No
Constitutional		
Loss of appetite	☐	☐
Weight gain	☐	☐
Weight loss	☐	☐
ENMT		
Sore throat	☐	☐
Nose bleeds	☐	☐
Hoarseness	☐	☐
Endocrine		
Excessive thirst	☐	☐
Hair Loss	☐	☐
Heat intolerance	☐	☐
Gastrointestinal		
Abdominal pain	☐	☐
Abdominal bloating	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Difficulty swallowing	☐	☐
Gas	☐	☐
Heartburn	☐	☐
Nausea	☐	☐
Rectal bleeding	☐	☐
Vomiting	☐	☐

Symptoms	Yes	No
Integumentary		
Yellowing of the skin	☐	☐
Rash	☐	☐
Tattoos	☐	☐
Piercings	☐	☐
Musculoskeletal		
Arthritis	☐	☐
Back pain	☐	☐
Neurological		
Dizziness	☐	☐
Frequency headaches	☐	☐
Numbness or tingling	☐	☐
Confusion	☐	☐
Psychiatric		
Anxiety	☐	☐
Depression	☐	☐
Respiratory		
Cough	☐	☐
Coughing up blood	☐	☐
Wheezing	☐	☐
Others:		
	☐	☐
	☐	☐

PREPARED BY

This intake form was reviewed by ☐ Patient ☐ Parent ☐ Guardian ☐ Not one was present

COMPLETED BY

DATE