LIVER HEALTH RISK ASSESSMENT

PATIENT NAME: _____

DATE OF BIRTH: _____

DATE OF APPOINTMENT: _____

SECTION A: MEDICAL HISTORY

☐ DO YOU HAVE TYPE 2 DIABETES?

☐ DO YOU HAVE HYPERTENSION (HIGH BLOOD PRESSURE)?

☐ DO YOU HAVE HIGH CHOLESTEROL/ TRIGLYCERIDES?

☐ DO YOU HAVE FATTY LIVER/ NAFLD

☐ DO YOU HAVE ANY LIVER DISEASES?

☐ DO YOU HAVE HEPATITS B OR C?

THE LIVER SCAN IS COVERED BY MOST INSURANCE PLANS BASED ON THE ANSWERS PROVIDED ON THIS FORM. IF YOUR PLAN DOES NOT COVER THIS TEST THE SELF PAY COST IS $75. YOU MAY DECLINE THIS TEST IF YOU DECIDE TO DO SO. HOWEVER THE SCAN IS BENEFICIAL FOR THE PROVIDER TO PROVIDE THE BEST CARE.

SECTION B:

HOW MUCH DO YOU WEIGH? _____

HOW TALL ARE YOU? _____

IS YOUR BMI > 26? _____

SECTION C:

DO YOU DRINK ALCOHOL? ☐ NEVER ☐ OCCASSIONALLY/SOCIALLY ☐ DAILY

HOW MANY DRINKS PER WEEK? _____

SECTION D: SYMTPOMS

☐ ARE YOU EXPERIENCING FATIGUE?

☐ RIGHT UPPER ABDOMINAL PAIN?

☐ UNEXPLAINED WEIGHT CHANGES?

☐ JAUNDICE?

☐ LEG OR ABDOMINAL SWELLING

SECTION E: FAMILY HISTORY

☐ LIVER DISEASE?

☐ DIABETES?

☐ OBESITY