

SCREENING EVALUATION

Date of Evaluation ____/____/____
mm dd yy

SECTION I: DEMOGRAPHICS

1. Gender: Male Female

2. Date of birth ____/____/____
mm dd yy

3. Is the patient Hispanic, Latino, or Latina?

No

Yes

3.1 Specify origin:

1 Cuban

2 Mexican

3 Puerto Rican

4 Other: _____

4. With what race does the patient most identify?

White or Caucasian

Black or African-American

Asian

American Indian or Alaska Native

Native Hawaiian or other Pacific Islander

Other _____

5. In what country was the patient born?

1 Continental U.S., Alaska, or Hawaii

2 Other: _____

If the patient identifies a race other than White/Caucasian only or Black/African-American only OR was not born in the continental U.S., Alaska, or Hawaii the patient is not eligible to participate in this study. Discontinue the Screening Evaluation and do not complete the remainder of this form.

SECTION II: LIVER HISTORY

Does the patient have any of the following:

	<u>Yes</u>	<u>No</u>	<u>Unk</u>
1. Current or history of hepatic encephalopathy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Current or history of variceal hemorrhage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Current or history of ascites	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Current jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If the response to any of the above liver conditions is YES, the patient is not eligible to participate in this study. Discontinue the Screening Evaluation and do not complete the remainder of this form.

SECTION III: MEDICAL HISTORY

1. Has the patient been told by a doctor that he/she has diabetes? Yes No

IF YES

1.1 Current treatment: <input type="checkbox"/> 0 None <input type="checkbox"/> 1 Diet <input type="checkbox"/> 2 Oral medications <input type="checkbox"/> 3 Insulin
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2. Has the patient been told by a doctor that he/she has high blood pressure or hypertension?

Yes

IF YES

No

2.1 Current treatment (check all that apply): <input type="checkbox"/> None <input type="checkbox"/> Diet <input type="checkbox"/> ACE inhibitors <input type="checkbox"/> Beta blockers <input type="checkbox"/> Ca channel blockers <input type="checkbox"/> Diuretic <input type="checkbox"/> Vasodilators <input type="checkbox"/> Other: _____

3. Is the patient currently taking any of the following medications (check all that apply):

Lipid-lowering agents

IF YES

Specify type: <input type="checkbox"/> 1 Statins <input type="checkbox"/> 2 Other: _____

Gastro-intestinal medications

IF YES

Specify type: <input type="checkbox"/> 1 Histamine (H ₂) receptor antagonists <input type="checkbox"/> 2 Proton pump inhibitors <input type="checkbox"/> 3 Other: _____
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Antidepressant medications

Anxiolytic medications

Antipsychotic medications

Respiratory agents

Thyroid medications

Methadone

4. Is the patient currently taking any herbal supplements for chronic hepatitis C? Yes No

IF YES

Specify code(s): 4.1 ____ 4.3. ____ 4.5 ____ 4.2 ____ 4.4 ____ 4.6 ____

SECTION IV: SYMPTOMS

Does the patient currently have the following symptoms (within 48 hours):

- | | <u>Yes</u> | <u>No</u> | | <u>Yes</u> | <u>No</u> |
|--------------------------|--------------------------|--------------------------|------------------------------|--------------------------|--------------------------|
| 1. Fatigue | <input type="checkbox"/> | <input type="checkbox"/> | 14. Hair loss | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Weakness | <input type="checkbox"/> | <input type="checkbox"/> | 15. Fever | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Nausea | <input type="checkbox"/> | <input type="checkbox"/> | 16. Chills | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Vomiting | <input type="checkbox"/> | <input type="checkbox"/> | 17. Night sweats | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Poor appetite | <input type="checkbox"/> | <input type="checkbox"/> | 18. Cough | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Weight loss | <input type="checkbox"/> | <input type="checkbox"/> | 19. Shortness of breath | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Muscle aches | <input type="checkbox"/> | <input type="checkbox"/> | 20. Irritability | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Joint aches | <input type="checkbox"/> | <input type="checkbox"/> | 21. Trouble sleeping | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Headache | <input type="checkbox"/> | <input type="checkbox"/> | 22. Difficulty concentrating | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Pain over liver | <input type="checkbox"/> | <input type="checkbox"/> | 23. Depression | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Other abdominal pain | <input type="checkbox"/> | <input type="checkbox"/> | 24. Diarrhea | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Rash | <input type="checkbox"/> | <input type="checkbox"/> | 25. Constipation | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Itching | <input type="checkbox"/> | <input type="checkbox"/> | 26. Other | <input type="checkbox"/> | <input type="checkbox"/> |

IF YES

Specify: _____

SECTION V: DEPRESSION MANAGEMENT

1. Have you felt depressed, sad, or blue most of the time? Yes No
2. Have you often felt helpless about the future? Yes No
3. Have you had thoughts about harming or killing yourself or others? Yes No

SECTION VI: PHYSICAL EXAM

Height: _____ inches Hip: _____ inches
 Weight: _____ lbs. Waist: _____ inches
 Temperature: _____ °F
 Heart rate: _____ beats/min Blood pressure: _____ / _____ mmHg

Does the patient currently have the following conditions:

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
1. Muscle wasting	<input type="checkbox"/>	<input type="checkbox"/>	4. Enlarged liver	<input type="checkbox"/>	<input type="checkbox"/>
2. Spider angiomata	<input type="checkbox"/>	<input type="checkbox"/>	5. Tender liver	<input type="checkbox"/>	<input type="checkbox"/>
3. Pedal edema	<input type="checkbox"/>	<input type="checkbox"/>	6. Spleen enlargement	<input type="checkbox"/>	<input type="checkbox"/>

SECTION VII: SEROLOGIES

	<u>Results</u>		Date of sample mm/dd/yy	Not done	
	Positive	Negative			
1. Anti-HAV	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	Within past 12 months
2. Anti-HBs	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	
3. HBsAg	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	
4. Anti-HBc	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	
5. Anti-HIV	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	Screen 1
6. Anti-HCV	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	

SECTION VIII: SCREENING LABS

	Result	Not done	
1. Alpha-fetoprotein	_____ ng/ml	<input type="checkbox"/>	Screen 1
2. Cholesterol	_____ mg/dl	<input type="checkbox"/>	
3. TIBC	_____ mcg/dl	<input type="checkbox"/>	Within past 12 months
4. Serum iron	_____ mcg/dl	<input type="checkbox"/>	
5. Ferritin	_____ ng/ml	<input type="checkbox"/>	
6. ANA	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	<input type="checkbox"/>	
	Titer _____		
7. Alpha-1-antitrypsin	_____ mg/dl	<input type="checkbox"/>	Ever
8. Ceruloplasmin	_____ mg/dl	<input type="checkbox"/>	

SECTION IX: COMMENTS: Yes No

IF YES

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