SUMMIT MEDICAL GROUP

Hepatobiliary Questionnaire

MRN# DOB:

Patient Name: Date:

Provider:

Patient Name: _____ Ordering Provider**:** _____

Reason for today's exam: _____

1. **Have you had anything to eat or drink in the last 4 hours?** ☐ YES ☐ NO

   If yes, please describe: _____

2. **When was your last solid meal?** _____

3. **Have you taken any narcotic based pain medication in the last 4 hours?** ☐ YES ☐ NO

   If yes, please describe: _____

4. **Do you have a history of gallbladder or liver disease (e.g. gallstones, cirrhosis, hepatitis)?**

   ☐ YES ☐ NO

   If yes, please describe: _____

5. **Have you had any recent surgeries? (e.g. cholecystectomy, abdominal)** ☐ YES ☐ NO

   If yes, please specify surgery and date:

   _____

6. **Have you had testing pertaining to why you are here?** ☐ YES ☐ NO

   If yes, what test and when? _____

Female Patients Only:

7. **Is there a possibility you are pregnant**? ☐ YES ☐ NO

Signature

I have answered all the above questions to the best of my ability.

_____ _____

Patient Signature (or person authorized to sign for Patient) Date

_____

Relationship to Patient if signing for Patient

_____ _____

Interpreter Signature (or ID# if using service), as applicable Date