

Diagnosis	<input type="checkbox"/> Healthy Control	
Prior Hospitalization	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Reason for hospitalization (if yes, above, please answer)		
Prior Surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Type of surgery (if yes, above, please answer)		
Alcohol consumption (select one)	<input type="checkbox"/> None <input type="checkbox"/> less than 1 drink per week <input type="checkbox"/> 1-3 drinks per week	<input type="checkbox"/> 7 drinks per week <input type="checkbox"/> 14 drinks per week <input type="checkbox"/> more than 14 drinks per week
History of Hepatitis A	<input type="checkbox"/> Yes	<input type="checkbox"/> No
History of Hepatitis B	<input type="checkbox"/> Yes	<input type="checkbox"/> No
History of Hepatitis C	<input type="checkbox"/> Yes	<input type="checkbox"/> No
History of Other Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
History of Jaundice	<input type="checkbox"/> Yes	<input type="checkbox"/> No
History of Mononucleosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
History of HIV Infection	<input type="checkbox"/> Yes	<input type="checkbox"/> No
AST IU/L (range 10-41) (enter numeric value)		
ALT IU/L (range 10-40) (enter numeric value)		
Alkaline phosphatase mg/dL (range 605-1536) (enter numeric value)		
Bilirubin mg/dL (range 0.1-1.2) (enter numeric value)		
HCV antibody	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative
HBsAg	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative
HIV antibody	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative
IgG mg/dL (enter numeric value)		

<p>Subject Disease History (select all that apply)</p>	<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Attack <input type="checkbox"/> Heart Failure <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Dialysis or other kidney disease <input type="checkbox"/> Inflammatory Bowel Disease <input type="checkbox"/> Pancreatitis <input type="checkbox"/> Fatty Liver Disease <input type="checkbox"/> Cirrhosis	<input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Systemic Lupus Erythematous <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Other Muscle or Bone Disease <input type="checkbox"/> Lymphoma <input type="checkbox"/> Leukemia <input type="checkbox"/> Myeloma <input type="checkbox"/> Lung Cancer <input type="checkbox"/> Colon Cancer <input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Other Cancer <input type="checkbox"/> Alzheimer's Disease <input type="checkbox"/> Autism <input type="checkbox"/> Epilepsy <input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Manic-Depressive Disorder <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Drug or alcohol addiction <input type="checkbox"/> Viral Hepatitis
<p>Subject Disease History Comments</p>			
<p>Family Disease History (select all that apply)</p>	<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Attack <input type="checkbox"/> Heart Failure <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Dialysis or other kidney disease <input type="checkbox"/> Inflammatory Bowel Disease <input type="checkbox"/> Pancreatitis <input type="checkbox"/> Fatty Liver Disease <input type="checkbox"/> Cirrhosis	<input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Systemic Lupus Erythematous <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Other Muscle or Bone Disease <input type="checkbox"/> Lymphoma <input type="checkbox"/> Leukemia <input type="checkbox"/> Myeloma <input type="checkbox"/> Lung Cancer <input type="checkbox"/> Colon Cancer <input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Other Cancer <input type="checkbox"/> Alzheimer's Disease <input type="checkbox"/> Autism <input type="checkbox"/> Epilepsy <input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Manic-Depressive Disorder <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Drug or alcohol addiction <input type="checkbox"/> Viral Hepatitis
<p>Family Disease History Comments</p>			