Piedmont TRANSPLANT

Living Donor Medical Questionnaire

Please complete this form as well as you can. All information will be kept confidential.

Date form completed: _____ Person You Wish To Donate To: _____

Relationship: _____ Recipient's Date of Birth: _____

Do You Know Your Blood Type? Yes ☐ No ☐ If Yes, Please Specify: _____

Why would you like to be considered as a kidney donor**?** _____

Are you interested in Kidney Paired Donation if you are not compatible to your Recipient?

Yes ☐ No ☐ Need More Information ☐

Legal Name: _____ Maiden Name: _____

Address: _____ City/State: _____

Zip Code: _____ Email Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Race: _____

Age: _____ Date of Birth: _____ Sex: Male ☐ Female ☐

Height: _____ Weight: _____ Do You Have Health Insurance? Yes ☐ No ☐

Family Physician Name: _____ Phone Number: _____

Emergency Contact Name: _____ Phone Number: _____

Drug Allergies: _____ Latex Allergy: Yes ☐ No ☐

Food Allergy: _____ Iodine Allergy: Yes ☐ No ☐

Are you currently working? Yes ☐ No ☐

Please list your occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other/partner

Is your spouse/significant other supportive of you donating? Yes ☐ No ☐

Do you live alone? Yes ☐ No ☐ Who will help you after surgery? _____

Will donation create a financial burden? Yes ☐ No ☐

Does your employer know? Yes ☐ No ☐ Are they supportive? Yes ☐ No ☐

Are you willing to accept <u>BLOOD PRODUCTS / TRANSFUSIONS</u>? Yes ☐ No ☐

Have you ever had a blood transfusion? Yes ☐ No ☐ Date of transfusion: _____

If so, please provide more information:_____

<u>Past Medical History</u>: Please indicate if you have **EVER** had any of the following problems:

Anemia	Yes ☐	No ☐	HIV/AIDS	Yes ☐	No ☐
Arthritis	Yes ☐	No ☐	Kidney Disease	Yes ☐	No ☐
Back Problems	Yes ☐	No ☐	Bladder/Kidney Infections	Yes ☐	No ☐
Cancer	Yes ☐	No ☐	Kidney Stones	Yes ☐	No ☐
Chemical Dependency	Yes ☐	No ☐	Blood In Urine	Yes ☐	No ☐
Circulatory Problems	Yes ☐	No ☐	Protein In Urine	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐	Tuberculosis	Yes ☐	No ☐
Depression/Anxiety	Yes ☐	No ☐	Liver Disease	Yes ☐	No ☐
Emphysema/COPD	Yes ☐	No ☐	Stroke	Yes ☐	No ☐
Seizures	Yes ☐	No ☐	Pneumonia	Yes ☐	No ☐
Prostate Problems	Yes ☐	No ☐	Heart Murmur	Yes ☐	No ☐
Sleep Apnea	Yes ☐	No ☐	Abnormal Heart Rhythm	Yes ☐	No ☐
Heart Attack	Yes ☐	No ☐	Skin Ulcers	Yes ☐	No ☐
Heart Disease	Yes ☐	No ☐	Eclampsia/Pre-Eclampsia	Yes ☐	No ☐
Heart Valve Dysfunction	Yes ☐	No ☐	Gestational Diabetes	Yes ☐	No ☐
Asthma	Yes ☐	No ☐	Stomach Ulcers	Yes ☐	No ☐
Hepatitis	Yes ☐	No ☐	Gout	Yes ☐	No ☐
High Blood Pressure	Yes ☐	No ☐	Chronic Pain	Yes ☐	No ☐
Thyroid Problems	Yes ☐	No ☐	Blood Clots	Yes ☐	No ☐
Auto Immune Disease	Yes ☐	No ☐	Sexually Transmitted Disease	Yes ☐	No ☐

If yes to any of the above questions, please explain:

_____

_____

_____

_____

<u>Psychiatric History</u>:

- Have you ever been under the care of a counselor or psychiatrist? Yes ☐ No ☐
- Have you ever had a suicide attempt? Yes ☐ No ☐

Tuberculosis Exposure History: Please check Yes or No and enter dates and locations if know

Have you had close contact with a person (household or family member) known to have TB?

Yes ☐ No ☐ If yes, when? _____

Were you born or have you lived outside of the USA?

Yes ☐ No ☐ If yes, what country? _____

Have you **lived or traveled** to any of the following countries/regions? (mark those that apply)

☐ Asia ☐ Africa ☐ Mexico ☐ Haiti ☐ Central America ☐ South America

If yes, when? _____ How long? _____

Lived or worked in a homeless shelter, correctional facility, nursing home, medical clinic, rehab facility or hospital?

Yes ☐ No ☐ If yes, when? _____

Do you have a history of intravenous (IV) drug use?

Yes ☐ No ☐ If yes, when? _____

Have you had an abnormal chest X-ray or told you have scars on your lungs?

Yes ☐ No ☐ If yes, when? _____

Surgical History: List Any Operations You Have Had (Including Childhood)

SURGERIES/PROCEDURES	HOSPITAL	DATE

Medicines: Please list your current medications. Include over-the-counter drugs and any herbal or protein supplements:

MEDICATION	DOSE	REASON

How often do you take aspirin, ibuprofen (Motrin), naproxen (Alleve), or cold medications?

Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily ☐

Personal Habits:

Do you exercise regularly? Yes ☐ No ☐ If yes, what do you do? _____

Tobacco Use: Do you or have you ever smoked cigarettes? Yes ☐ No ☐

If yes, # packs per day? _____ How many years? _____ Date quit: _____

Alcohol Use: Do you or have you ever consumed alcohol on a regular basis? Yes ☐ No ☐

If yes, what type? _____ How much each day? _____

How often? _____ Date quit _____

Substance Use: Have you ever used any of the substances below?

Marijuana	Yes ☐	No ☐	If yes, date last used: _____
Cocaine/Crack	Yes ☐	No ☐	If yes, date last used: _____
Heroin or Narcotics	Yes ☐	No ☐	If yes, date last used: _____
Stimulants	Yes ☐	No ☐	If yes, date last used: _____
Sedatives	Yes ☐	No ☐	If yes, date last used: _____
Diet Pills	Yes ☐	No ☐	If yes, date last used: _____

When did you last use those substances? _____

Health Care Screening:

Have you had any of the following examinations? Please list date and result if known.

Colonoscopy? _____

Cardiac stress test? _____

MALES:

Have you had prostate cancer screening? _____

FEMALES:

If applicable, when was your last mammogram? _____

When was your last pap smear? _____

Have you ever had an abnormal pap smear or mammogram? Yes ☐ No ☐

Please indicate (if any): Total # of pregnancies _____ # of deliveries _____

Have you ever had pre-eclampsia, high blood pressure, or high blood sugar (diabetes) during a pregnancy? Yes ☐ No ☐

What is the date of your last menstrual period? _____

Are you currently pregnant? Yes ☐ No ☐

Family History:

*** Please check those that apply:**

	Mother	Father	Sister	Brother	Daughter	Son
Cancer						
Diabetes						
Heart Disease						
High Blood Pressure						
Kidney Disease						
Kidney Stones						

Review of Symptoms: Are you having any of the following problems NOW?

Please check all that apply.

General
- ☐ Weight loss
- ☐ Weight gain
- ☐ Fatigue
- ☐ Fevers
- ☐ Weakness

Respiratory
- ☐ Cough
- ☐ Wheezing
- ☐ Shortness of breath with rest

Muscular/skeletal
- ☐ Chronic joint pains/arthritis
- ☐ Chronic pain medications

Head, Eyes, Ears
- ☐ Severe headaches
- ☐ Double vision
- ☐ Earache

Cardiovascular
- ☐ Dizziness/Fainting
- ☐ Chest pain/discomfort/tightness
- ☐ Pain in calf muscles with walking
- ☐ Palpitations/fluttering in chest
- ☐ Swelling in legs

Neurologic/ Psychiatric
- ☐ Memory Loss
- ☐ Severe Anxiety
- ☐ Severe Depression

Skin
- ☐ Rashes

Gastrointestinal
- ☐ Severe heartburn
- ☐ Chronic diarrhea

Urinary
- ☐ Blood in urine
- ☐ Burning/pain with urination

Contact Information:

If you have internet access, may your **coordinator** correspond with you by email?

☐ **Yes. Please provide email address:** _____

☐ **No. Please provide preferred telephone number:** _____

Patient Signature: _____, **Date/Time:** _____

Reviewed By: _____, **Living Donor Coordinator, Date/Time:** _____