Piedmont TRANSPLANT

Living Donor Medical Questionnaire

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

Person You Wish To Donate To: _____

Relationship: _____

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

Why would you like to donate a kidney? _____

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

Yes ☐ No ☐ Need More Information ☐

Legal Name: _____ Address: _____

City/State: _____ Zip Code: _____

Email Address: _____ Cell/Home: _____

Preferred method(s) of contact: Email ☐ Cell/home ☐ Other: _____

Race/Ethnicity: _____ 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 Allergies: _____ 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 ☐

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Are you willing to accept <u>BLOOD PRODUCTS/TRANSFUSIONS if needed after surgery</u>? **Yes** ☐ **No** ☐

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

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

Anemia	Yes ☐	No ☐	Diabetes	Yes ☐	No ☐
Sickle cell/trait	Yes ☐	No ☐	Kidney Disease	Yes ☐	No ☐
Blood clots (legs/lungs)	Yes ☐	No ☐	Bladder/Kidney Infections	Yes ☐	No ☐
Cancer	Yes ☐	No ☐	Kidney Stones	Yes ☐	No ☐
Asthma	Yes ☐	No ☐	Blood In Urine	Yes ☐	
Tuberculosis	Yes ☐	No ☐	Protein In Urine	Yes ☐	No ☐
Emphysema/COPD	Yes ☐	No ☐	Hepatitis A, B or C	Yes ☐	No ☐
Sleep Apnea	Yes ☐	No ☐	Liver Disease	Yes ☐	No ☐
Pneumonia	Yes ☐	No ☐	Stroke	Yes ☐	No ☐
Heart murmur	Yes ☐	No ☐	Seizures	Yes ☐	No ☐
Heart attack, stent or bypass surgery	Yes ☐	No ☐	Stomach Ulcers/Reflux	Yes ☐	No ☐
Congestive heart failure	Yes ☐	No ☐	Skin Ulcers	Yes ☐	No ☐
Heart valve disorder	Yes ☐	No ☐	Arthritis	Yes ☐	No ☐
Arrhythmia	Yes ☐	No ☐	Back problems	Yes ☐	No ☐
High blood pressure	Yes ☐	No ☐	Chronic pain	Yes ☐	No ☐
Thyroid disorder	Yes ☐	No ☐	Gout	Yes ☐	No ☐
Autoimmune disease	Yes ☐	No ☐	Prostate problems	Yes ☐	No ☐
STD	Yes ☐	No ☐	HIV/AIDS	Yes ☐	No ☐

If you are (or have been) treated for **High Blood Pressure**, please indicate the number of years you were treated and medication prescribed:

_____

If you have a history of **Kidney Stones**, please indicate the number of episodes and treatment:

_____

_____

If yes to **ANY OTHER** of the above medical questions, please explain:

_____

_____

_____

Females:

Please indicate total number of Pregnancies: _____ Deliveries: _____

Have you ever had Pre-Eclampsia, High Blood Pressure, or High Blood Sugar (Diabetes) during pregnancy?

Yes ☐ No ☐ If yes, explain: _____

When was the date of your last menstrual period? _____

Are you currently pregnant? Yes ☐ No ☐ Nursing? Yes ☐ No ☐

Psychiatric History:

Have you been diagnosed and/or treated for any of the following:

Anxiety	Yes ☐ No ☐
Depression	Yes ☐ No ☐
Postpartum Depression	Yes ☐ No ☐
Schizophrenia	Yes ☐ No ☐
Bipolar disorder	Yes ☐ No ☐
PTSD	Yes ☐ No ☐
ADHD	Yes ☐ No ☐
Chronic Pain	Yes ☐ No ☐
Alcohol +/- Drug Addiction	Yes ☐ No ☐
Eating Disorder	Yes ☐ No ☐

Have you ever been under the care of a therapist, counselor or psychiatrist? Yes ☐ No ☐

Have you ever attempted suicide or intentionally hurt yourself? Yes ☐ No ☐

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

_____
_____
_____
_____
_____

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Tuberculosis Exposure History:

Have you had close contact (lived/worked) with a person known to have TB? Yes ☐ No ☐

Were you born or have you lived outside of the USA? Yes ☐ No ☐

Have you lived or traveled to Asia, Africa, Mexico, Haiti, Central America or South America? Yes ☐ No ☐

Lived or worked in a homeless shelter, correctional facility, nursing home, medical clinic, rehab facility or hospital? Yes ☐ No ☐

Do you have a history of intravenous (IV) drug use? Yes ☐ No ☐

Have you had an abnormal chest X-ray or told you have scars on your lungs? Yes ☐ No ☐

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

_____
_____
_____
_____
_____

Surgical History: List Any Operations You Have Had (including childhood)

SURGERIES/PROCEDURES	HOSPITAL	DATE

Medications: 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, number of 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 ☐

Cocaine/Crack Yes ☐ No ☐

Heroin or Narcotics Yes ☐ No ☐

Methamphetamine Yes ☐ No ☐

Stimulants Yes ☐ No ☐

Sedatives Yes ☐ No ☐

Diet Pills Yes ☐ No ☐

If yes, please describe drug, method of use (pill/smoked/injection), length of use and date last used:

_____

_____

_____

_____

Health Care Screening:

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

Colonoscopy Yes ☐ No ☐ _____

Cardiac Stress Test Yes ☐ No ☐ _____

Mammogram Yes ☐ No ☐ _____

Pap Smear Yes ☐ No ☐ _____

Family History:

Please check all that apply

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

Thank you for your interest in the Piedmont Kidney Living Donor Program.

A living donor coordinator will contact you within 5 business days.