HealthCare

Questionnaire for Living Kidney Donor Evaluation

Date: _____

Donor for: _____
Relationship: _____
MRN(*Office Use*) _____

Name: _____
Last First Middle Maiden

Address: _____

City: _____State: _____Zip Code: _____

Telephone Number: _____
Home Work Cell

E-mail address: _____

Date of Birth: _____Social Security Number: _____

Sex: _____ Marital Status: _____Race:_____

Height: _____ Weight: _____ Weight 1 year ago:_____

U.S. Citizen: ☐ Yes ☐ No If no, explain: _____

Where were you born?_____

Have you lived/traveled to Southeast Asia (Vietnam, Cambodia, Laos), Africa, Central or South America? ☐ Yes ☐ No

Mother's Maiden Name: _____

Name of Spouse/Significant Other: _____

Name of Employer: _____

Do you work outside the home? ☐ Yes ☐ No
If yes, describe occupation: _____

How long have you been at this job? _____

Will being off work put your job in jeopardy/cause unmanageable financial problems?
☐ Yes ☐ No

Do you receive a disability check? ☐ Yes ☐ No
If yes, what is your disability? _____

Does the recipient know of your wish to donate? ☐ Yes ☐ No

Have you ever been treated as a patient at the University of Kentucky? ☐ Yes ☐ No

Medical History

List all current medication: (include any pain medicines, "nerve" pills, over-the-counter, and herbal supplements)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Do you frequently use ibuprofen, naproxen, etc? ☐ Yes ☐ No

Allergies: (to medications and other allergies, **explain the reaction**)

_____ _____
_____ _____
_____ _____

Check if allergic to: ☐ Eggs ☐ Soybeans ☐ Shellfish ☐ PABA (sunscreen) ☐ Latex

Do you currently have **Health Insurance**? ☐ Yes ☐ No

Habits:

Smoking: ☐ Yes ☐ No _____ Packs per day for ___Years
Quit smoking: ☐ Yes ☐ No Date: _____
Smokeless tobacco: ☐ Yes ☐ No Date: _____
Alcoholic Beverages:
Present: ☐ Yes ☐ No Frequency_____ Amount____
Past: ☐ Yes ☐ No Frequency_____ Amount____
Recreational Drugs: ☐ Yes ☐ No Date: _____
Type: _____
Marijuana:
Present: ☐ Yes ☐ No Frequency _____
Past: ☐ Yes ☐ No Date_____
Tattoos ☐ Yes ☐ No
If yes, date of most recent tattoo: _____

Illnesses/Exposure to Infectious Disease:

Hepatitis ☐ Yes ☐ No
If yes, what type?_____ When?_____

Diabetes (High Sugar) ☐ Yes ☐ No
Yes? When _____ Treatment_____ How long? _____

Cancer: ☐ Yes ☐ No
If yes, what type? _____
How long ago? _____Was it treated? _____
Have you even been screened for skin cancer? ☐ Yes ☐ No
If yes, where & when? _____

Tuberculosis	☐ Yes ☐ No	Circulation disease	☐ Yes ☐ No
Chicken Pox	☐ Yes ☐ No	Muscle disease	☐ Yes ☐ No
HIV	☐ Yes ☐ No	Excessive bleeding/bruises	☐ Yes ☐ No
High cholesterol	☐ Yes ☐ No	Clotting disorders	☐ Yes ☐ No
High blood pressure	☐ Yes ☐ No		

Heart and Lungs:

Cough that doesn't go away	☐ Yes ☐ No	Heart Attack	☐ Yes ☐ No
Coughing up blood	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No
Shortness of breath	☐ Yes ☐ No	Cardiac Cath	☐ Yes ☐ No
Night sweats	☐ Yes ☐ No	Heart valve disease	☐ Yes ☐ No
Chest pain or pressure	☐ Yes ☐ No	Heart valve replacement	☐ Yes ☐ No
Rapid heartbeat/fluttering	☐ Yes ☐ No	Heart bypass surgery	☐ Yes ☐ No
Asthma/wheezing	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No
Abnormal EKG	☐ Yes ☐ No	Treatment required?	☐ Yes ☐ No
Abnormal Chest X-ray	☐ Yes ☐ No	Currently followed by a doctor?	☐ Yes ☐ No
		Rheumatic Fever	☐ Yes ☐ No

Intestinal:

Vomiting blood	☐ Yes ☐ No
Blood in stool/black tarry stools	☐ Yes ☐ No
Jaundice	☐ Yes ☐ No
Have you had a colonoscopy?	☐ Yes ☐ No

If yes- where and when _____

Women's Health:

Date of last pap smear _____Doctor/Center's name _____
Number of pregnancies____
During pregnancy, did you require treatment of high blood pressure? ☐ Yes ☐ No
During pregnancy, did you require treatment of elevated blood sugar? ☐ Yes ☐ No
Date of last mammogram_____ Doctor/Center's name _____

Neurologic:

Have you ever had a stroke? ☐ Yes ☐ No
Convulsions (epilepsy, seizures) ☐ Yes ☐ No
Depression ☐ Yes ☐ No
Anxiety ☐ Yes ☐ No

Urologic:

Kidney / Bladder infections ☐ Yes ☐ No
When was your last UTI? ____ How many have you had in the past 5 yrs? ____
How many have you had in your lifetime? _____
Treatment required _____
Painful urination ☐ Yes ☐ No
Blood in urine ☐ Yes ☐ No
When? _____ Were you evaluated or treated?_____
Where?_____
Problems emptying bladder ☐ Yes ☐ No
Kidney stones ☐ Yes ☐ No
If yes, how many? ____
Any other known information about the stones _____

Blood/Transfusions

What is your blood type? (If known) _____
Have you ever had a transfusion? ☐ Yes ☐ No
Are you willing to accept transfusions? ☐ Yes ☐ No

Surgery:

List any operations, dates, and reason for surgery

_____
_____
_____

With previous anesthesia, did you have any unexplained fever, or any other problem?

_____

Have you been hospitalized or seen by a health care provider in the last 12 months? ____
If yes, please give dates & reason:

_____
_____

Have you had lab work done in the last 6 months? ☐ Yes ☐ No
If so, where?_____

Family History

Please give current health history of each relative. Include any Chronic Diseases such as Diabetes, High Blood Pressure, Kidney Disease, etc. *(If deceased, please check the box at left and list cause of death and age at death.)*

Relative	**Age**	
☐ Father	___	_____
☐ Mother	___	_____
☐ Brother/Sister	___	_____
☐ Brother/Sister	___	_____
☐ Brother/Sister	___	_____
☐ Brother/Sister	___	_____

Children

Number of children _____

Age	Health History
___	_____
___	_____
___	_____
___	_____
___	_____

Other important information related to your medical history: