

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
 Chicken Pox Yes No
 HIV Yes No
 High cholesterol Yes No
 High blood pressure Yes No

Circulation disease Yes No
 Muscle disease Yes No
 Excessive bleeding/bruises Yes No
 Clotting disorders Yes No

Heart and Lungs:

Cough that doesn't go away Yes No
 Coughing up blood Yes No
 Shortness of breath Yes No
 Night sweats Yes No
 Chest pain or pressure Yes No
 Rapid heartbeat/fluttering Yes No
 Asthma/wheezing Yes No
 Abnormal EKG Yes No
 Abnormal Chest X-ray Yes No

Heart Attack Yes No
 Pacemaker Yes No
 Cardiac Cath Yes No
 Heart valve disease Yes No
 Heart valve replacement Yes No
 Heart bypass surgery Yes No
 Heart Murmur Yes No
 Treatment required? 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 Depression Yes No
Convulsions (epilepsy, seizures) 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.)*

<u>Relative</u>	<u>Age</u>	
<input type="checkbox"/> Father	—	_____
<input type="checkbox"/> Mother	—	_____
<input type="checkbox"/> Brother/Sister	—	_____
<input type="checkbox"/> Brother/Sister	—	_____
<input type="checkbox"/> Brother/Sister	—	_____
<input type="checkbox"/> Brother/Sister	—	_____

Children

Number of children _____

<u>Age</u>	<u>Health History</u>
—	_____
—	_____
—	_____
—	_____
—	_____

Other important information related to your medical history: