Living Donor Application/Health History

Please mail or fax to:
Dallas Transplant Institute
Pre-Transplant Group
1420 Viceroy Drive
Dallas, TX 75235
Fax: (214) 366-6088

Donor Name: _____ **SS#**: _____
Date of birth: _____ **Age**: _____ **Sex**: _____ **Male** _____ **Female**
Address: _____
City/State/Zip Code: _____
Home phone number: _____ **Cell phone number:** _____
Work phone number: _____ **May we contact you are work? ☐ Yes ☐ No**
Additional phone numbers: _____ _____
Emergency contact name and phone number: _____

____**Married** ____**Single** ____**Divorced** ____**Widow**(er) ____**Separated**

Do you speak English? ____ Yes ____ No **If NO, what language do you speak?** _____

Race (Check one): ____White ____Black ____Asian ____American Indian/Eskimo/ALEU
____Hawaiian Native/Pacific Islander ____Other

Ethnicity (Check one): ____Hispanic origin ____Not of Hispanic origin

POTENTIAL DONOR FOR: _____

Your relationship to the recipient: _____
How long have you known the recipient? _____
Why do you wish to donate to this recipient? _____
If unable to donate due to blood type / crossmatch issues, would you be interested in information regarding a paired exchange program? Yes: ____ No: _____

MEDICATIONS

List all medications (including dose and how often you take it):

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Please list all over the counter medications (examples: Tylenol, Advil) herbal supplements and vitamins you currently take:

_____ _____
_____ _____
_____ _____

Allergies: _____
_____

Occupational / Social History

Your Occupation: _____
Are you currently working? Yes: ____ No: _____ Disabled: _____ Retired: _____
Are you working full time? Yes: ____ No: _____ Part time? Yes: ____ No: _____
How many hours/day? _____ Is your work stressful? Yes: ____ No: _____
Indoors: ____ Outdoors: ____ Is heavy lifting involved? Yes: ____ No: _____
Do you have health insurance? Yes: ____ No: _____
What are the best days/times for appointments to be scheduled? _____
What days/times cannot be used to schedule appointments? _____

Do you currently smoke? Yes: ____ No: _____ If yes - _____packs per day
How long have you smoked? _____ When did you last smoke? _____

Have you ever smoked? Yes: ____ No: _____ If yes - _____packs per day
How long did you smoke? _____ When did you quit? _____

Have you ever used illegal drugs? Yes: ____ No: _____
What type of drugs have you used? _____
When did you last use drugs? _____

How many meals do you eat? _____ per day
Amount of coffee? _____ cups per day. Amount of tea? _____ cups per day
Other caffeinated beverages (colas, energy drinks)? _____ per day

Do you currently consume alcoholic drinks? Yes: ____ No: _____
How many alcoholic drinks do you consume per day? _____ Per week? _____
When did you last consume alcohol? _____

If you are approved to donate:

Who will be with you at the hospital when you donate? _____

Who will assist you after you go home? _____

FAMILY HISTORY

	Age	Medical Problems	Cause of Death/Age at death (If no longer living)
Father	____	_____	_____
Mother	____	_____	_____
Brothers	____	_____	_____
	____	_____	_____
	____	_____	_____
	____	_____	_____
Sisters	____	_____	_____
	____	_____	_____
	____	_____	_____
	____	_____	_____
Sons	____	_____	_____
	____	_____	_____
	____	_____	_____
Daughters	____	_____	_____
	____	_____	_____
	____	_____	_____

Check if any of your blood relatives had any of the following:

	Disease	Relationship to you
☐	Diabetes	_____
☐	Heart Disease	_____
☐	Stroke	_____
☐	High Blood Pressure	_____
☐	Kidney Disease	_____
☐	Kidney Cancer	_____
☐	Malignancy/Cancer	_____
☐	Tuberculosis	_____
☐	Chemical Dependency	_____
☐	Systemic Lupus Erythematosus	_____
☐	Other	_____

ADDITIONAL INFORMATION

Name, address and telephone # of your personal physician:
Dr. _____

Did you have any serious illnesses as a child? ☐ Yes ☐ No
If yes, please explain _____

Have you had the following?:

Mumps	Yes: ____ No: _____	Measles	Yes: ____ No: _____
Chickenpox	Yes: ____ No: _____	Rheumatic Fever	Yes: ____ No: _____
Mononucleosis	Yes: ____ No: _____		

Do you travel outside the United States? ☐ Yes ☐ No
If yes, where and when _____

Any other Medical Problems: _____
_____

Have you had any surgeries? Yes: ____ No: _____
If yes, please list_____

Have you had any complications from anesthesia or surgery? Yes: ____ No: _____
If yes, please list_____

Have you had any other hospitalizations? Yes: ____ No: _____
If yes, please list_____

Are you willing to receive blood products if needed at time of donation if needed?
Yes: ____ No: _____

GENERAL:

Your height is: _____ Your current weight is: _____
Is this your usual weight? Yes: ____ No: ____

Have you had any weight loss surgery (gastric bypass, lap banding)? Yes: ___ No: ____
If yes, when was the surgery? _____ How much weight did you lose? _____

Please indicate any of the following that apply to your health condition in the past 6 months:

Weight Gain:	Yes: ____ No: ____
Weight Loss:	Yes: ____ No: ____
Fever:	Yes: ____ No: ____
Chills:	Yes: ____ No: ____
Night Sweats:	Yes: ____ No: ____

EYE, EAR, NOSE, AND THROAT *Check any that apply to you…*

Blindness	Yes: ____ No: ____
Deafness/Hearing Loss	Yes: ____ No: ____
Sinus infections	Yes: ____ No: ____

ENT Doctor: _____ Telephone #: _____

PULMONARY (Lungs) *Check any that apply to you…*

TB/Tuberculosis	Yes: ____ No: ____
Bronchitis	Yes: ____ No: ____
Asthma	Yes: ____ No: ____
Wheezing	Yes: ____ No: ____
Sleep Apnea	Yes: ____ No: ____
Do you use CPAP?	Yes: ____ No: ____
Shortness of breath	Yes: ____ No: ____
Coughing up blood	Yes: ____ No: ____
History of lung masses/nodules/lung cancer	Yes: ____ No: ____

Pulmonologist (Lung Doctor):_____ Telephone #: _____

CARDIAC (Heart) *Check any that apply to you…*

High Blood Pressure	Yes: ____ No: ____
Heart disease	Yes: ____ No: ____
Heart Attack	Yes: ____ No: ____
Pacemaker	Yes: ____ No: ____
Heart surgery	Yes: ____ No: ____
Heart palpitations	Yes: ____ No: ____

Cardiologist (Heart Doctor):_____ Telephone # :_____

GASTROENTEROLOGY (Abdomen/intestines/liver/stomach) *Check if any apply…*

History of Hepatitis? Yes: ____ No: ____
Ulcer in stomach / intestines Yes: ____ No: ____
History of blood in stools Yes: ____ No: ____
History of gallstones / gallbladder problems Yes: ____ No: ____
Diverticulosis Yes: ____ No: ____
History of vomiting blood? Yes: ____ No: ____
Problems with esophagus? Yes: ____ No: ____
History of diarrhea? Yes: ____ No: ____ History of constipation? Yes: ____ No: ____
Have you ever had a colonoscopy (lower endoscopy) or EGD (upper endoscopy)? Yes: ____ No: ____
When? _____ Why? _____
Any additional GI problems/surgeries/recent testing: _____
Gastroenterologist (Doctor for abdomen, stomach, liver and/or intestines): _____
Telephone #: _____

UROLOGY (Kidney/bladder/ureter/urethra) *Check all that apply…*

Frequent bladder infections Yes: ____ No: ____
Painful urination Yes: ____ No: ____
Difficult to urinate Yes: ____ No: ____
Blood in your urine Yes: ____ No: ____
Protein in your urine Yes: ____ No: ____
Urinate frequently Yes: ____ No: ____
Lose control of bladder Yes: ____ No: ____
History of kidney infections Yes: ____ No: ____
History of kidney stones Yes: ____ No: ____
If yes – When? _____
History of enlarged prostate Yes: ____ No: ____
History of bladder surgeries Yes: ____ No: ____
If yes, why_____
Urologist (Doctor for bladder/ureter/urethra): _____ Telephone #: _____

GYNECOLOGY (Breasts/Female Organs)

Date of last pap smear: _____ Date of last mammogram: _____
Number of times you have been pregnant? _____
Number of living children you have? _____
How many miscarriages have you had? _____
Was your blood pressure elevated while you were pregnant? Yes: ____ No: ____
Was your blood sugar elevated while you were pregnant? Yes: ____ No: ____
Have you had a hysterectomy (uterus surgically removed) Yes: ____ No: ____
If yes, why? _____
Have you ever had an abnormal pap smear? Yes: ____ No: ____
If yes, what was wrong? _____
Have you ever had an abnormal mammogram? Yes: ____ No: ____
If yes, what was wrong? _____
Treatment for abnormal mammogram was _____
History of breast biopsy? Yes: ____ No: ____
Gynecologist (Female Doctor):_____Telephone #:_____
Breast Doctor: _____Telephone #:_____

MUSCULOSKELETAL *Check any that apply to you…*

Arthritis Yes: ____ No: ____
Joint Pain / Swelling Yes: ____ No: ____
Broken Bones Yes: ____ No: ____
Osteoporosis Yes: ____ No: ____

NEUROLOGY (Brain and Spinal Cord) *Check any that apply to you…*

Headaches Yes: ____ No: ____
Head Injury Yes: ____ No: ____
Seizures Yes: ____ No: ____
Back pain Yes: ____ No: ____
Additional problems/surgeries/any recent testing that you have had related to your brain or spinal cord:
_____
Neurologist (Brain Doctor):_____Telephone #:_____

ENDOCRINOLOGY (Diabetes or Thyroid) *Check any that apply to you…*

Do you have diabetes? Yes: ____ No: ____
Age when diagnosed _____
Thyroid problems? Yes: ____ No: ____
Endocrinologist (Diabetes/Thyroid Doctor):_____ Telephone #:_____

HEMATOLOGY/ONCOLOGY/RHEUMATOLOGY (Blood/Cancer) *Check any that apply…*

History of Bleeding Problems Yes: ____ No: ____
History of Difficulty Clotting Yes: ____ No: ____
Frequent bruising Yes: ____ No: ____
Blood clots in legs or lungs Yes: ____ No: ____
Frequent nosebleeds Yes: ____ No: ____
Do you have arthritis? Yes: ____ No: ____
Do you have muscle or joint pains? Yes: ____ No: ____
Do you have a history of cancer? Yes: ____ No: ____
If yes, what type?_____ _____
When was the cancer diagnosed?_____
What treatment was done?_____ Date of last treatment was: _____
Have you ever had a blood transfusion? Yes: ____ No: ____
Total number of blood transfusions_____ When was the last blood transfusion? _____
Additional problems/surgeries/recent testing that you have had related to your blood problem or cancer:
_____
Hematologist/Oncologist/Rheumatologist: _____ Telephone #: _____

PSYCHOSOCIAL (Mental/Social) *Check any that apply to you…*

History of Mental Illness ☐ Yes ☐ No
Anxiety ☐ Yes ☐ No
Depression ☐ Yes ☐ No
Have you ever attempted to kill yourself? ☐ Yes ☐ No
History of Alcohol/Substance Abuse ☐ Yes ☐ No
Have you ever been incarcerated? ☐ Yes ☐ No
Psychiatrist/Psychologist: _____ Telephone #: _____

Potential donor's signature: _____ Date: _____

LIVING DONOR –
POTENTIAL HIGH RISK CHARACTERISTICS QUESTIONNAIRE

UNOS Policy 4.1.1 (Communication of Donor History) requires us to tell the transplant recipient if their living donor meets the criteria for **high risk status**.

THE QUESTIONS BELOW ADDRESS THE REQUIRED INFORMATION AND MUST BE ANSWERED BEFORE YOU MOVE FORWARD WITH THE LIVING DONOR PROCESS.

The questions are taken from the CDC (Centers for Disease Control) guidelines for high risk behavior. Living organ donation is voluntary.

YOU CAN DECIDE NOT TO ANSWER THESE QUESTIONS, AND THE DONATION PROCESS WILL BE STOPPED.

A "**yes**" answer to any of the questions means there is "**high risk**" for spread of disease (e.g., HIV, Hepatitis C and Hepatitis B) to the person who will receive your organ. It is required of the doctors and nurses working with you to inform the person who will receive the organ of this risk. Specific details **will not** be revealed, only that there is a risk for the spread of disease. At any time, you have the right to stop the donor process rather than have the high risk status disclosed to the person who will receive the organ or transplant center.

By signing below, you indicate that you understand that any high-risk concerns will be shared with the person who will receive the organ.

Donor Signature _____

Date: _____ **Time_____**

Are you currently in jail or prison? ☐ Yes ☐ No

Have you, in the past 12 months, been exposed to HIV-infected blood through needle stick or through contact with an open wound, non-intact skin, or mucous membrane (mouth, eyes)? ☐ Yes ☐ No

Have you used non-medical IV drugs, or shots in your muscle or fat in the past 5 years?
☐ Yes ☐ No

If you are male, have you had sex with another man in the last 5 years?
☐ Yes ☐ No ☐ N/A

Have you engaged in sex in exchange for money or drugs in the past 5 years?
☐ Yes ☐ No

Have you engaged in sex in the past 12 months with any person who may have answered yes to any of the above questions or with anyone known to be HIV positive? ☐ Yes ☐ No

Reviewed by : _____
Pre-Transplant Coordinator