Medical City Transplant℠

Living Kidney Donor Medical and Personal History Screening Form

One of the greatest gifts a person can give.

Name: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ **Cell Phone:** _____

Work Phone: _____ **Email Address:** _____

Gender: Male Female **Marital Status:** _____

Date and Location of Birth: _____ **Citizenship:** _____

SS#: _____ **Ethnicity:** _____

Potential Donor For: _____ **Relationship:** _____

If unable to donate due to blood type/crossmatch issues, would you be interested in a paired exchange program? Yes No

Would you like more information regarding a paired exchange program? Yes No

Height: _____ **Weight:** _____

Is this your usual weight? _____

In general, would you say your health is: Excellent Very Good Good Poor

Do you get regular medical checkups by a Physician, Physician Assistant, or Nurse Practitioner? Yes No

If yes, please provide the name and contact information for the medical practitioner:

_____

Highest Level of Education Completed: _____

Are you currently employed? Yes No **May we contact you at work if needed?** Yes No

If yes, what is your current occupation? _____

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Do you perform strenuous activities at work? Yes No

If yes, please explain: _____

If not working are you: Retired Disabled Other: _____

Do you have healthcare insurance? Yes No

Do you receive disability or workman's compensation payments for any reason? Yes No

If yes, please explain: _____

Medical and Social History Questions:

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			

In the past 12 months, have you received any vaccination or immunization for any reason, including smallpox?

Yes No If yes, describe: _____

Do you have any allergies? Yes No

If yes, please describe: _____

Medical City Dallas Hospital Transplant • 7777 Forest Lane C-750 • Dallas, Texas 75230
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medicalcityhospital.com/service/line/transplant

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1. Neurology (Brain and Spinal Cord)	Please circle:	
Headaches	Yes	No
Head Injury	Yes	No
Seizures	Yes	No
Back pain	Yes	No
Periods of confusion or memory loss	Yes	No
Unexplained personality changes	Yes	No
Visual changes or hallucinations	Yes	No
Polio, degenerative neurological disease, MS or ALS	Yes	No
Encephalitis or Viral Meningitis	Yes	No

Any additional problems/surgeries/any recent testing that you have had related to your brain or spinal cord:

Neurologist: _____ **Phone:** _____

2. Eye, Ear, Nose and Throat	Please circle:	
Blindness	Yes	No
Deafness/Hearing Loss	Yes	No
Sinus Infections	Yes	No

Any additional problems/surgeries/recent testing that you have had related to your eyes, ears, nose and/or throat:

ENT: _____ **Phone:** _____

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3. Cardiac (Heart)	Please circle:	
High Blood Pressure	Yes	No
Swollen ankles	Yes	No
Heart disease	Yes	No
Heart attack	Yes	No
Pacemaker	Yes	No
Heart surgery	Yes	No
Heart palpitations	Yes	No
Chest pain, difficulty breathing, tightness in the chest	Yes	No
Poor circulation, especially in the legs	Yes	No

Any additional problems/surgeries/recent testing that you have had related to your heart:

Cardiologist: _____ **Phone:** _____

4. Pulmonary (Lungs)	Please circle:	
TB/Tuberculosis	Yes	No
Positive skin test for tuberculosis (TB)	Yes	No
Bronchitis	Yes	No
Asthma	Yes	No
Wheezing	Yes	No
Shortness of breath	Yes	No
History of lung masses/nodules	Yes	No
History of lung cancer	Yes	No
Emphysema	Yes	No

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Any additional problems/surgeries/recent testing that you have had related to your lungs:

Pulmonologist: _____ **Phone:** _____

5. Endocrinology (Diabetes or Thyroid)	**Please circle:**	
Diabetes	Yes	No
Elevated blood sugar	Yes	No
Thyroid problems	Yes	No
Night sweats for greater than 10 days	Yes	No
Fever greater than 100.5 F for greater than 10 days	Yes	No

Endocrinologist: _____ **Phone:** _____

6. Gastroenterology (stomach, liver, intestines)	**Please circle:**	
History of Hepatitis	Yes	No
Ulcer in stomach/intestines	Yes	No
History of blood in the stools	Yes	No
History of gallstones/gallbladder problems	Yes	No
Diverticulosis	Yes	No
History of vomiting blood	Yes	No
Problems with esophagus	Yes	No
Liver disease	Yes	No
Digestive or intestinal problems	Yes	No
Unexplained persistent nausea, vomiting or diarrhea	Yes	No

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Have you ever lived with or had close contact with anyone diagnosed with viral hepatitis in the past twelve months? Yes No

Have you ever had a colonoscopy (lower endoscopy) or EGD (upper endoscopy)? Yes No

When? _____ Why? _____

Any additional problems/surgeries/recent testing that you have had related to your abdomen, intestines, liver and/or stomach:

_____

Gastroenterologist: _____ **Phone:** _____

7. Urology (Kidney/bladder/ureter/urethra) **Please circle:**

Frequent bladder infections	Yes	No
Painful urination	Yes	No
Difficult to urinate	Yes	No
Urinate frequently	Yes	No
Lose control of bladder when you cough, laugh, sneeze	Yes	No
History of kidney infections	Yes	No
History of kidney stones	Yes	No
History of enlarged prostrate	Yes	No
Any kidney related problems or diseases	Yes	No
History of bladder surgeries	Yes	No

If yes, why? _____

Additional problems/surgeries/recent testing that you have had related to your kidneys, bladder, ureters, and/or urethra:

_____

Urologist: _____ **Phone:** _____

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8. Hematology/Oncology/Rheumatology	Please circle:	
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
Blood transfusion	Yes	No
History of Systemic Lupus Erthematosis,		
Polyarteritis Nodosa, or Sarcoidosis	Yes	No
Varicose veins, phlebitis/deep venous thrombosis		
or Muscular dystrophy	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 _____

Additional problems/surgeries/recent testing that you have had related to your blood problem or cancer:

_____

Hematologist/Oncologist/Rheumatologist: _____ **Phone:** _____

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9. Gynecology

How many times have you been pregnant? _____

How many children do you have? _____

Are you considering having children in the future? Yes No

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? Yes No

If yes, why? _____

Date of last pap smear: _____

Have you ever had an abnormal pap smear? Yes No

If yes, what was wrong? _____

Date of last mammogram: _____

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

Additional problems/surgeries/recent testing that you have had related to your female organs:

_____

Gynecologist: _____ **Phone:** _____

Breast Doctor's Name: _____ **Phone:** _____

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10. Communicable Diseases

In the past have you ever traveled or lived outside of the United States?

Yes No

If yes, describe when, where, length of stay and reason for trip:

_____

Have you ever been diagnosed with or had suspicion that you had the West Nile Virus infection within the last 4 months?

Yes No If yes, describe: _____

Have you ever been tested for HIV?

Yes No If yes, when and where: _____

In the past 12 months, have you had or been treated for any sexually transmitted disease such as syphilis, gonorrhea, genital herpes or venereal warts, chlamydia or trichomoniasis?

Yes No If yes, when and where: _____

In the past six months, have you been treated for rabies or bitten by an animal suspected of having rabies?

Yes No If yes, when and what type of animal? _____

Psychosocial:	**Please circle:**	
History of Mental Illness	Yes	No
Anxiety	Yes	No
Depression	Yes	No
Alcohol/Substance Abuse	Yes	No
Do you have or did you ever have any tattoos?	Yes	No
If yes, were any tattoos done in the past 12 months?	Yes	No
If yes, was the tattoo done professionally?	Yes	No
Do you have any ear or body piercings?	Yes	No
If yes, was the piercing done professionally?	Yes	No

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Have you ever been in jail, prison, correctional system, or juvenile detention center? Yes No

If yes, please describe when and for how long:

Do you drink alcohol?

Yes No If yes, how often and what type?

Do you currently smoke?

Yes No If yes, describe what and how often:

Have you ever smoked?

Yes No If yes, describe what and how often:

When did you quit?

Have you ever used illegal drugs?

Yes No If yes, please explain what and how often it was taken, when you started and when/if you stopped?

Are you physically active (I.e. exercise regularly, take walks, participate in sports, etc)?

Yes No If yes, describe:

Do you take any prescriptions or over the counter medications, vitamins, or supplements on a regular basis or recently?

Yes No If yes, please list all:

In the past two years, have you been treated by a physician or have a family physician?

Yes No If yes, describe:

Have you ever been hospitalized?

Yes No If yes, please describe:

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Have you ever been treated in a psychiatric facility?

Yes No If yes, please provide name of facility and reason for treatment:

In the past six months, have you experienced any weight loss?

Yes No If yes, please describe:

How many meals do you eat? **per day**

Amount of coffee? **per day**

Amount of tea? **per day**

Amount of caffeinated beverages? **per day**

Family History

Do you have a family member (parents, siblings, or children) with a history of the following?

Cancer	Yes	No	If yes, comment:
Diabetes	Yes	No	If yes, comment:
High Blood Pressure	Yes	No	If yes, comment:
Heart Disease	Yes	No	If yes, comment:
Kidney Disease	Yes	No	If yes, comment:
Kidney Infections	Yes	No	If yes, comment:
Kidney Stones	Yes	No	If yes, comment:

Potential donor's signature: **Date**

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