POTENTIAL KIDNEY DONOR QUESTIONNAIRE

Person you wish to donate to: _____

Relationship: _____

If not compatible to this person would you consider being a part of the Kidney Exchange Program?

YES NO (circle one)

DEMOGRAPHICS AND PERSONAL INFORMATION

Name: _____ Maiden Name: _____

Address: _____

City/State: _____ Zip Code: _____ County: _____

Home number: _____ Cell number: _____

Work number: _____ Which number is primary: _____

Email address: _____ SSN: _____

Primary Language: English Spanish Other: _____

Age: _____ DOB: _____ Sex: Male Female (circle one) Race: _____

Marital status: Single Married Separated/Divorced Widow/Widower (circle one)

Height: _____ Weight: _____ ABO: _____ (Must have)

Age(s) of children: _____ Pregnancies: _____ Miscarriages: _____

Place of employment: _____

Occupation: _____ Full-time Part-time Retired (circle one)

Highest level of education: _____

Name of Support Person: _____ Relationship: _____

Phone number of Support Person: _____

MEDICAL CARE

Name of Doctor and Type	Office Address	Phone number

When was you last physical exam (month/year): _____

If female, date of last gyn exam, pap smear, mammogram: _____

Date of colorectal screening (45yrs and older): _____

Do you currently have health insurance coverage? YES NO (circle one)

PERSONAL MEDICAL HISTORY

List all Allergies (Drug, Food, Iodine): _____

Type of Reaction to allergies: _____

Have you ever had a reaction to eating shellfish? YES NO (circle one)

Have you ever received x-ray dye? YES NO (circle one)

Have YOU ever had....			**Treatment**	**Date**
1. Tuberculosis or spent time with anyone who has TB	YES	NO		
2. Neurological				
Stroke/TIA	YES	NO		
Seizures	YES	NO		
Anxiety-Depression	YES	NO		
Other Psychiatric disorders	YES	NO		
3.Autoimmune disorder-Arthritis	YES	NO		
4. Sickle Cell trait	YES	NO		
5. Genitourinary				
Urinary tract infections	YES	NO		
Difficulty urinating	YES	NO		
Bladder infections	YES	NO		
Kidney disease/injury	YES	NO		
Kidney stones	YES	NO		
Protein/blood in urine	YES	NO		
4. Female				
Abnormal Pap Smear				
Trying to get pregnant	YES	NO		
5. Past pregnancies	YES	NO		
Gestational diabetes	YES	NO		
Preelampsia	YES	NO		
6. Male Prostate issues	YES	NO		
7.Liver disease-Hepatitis	YES	NO		
8. Blood transfusion	YES	NO		
9. Anemia/Bleeding disorder	YES	NO		
10. Gastric disorders	YES	NO		
Ulcertive colitis	YES	NO		
Crohn's disease	YES	NO		
11. Gastric surgery				

Have YOU ever had....			**Treatment**	**Date**
12. Cancer-Melanoma	YES	NO	_____	
13. Heart problems/Murmurs	YES	NO	_____	
14. Diabetes	YES	NO	_____	
15. High blood pressure	YES	NO	_____	
16. Heart disease or heart attack	YES	NO	_____	
17. Lung Problems/Asthma	YES	NO	_____	
18. Chronic pain	YES	NO		

HEALTH MAINTENANCE			**Date and place of most recent study**
1. Annual Physical Exam	YES	NO	_____
2. Pap smear	YES	NO	_____
3. Mammogram	YES	NO	_____
4. Prostate exam	YES	NO	_____
5. Colorectal screen or colonoscopy	YES	NO	_____
6. Heart stress test	YES	NO	_____
7. Echocardiogram	YES	NO	_____
8. Pulmonary function test	YES	NO	_____

Please provide us with the above information (by a patient portal) or provide us with your health care provider information and we can obtain it for you, with a signed record request authorization.

Tobacco use: YES NO How much _____ How long _____ Start age _____ Quit date _____
Alcohol use: Ever _____ Avg per month: Beer _____ Wine _____ Mixed drinks _____
Other drugs or substances: What type_____ Frequency _____ Last used _____

MEDICATIONS

List **all** medications and vitamins taken regularly (prescription and over-the counter)

Type	**Dose**	**Reason**

Medications taken in the past

_____
_____
_____
_____

SURGICAL HISTORY

List any operation or procedures you have had (including childhood)

Type of	When	Where

HOSPITALIZATIONS

Reason	When	Where

If needed would you accept blood products? YES NO (circle one)

If no, reason why: _____

FAMILY HISTORY

Has any blood relative had any of the following:

			RELATIONSHIP
1. Anemia (including sickle cell)	YES	NO	
2. Cancer/Leukemia	YES	NO	
3. Diabetes	YES	NO	
4. Heart disease	YES	NO	
5. High blood pressure	YES	NO	
6. Kidney disease	YES	NO	
7. Kidney stones	YES	NO	
8. Psychiatric disorder	YES	NO	
9. Migraine headaches	YES	NO	
10. Severe allergies (iodine/shell fish)	YES	NO	
11. Tuberculosis	YES	NO	

Please list for the following: Alive/Deceased, Age (current or at death), State of health ie: good, fair, poor or cause of death

Father: _____
Siblings: _____
Grandparents: _____

Mother: _____
Children: _____
Grandparents: _____