



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 at 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):

Blank lines for listing medications.

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

Blank lines for listing over-the-counter medications.

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

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

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

<u>Disease</u>	<u>Relationship to you</u>
<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Heart Disease	_____
<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> High Blood Pressure	_____
<input type="checkbox"/> Kidney Disease	_____
<input type="checkbox"/> Kidney Cancer	_____
<input type="checkbox"/> Malignancy/Cancer	_____
<input type="checkbox"/> Tuberculosis	_____
<input type="checkbox"/> Chemical Dependency	_____
<input type="checkbox"/> Systemic Lupus Erythematosus	_____
<input type="checkbox"/> 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