1935 Medical District Drive | Mailstop B2.02 |
Dallas, TX 75235

LIVING DONOR TRANSPLANT APPLICATION / HEALTH HISTORY

Donor Name: ______________________________

SS #: ____________ DOB: __________ Sex: ____ Race: ________ Marital Status: ________

Address, City, State, Zip: ______________________________

County: ____________ Home Phone: ____________ Work Phone: ____________

Cell Phone: ____________ Emergency contact and phone #: ____________

Email: ______________________________

POTENTIAL DONOR FOR: ______________________________

Your relationship to the recipient: ______________________________

Are you a U.S. Citizen? ☐ Yes ☐ No If "no", what country? ____________

Are you a legal resident? ☐ Yes ☐ No

DONOR INSURANCE INFORMATION

Insurance? ☐ Yes ☐ No

Insured Name: ______________________________ SSN: ____________

Insurance Company: ______________________________ Insured DOB: ____________

Address: ______________________________ Phone: ____________

Group Number: ____________ Policy / ID#: ____________ Precert Phone #: ____________

STATEMENT: The transplant evaluation, related services and transplant procedure are not billed to the Donor's insurance. The donor must demonstrate ability to pay for non-transplant related health issues that may arise.

If unable to donate due to blood type / crossmatch issues, would you be interested in a paired exchange program?

☐ Yes ☐ No (Kidney paired donation matches one incompatible donor/recipient pair to another pair.)

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

http://www.paireddonation.org/ ______________________________

Are you currently working? ☐ Yes ☐ No May we contact you at work if needed? ☐ Yes ☐ No

Occupation: ____________ Employer: ____________

Are you working: ☐ Full time ☐ Part time How many hours/day? ________

Do you perform strenuous activities at work? ☐ Yes ☐ No

If yes, please explain: ______________________________

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1. FAMILY HISTORY

	Current Age	Medical Problems	Cause of Death / Age at death (If no longer living)
Father			
Mother			
Brother(s)			
Sister(s)			
Son(s)			
Daughter(s)			

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

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

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2. HEALTH HABITS

Do you currently smoke? ☐ Yes ☐ No Amount? ____________________

Have you ever smoked? ☐ Yes ☐ No __________ packs per day

Date that you quit smoking ____________________

How long have/did you smoke? ____________________

Have you ever used illegal drugs? ☐ Yes ☐ No

What type of drugs have you used? ____

How many meals do you eat? __________ per day

Amount of coffee? __________ cups per day

Amount of tea? __________ cups per day

Caffeinated beverages? __________ per day

Amount of Alcohol? __________ daily

Your height is: ____________________ Your weight is: ____________________

Is this your usual weight? ☐ Yes ☐ No

Please list the name of any medications you take (prescribed and over the counter):

____

____

____

Allergies: ____

3. EYE, EAR, NOSE, AND THROAT

Check any that apply to you:

Blindness ☐ Yes ☐ No
Deafness / Hearing Loss ☐ Yes ☐ No
Sinus infections ☐ Yes ☐ No

4. PULMONARY (Lungs)

Check any that apply to you:

TB/Tuberculosis ☐ 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

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

Pulmonologist (Lung Doctor): ______________________________ Telephone #: ____________________

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5. CARDIAC (Heart) *Check any that apply to you:*

High Blood Pressure	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No
Swollen ankles	☐ Yes	☐ No	Heart surgery	☐ Yes	☐ No
Heart disease	☐ Yes	☐ No	Heart palpitations	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No			

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

Cardiologist (Heart Doctor): ______________________ Telephone #: ______________

6. GASTROENTEROLOGY (Abdomen/intestines/liver/stomach) *Check any that apply to you:*

History of Hepatitis	☐ Yes	☐ No	History of vomiting blood	☐ Yes	☐ No
Ulcer in stomach / intestines	☐ Yes	☐ No	Problems with esophagus	☐ Yes	☐ No
History of blood in stools	☐ Yes	☐ No	History of diarrhea	☐ Yes	☐ No
History of gallstones / gallbladder problems	☐ Yes	☐ No	History of constipation	☐ Yes	☐ No
Diverticulosis	☐ 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 (Doctor for abdomen, stomach, liver and/or intestines): ______________________

Telephone #: ______________

7. UROLOGY (Kidney/bladder/ureter/urethra) *Check any that apply to you:*

Frequent bladder infections	☐ Yes	☐ No	History of kidney infections	☐ Yes	☐ No
Painful urination	☐ Yes	☐ No	History of kidney stones	☐ Yes	☐ No
Difficult to urinate	☐ Yes	☐ No	History of enlarged prostate	☐ Yes	☐ No
Urinate frequently	☐ Yes	☐ No	History of bladder surgeries	☐ Yes	☐ No
Lose control of bladder when you cough, laugh, sneeze	☐ Yes	☐ No			

If yes, why? ______________________

Any additional problems/surgeries/recent testing that you have had related to your kidneys, bladder, ureter, and/or urethra:

Urologist (Doctor for kidney/bladder/ureter/urethra): ______________________

Telephone #: ______________

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8. GYNECOLOGY (Breasts/Female Organs)

How many times have you been pregnant? ________________ How many children do you have? ________________

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? ____

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 (Female Doctor): ________________________________ Telephone #: ________________

Breast Doctor: ________________________________ Telephone #: ________________

9. 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

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

Neurologist (Brain Doctor): ________________________________ Telephone #: ________________

10. ENDOCRINOLOGY (Diabetes or Thyroid) *Check any that apply to you:*

Diabetic ☐ Yes ☐ No Age when diagnosed: ________________

Does anyone in your family have diabetes? ☐ Yes ☐ No

Thyroid problems ☐ Yes ☐ No

Any additional problems/surgeries/recent testing that you have had related to your kidneys, bladder, ureter, and/or urethra:

Endocrinologist (Doctor for diabetes/thyroid): ________________________________ Telephone #: ________________

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11. HEMATOLOGY/ONCOLOGY/RHEUMATOLOGY (Blood/Cancer) *Check any that apply to you:*

History of Bleeding Problems ☐ Yes ☐ No
Frequent bruising ☐ Yes ☐ No
Frequent nosebleeds ☐ Yes ☐ No
Do you have a history of cancer? ☐ Yes ☐ No
History of Difficulty Clotting ☐ Yes ☐ No
Blood clots in legs or lungs ☐ Yes ☐ No
Do you have arthritis? ☐ Yes ☐ No
Do you have muscle or joint pains? ☐ Yes ☐ No

If yes, what type? ______
When was the cancer diagnosed? ______
What treatment was done? ______
Date of last treatment was ______

Do you have a family history of any type of cancer? ☐ Yes ☐ No
If yes, what relative and type of cancer? ______
Have you ever had a blood transfusion? ☐ Yes ☐ No
Total number of blood transfusions: ______ When was the last blood transfusion? ______

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

Hematologist/Oncologist/Rheumatologist: ______

Telephone #: ______

12. PSYCHOSOCIAL (Mental/Social) *Check any that apply to you:*

History of Mental Illness ☐ Yes ☐ No
History of Alcohol/Substance Abuse ☐ Yes ☐ No
Anxiety ☐ Yes ☐ No
Depression ☐ Yes ☐ No
Have you ever been incarcerated? ☐ Yes ☐ No

Psychiatrist/Psychologist: ______ Telephone #: ______

13. ADDITIONAL INFORMATION

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: ______

Potential donor's signature: ______ Time: ______ Date: ______