KIDNEY TRANSPLANT HEALTH HISTORY FORM

Today's Date:_____

Patient Name: _____ Date of Birth: _____ Age: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow(er) ☐ Separated

What is the cause of your kidney failure? _____

Do you have potential living donors? ☐ Yes ☐ No

Ethnicity (Please check all that apply):

American Indian/ Alaska Native	Hispanic/Latino	Black or African American	Asian	Native Hawaiian/ Other Pacific Islander	White
☐ American Indian ☐ Eskimo ☐ Aleutian ☐ Alaska Indian ☐ American Indian or Alaska Native: Other	☐ Mexican ☐ Puerto Rican (Living in US) ☐ Puerto Rican (Island) ☐ Cuban ☐ Hispanic/Latino: Other	☐ African American ☐ African (Continental) ☐ West Indian ☐ Haitian ☐ Black or African American: Other	☐ Asian Indian/Indian Sub-Continent ☐ Chinese ☐ Filipino ☐ Japanese ☐ Vietnamese ☐ Korean ☐ Asian: Other	☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Native Hawaiian or Other ☐ Pacific Islander: Other	☐ European Descent ☐ Arab or Middle Eastern ☐ North African (non-Black) ☐ White: Other

REFERRING PHYSICIAN INFORMATION

Nephrologist (Dialysis/Kidney Doctor): _____ Telephone Number: _____

Primary Care Doctor: _____ Telephone Number: _____

Are you on the waiting list at another transplant center? ☐ Yes ☐ No

If yes - Where are you listed? _____ When were you listed? _____

Coordinator at that center? _____ Coordinator's Phone#: _____

MEDICATIONS: List all medications: (attach an additional page if needed)

Medication Name	Dose	Frequency

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

Medication Name	Dose	Frequency

DRUG/FOOD ALLERGIES: _____

_____

GENERAL:

Your height is: _____ Your current weight is: _____ □ kg □ lbs Is this your usual weight? □ Yes □ No

Please check any of the following that apply to your health condition in the past 12 months:

□ Weight gain □ Weight loss □ Fever □ Chills □ Night sweats

Social History

Smoking history: Do you currently smoke? □ Never □ Current □ Previous If current: _____ packs per day; _____ years

If previous, how long did you smoke?_____ When did you quit?_____

Have you ever used recreational drugs? □ Yes □ No When did you last use drugs?_____

What type of drugs have you used? _____

_____

Do you currently consume alcoholic drinks? □ Yes □ No When did you last consume alcohol?_____

How many alcoholic drinks do you consume per day?_____ Per week?_____

Have you ever been incarcerated? □ Yes □ No Are you currently on probation? □ Yes □ No

Are you the primary caregiver for anyone? □ Yes □ No If so, who? _____

Do you have special transportation issues that need to be considered? □ Yes □ No

Occupational Information

Your Occupation:_____

Work status: □ Work full time □ Work part time □ Unemployed □ Disabled □ Retired □ Student

If working, is heavy lifting involved? □ Yes □ No Do you work outdoors? □ Yes □ No

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	_____
□ Malignancy/Cancer	_____
□ Tuberculosis	_____
□ Other	_____

Check any that apply to you

EYE, EAR, NOSE, AND THROAT

- ☐ Blindness
- ☐ Glaucoma
- ☐ Diabetic Retinopathy
- ☐ Deafness/Hearing Loss

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

_____

_____

PULMONARY (Lungs)

- ☐ TB/Tuberculosis
- ☐ History of positive TB Skin Test
  If yes, when were you treated_____
- ☐ History of abnormal chest x-ray
- ☐ Chronic Bronchitis
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Oxygen Use
- ☐ Sleep Apnea
- ☐ CPAP Use
- ☐ History of lung masses/nodules
- ☐ History of lung cancer

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

_____

_____

Pulmonologist (Lung Doctor): _____
Telephone Number: _____

CARDIAC (Heart) **and VASCULAR** (Circulation)

- ☐ Hypertension/High Blood Pressure
- ☐ Frequent Fluid Overload/Congestive Heart Failure
- ☐ Coronary Artery Disease/Heart Disease
- ☐ Heart Attack
- ☐ Heart Surgery
- ☐ Poor Circulation
- ☐ Pain in Legs When Walking
- ☐ Ulcers on Feet
- ☐ Amputations
- ☐ Blood clots/DVT

Additional problems/recent testing you have had related to your heart or circulation: _____

_____

_____

Cardiologist (Heart Doctor):_____
Telephone Number: _____
Vascular Surgeon: _____
Telephone Number: _____

GASTROENTEROLOGY (Abdomen/intestines/liver/stomach)

- ☐ Liver Disease
- ☐ History of Hepatitis B
- ☐ Received Hepatitis B Vaccine
- ☐ History of Hepatitis C
- ☐ Reflux/Heartburn
- ☐ Problems with swallowing
- ☐ History of vomiting blood
- ☐ History of intestinal problems
- ☐ Stomach Ulcer
- ☐ History of Polyps
- ☐ History of Blood in Stools
- ☐ Diverticulosis

Have you ever had a colonoscopy? ☐ Yes ☐ No
When? _____
Why? _____

(Gastroenterology continued)

Have you ever had an 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 Number: _____
Hepatologist (Liver doctor):_____
Telephone Number: _____

NEPHROLOGY/UROLOGY (Kidney/bladder/ureter/urethra)

- ☐ Frequent Bladder Infections
- ☐ History of Kidney Infections
- ☐ Kidney Stones
  If yes, when_____
- ☐ History of Enlarged Prostate
- ☐ History of Bladder Surgeries
  If yes, why? _____

Have you had one of your kidneys removed? ☐ Yes ☐ No
If yes, which kidney? ☐ RIGHT ☐ LEFT ☐ BOTH
Why? _____

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

_____

_____

Urologist (Doctor for bladder/ureter/urethra/prostate):

_____

Telephone Number: _____

GYNECOLOGY (Breasts/Female Organs)

- ☐ Have you had a hysterectomy (uterus surgically removed)
- ☐ Abnormal pap smear
- ☐ History of breast lumps or masses
- ☐ Abnormal mammogram
- ☐ History of breast biopsy

Date of last pap smear: _____
Date of last mammogram: _____
How many times have you been pregnant? _____
How many miscarriages have you had? _____
Additional problems/surgeries/recent testing that you have had related to your female organs: _____

_____

_____

Gynecologist(FemaleDoctor):_____
Telephone Number: _____

NEUROLOGY (Brain and Spinal Cord)

- ☐ Headaches
- ☐ Head injury
- ☐ Seizures
- ☐ Stroke
- ☐ Spinal Cord Injury

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

_____

_____

Neurologist (Brain Doctor): _____
Telephone Number: _____

ENDOCRINOLOGY (Diabetes or Thyroid)

- ☐ Type 1 Diabetes; Age at diagnosis _____
- ☐ Type 2 Diabetes; Age at diagnosis _____
- ☐ Thyroid nodule/masses
- ☐ Thyroid surgically removed

Hospitalizations related to your diabetes (Please give the date/name of hospital/and what problem(s) caused you to be hospitalized.) _____

_____

_____

Endocrinologist (Diabetes/Thyroid Doctor):

_____

Telephone Number: _____

MUSCULOSKELETAL

- ☐ Arthritis
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Broken Bones
- ☐ Osteoporosis

HEMATOLOGY/ONCOLOGY/RHEUMATOLOGY

- ☐ History of Bleeding Problems
- ☐ Hemophilia
- ☐ Sickle Cell Disease
- ☐ Amyloidoisis
- ☐ Systemic Lupus Erythematosus
- ☐ Vasculitis
- ☐ Goodpasture's Disease
- ☐ History of Cancer
  What type? _____
  What treatment was done?_____
  _____
  When was the cancer diagnosed?_____
  Date of last treatment was _____

Have you ever had a blood transfusion? ☐ Yes ☐ No
Additional problems/surgeries/recent testing that you have had related to your blood problem or cancer:_____

_____

_____

Hematologist/Oncologist: _____
Telephone Number: _____
Rheumatologist:_____
Telephone Number: _____

INFECTIOUS DISEASE (HIV)

Do you have HIV? ☐ Yes ☐ No
_____ If yes, length of time on HIV treatment: _____
Is your viral load undetectable? ☐ Yes ☐ No
Doctor Seen for HIV Treatment:_____
Telephone Number: _____

DERMATOLOGY

Do you have any skin disorders? ☐ Yes ☐ No
What kind? _____
Dermatologist:_____
Telephone Number: _____

PSYCHOLOGICAL (Mental/Social)

- ☐ History of Mental Illness
- ☐ History of Alcohol/Substance Abuse
- ☐ Anxiety
- ☐ Depression

Psychiatrist/Psychologist:_____
Telephone Number: _____

ADDITIONAL INFORMATION

Do you have frequent problems with your dialysis access? □ Yes □ No

Other Medical Problems: _____

_____

_____

_____

Have you had any surgeries (not previously stated)? □ Yes □ No

If yes, please list _____

_____

_____

_____

Have you had any complications from anesthesia or surgery? □ Yes □ No

If yes, please list _____

_____

Are you willing to receive blood products if needed at time of transplant? □ Yes □ No

Have you had any hospitalizations within the past year? □ Yes □ No

If yes, please list _____

_____

_____

_____

SPECIAL CONCERNS

Do you have any concerns / fears regarding a transplant? _____

_____

_____

What can we do to help with these concerns / fears? _____

_____

_____