

## 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
<input type="checkbox"/> American Indian <input type="checkbox"/> Eskimo <input type="checkbox"/> Aleutian <input type="checkbox"/> Alaska Indian <input type="checkbox"/> American Indian or Alaska Native: Other	<input type="checkbox"/> Mexican <input type="checkbox"/> Puerto Rican (Living in US) <input type="checkbox"/> Puerto Rican (Island) <input type="checkbox"/> Cuban <input type="checkbox"/> Hispanic/Latino: Other	<input type="checkbox"/> African American <input type="checkbox"/> African (Continental) <input type="checkbox"/> West Indian <input type="checkbox"/> Haitian <input type="checkbox"/> Black or African American: Other	<input type="checkbox"/> Asian Indian/Indian Sub-Continent <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Korean <input type="checkbox"/> Asian: Other	<input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Native Hawaiian or Other <input type="checkbox"/> Pacific Islander: Other	<input type="checkbox"/> European Descent <input type="checkbox"/> Arab or Middle Eastern <input type="checkbox"/> North African (non-Black) <input type="checkbox"/> 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
<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"/> Malignancy/Cancer	_____
<input type="checkbox"/> Tuberculosis	_____
<input type="checkbox"/> 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(Female Doctor): \_\_\_\_\_  
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
- ☐ Amyloidosis
- ☐ 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? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_