

DONOR INFO	Date: _____		
	Donor Name: _____	SS#: _____	
	Donor Address: _____		
	City, State, Zip: _____		
	Telephone: (H): _____	(W): _____	(C): _____
	DOB: _____	Age: _____	Height: _____
	Weight: _____		
	Potential Donor To: _____		
Relationship to recipient: _____			

PART 1 Donor Medical Information	
Medications and Herbal Supplements: _____	
Medication Allergies: _____	Blood Type (If Known): _____
Date of Last: _____	Physical: _____
Mammogram: _____	Prostate Specific Antigen (PSA): _____
Doctor's Name: _____	PAP Smear: _____
	Phone #: _____

PART 2 Do you have or have you ever had?		Please Check Yes or No	
	YES	NO	
Diabetes:	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure: <input type="checkbox"/> <input type="checkbox"/>
Kidney Stones:	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Lung Disease: <input type="checkbox"/> <input type="checkbox"/>
Cancer:	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease: <input type="checkbox"/> <input type="checkbox"/>
Active Hepatitis:	<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant? Or trying? <input type="checkbox"/> <input type="checkbox"/>
Lupus:	<input type="checkbox"/>	<input type="checkbox"/>	Gestational Diabetes: <input type="checkbox"/> <input type="checkbox"/>

PART 3 Do you have or have you ever had?		Check Yes or No and Fill-in Amount and Frequency		
	YES	NO	YES	NO
Asthma:	<input type="checkbox"/>	<input type="checkbox"/>	Use Alcohol:	<input type="checkbox"/> <input type="checkbox"/>
Anemia:	<input type="checkbox"/>	<input type="checkbox"/>	Smoke:	<input type="checkbox"/> <input type="checkbox"/>
High Cholesterol:	<input type="checkbox"/>	<input type="checkbox"/>	Quit Smoking:	<input type="checkbox"/> <input type="checkbox"/>
Blood Transfusion:	<input type="checkbox"/>	<input type="checkbox"/>	Use Illicit IV Drugs:	<input type="checkbox"/> <input type="checkbox"/>
Seizures:	<input type="checkbox"/>	<input type="checkbox"/>	Cocaine, Marijuana:	<input type="checkbox"/> <input type="checkbox"/>
Heart Murmur:	<input type="checkbox"/>	<input type="checkbox"/>	Tattoo or Body Piercing:	<input type="checkbox"/> <input type="checkbox"/>
Urinary Tract Infection:	<input type="checkbox"/>	<input type="checkbox"/>	Irregular PAP or Mammogram:	<input type="checkbox"/> <input type="checkbox"/>
Kidney or Bladder Infection:	<input type="checkbox"/>	<input type="checkbox"/>	Elevated PSA:	<input type="checkbox"/> <input type="checkbox"/>
Protein in Urine:	<input type="checkbox"/>	<input type="checkbox"/>	Depression, Anxiety, Panic or other Psychiatric Disorder:	<input type="checkbox"/> <input type="checkbox"/>
Blood in Urine:	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>
Tuberculosis:	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>

PART 4 Donor Surgical and Hospitalization History

Please list any surgical procedures you have had in the past.

	Surgical Procedure	Date	Reason Performed
1	_____	_____	_____
2	_____	_____	_____
3	_____	_____	_____

Have you ever been hospitalized for any reason other than the above surgery? YES NO

	Describe	Date	Diagnosis
1	_____	_____	_____
2	_____	_____	_____

PART 5 Has anyone in your family ever had: Please check YES or NO

If YES, please indicate relative, i.e. mother, father, sister, etc.

	YES	NO	Relative	
Kidney Disease:	<input type="checkbox"/>	<input type="checkbox"/>	_____	On dialysis? _____ Transplanted? _____
High Blood Pressure:	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Heart Attack or Stroke:	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Coronary Artery Disease:	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Diabetes:	<input type="checkbox"/>	<input type="checkbox"/>	_____	Age of onset? _____
Cancer:	<input type="checkbox"/>	<input type="checkbox"/>	_____	Type: _____

PART 6 Additional Questions Please check YES or NO

	YES	NO		YES	NO
Are you married?	<input type="checkbox"/>	<input type="checkbox"/>	Is your spouse aware of you interest in donation?	<input type="checkbox"/>	<input type="checkbox"/>
Are you ready to donate?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any additional questions about being a live kidney donor?	<input type="checkbox"/>	<input type="checkbox"/>
Where were you born?	_____				
Where did you grow up?	_____				
How would you rate your family support system:	Excellent <input type="checkbox"/> Fair <input type="checkbox"/> No support <input type="checkbox"/> Against donation <input type="checkbox"/>				
How many children do you have?	_____ Ages: _____				
Employer:	_____				
Occupation:	_____				
Have you talked to your employer about giving you time off work to be a kidney donor?	YES <input type="checkbox"/> NO <input type="checkbox"/>				
Who will be able to take care of you after your kidney donor surgery?	_____				
Have you ever consulted a psychiatrist or felt the need to see one?	_____				