

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: _____ Blood Type (If Known): _____

Allergies: _____

Date of Last: _____ Physical: _____ Prostate Specific Antigen (PSA): _____

Mammogram: _____ PAP Smear: _____

Doctor's Name: _____ Phone #: _____

PART 2 Do you have or have you ever had? Please Check Yes or No

	YES	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	Amt. & Freq.
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"/>	When: _____
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"/>	(Women Only)
Kidney or Bladder Infection:	<input type="checkbox"/>	<input type="checkbox"/>	Elevated PSA:	<input type="checkbox"/>	<input type="checkbox"/>	(Men Only)
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"/>				
Tuberculosis:	<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** **Fair** **No support** **Against donation**

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 NO

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? _____