Texas Health Harris Methodist Hospital Fort Worth

Kidney Transplant Program

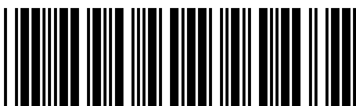
DONOR
Living Donor Application and Health History

If you wish to be considered as a living donor,
please complete this application and return by mail, fax or email to:

Texas Health Harris Methodist Hospital Fort Worth
Kidney Transplant Program
1325 Pennsylvania Avenue, Suite 450
Fort Worth, Texas 76104

Fax: 817-250-5136
Email: THFWKidneyTransplant@TexasHealth.org

For questions, please call 817-250-2443 or 800-411-2443.



TRNPLT

Application/Health History

Last name: ______________________ First name: ______________________

Middle name or initial: ______________________ Maiden name: ______________________

Date of birth: __________ Gender: ☐ Male ☐ Female Age: __________ Race: __________

Street address: ______________________ Apartment no: __________

County: __________ City: __________ State: __________ Zip: __________

Home phone: (______) ______________________ Work phone: (______) ______________________

Email address: ______________________ Cell phone: (______) ______________________

Emergency contact: ______________________ Phone: (_____) __________

Are you a U.S. citizen? ☐ Yes ☐ No Social Security No: _______ - _______ - _______

Resident Alien/Green Card? ☐ Yes ☐ No Non-resident Alien? ☐ Yes ☐ No

Education level: ☐ Grade school ☐ High school ☐ College/Tech school ☐ Post-graduate

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Potential donor for: ______________________

Your relationship to the recipient: ☐ Family (sibling, parent, etc.) ☐ Other family/in-law ☐ Friend ☐ Co-worker

☐ None; I do not have a specific person in mind ☐ Other: ______________________

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

Occupation: ______________________ Employer: ______________________

Employment: ☐ Full time ☐ Part time ☐ Self emloyed ☐ Unemployed How many hours/day? __________

Do you perform strenuous activities at work? ☐ Yes ☐ No If yes, please explain: ______________________

____

Do you have health insurance? ☐ Yes ☐ No

Who will be able to help you around the time of surgery? ______________________

Name of your personal physician: Dr. ______________________

Address: ______________________

Did you have any serious illnesses as a child? ☐ Yes ☐ No If yes, please explain: ______________________

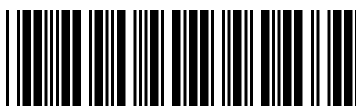
____

Have you had the following?

Mumps	☐ Yes	☐ No
Measles	☐ Yes	☐ No
Chickenpox	☐ Yes	☐ No
Mononucleosis	☐ Yes	☐ No
Rhumatic Fever	☐ Yes	☐ No

Do you travel outside the United States? ☐ Yes ☐ No If yes, where and when: ______________________

____



TRNPLT

Your height is: ______________ Your weight is: __________ ☐ lbs. ☐ kg Is this your usual weight? ☐ Yes ☐ No

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

____

Allergies: ______________

1. NEUROLOGY (brain and spinal cord) Check yes or no:

Headaches ☐ Yes ☐ No

Head injury ☐ Yes ☐ No

Seizures ☐ Yes ☐ No

Back pain ☐ Yes ☐ No

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

____

Neurologist (brain doctor): ______________ Phone: ______________

2. EYE, EAR, NOSE AND THROAT Check yes or no:

Blindness ☐ Yes ☐ No

Deafness/Hearing Loss ☐ Yes ☐ No

Sinus infections ☐ Yes ☐ No

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

____

ENT (eye, ear, nose and throat doctor): ______________ Phone: ______________

3. CARDIAC (heart) Check yes or no:

High blood pressure ☐ Yes ☐ No

Swollen ankles ☐ Yes ☐ No

Heart disease ☐ Yes ☐ No

Heart attack ☐ Yes ☐ No

Pacemaker ☐ Yes ☐ No

Heart surgery ☐ Yes ☐ No

Heart palpitations ☐ Yes ☐ No

Additional problems/surgeries/any recent testing that you have had related to your heart: ______________

____

Cardiologist (heart doctor): ______________ Phone: ______________

4. PULMONARY (lungs) Check yes or no:

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

Additional problems/surgeries/any recent testing that you have had related to your lungs: ______________

____

Pulmonologist (lung doctor): ______________ Phone: ______________

5. ENDOCRINOLOGY (diabetes or thyroid)

	Check yes or no:	
Diabetic	☐ Yes ☐ No	Age when diagnosed:________
Thyroid problems	☐ Yes ☐ No	
Does anyone in your family have diabetes?	☐ Yes ☐ No	
Does anyone in your family have thyroid problems?	☐ Yes ☐ No	

Endocrinologist (diabetes/thyroid doctor):________________ Phone:________________

6. GASTROENTEROLOGY (abdomen/intestines/liver/stomach)

	Check yes or no:
History of hepatitis	☐ Yes ☐ No
Ulcer in stomach/intestines	☐ Yes ☐ No
History of blood in stools	☐ Yes ☐ No
History of gallstones/gallbladder problems	☐ Yes ☐ No
Diverticulosis	☐ Yes ☐ No
History of vomiting blood	☐ Yes ☐ No
Problems with esophagus	☐ Yes ☐ No
History of diarrhea	☐ Yes ☐ No
History of constipation	☐ Yes ☐ No
Have you ever had a colonoscopy (lower endoscopy) or EGD (upper endoscopy)?	☐ Yes ☐ No

When:________________ Why:________________

Additional problems/surgeries/any recent testing that you have had related to your abdomen, intestines, liver and/or stomach:________________

____

Gastroenterologist (abdomen, stomach, liver and/or intestines doctor):________________ Phone:________________

7. UROLOGY (kidney/bladder/ureter/urethra)

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

If yes, why?________________

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

____

Urologist (kidney/bladder/ureter/urethra doctor):________________ Phone:________________

8. HEMATOLOGY/ONCOLOGY/RHEUMATOLOGY

(blood/cancer/arthritis) Check yes or no:

History of bleeding problems ☐ Yes ☐ No

History of difficulty clotting ☐ Yes ☐ No

Frequent bruising ☐ Yes ☐ No

Blood clots in legs or lungs ☐ Yes ☐ No

Frequent nosebleeds ☐ Yes ☐ No

Do you have arthritis? ☐ Yes ☐ No

Do you have muscle or joint pains? ☐ Yes ☐ No

Do you have a history of cancer? ☐ Yes ☐ No

If yes, what type of cancer?____________________

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?__________

Additional problems/surgeries/any recent testing that you have had related to your blood problem or cancer:__________

____

Hematologist/Oncologist/Rheumatologist
(blood/cancer/arthritis doctor): ____________________ Phone:____________________

9. GYNECOLOGY (breasts/female organs)

Check yes or no:

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/any recent testing that you have had related to your your female organs:__________

____

Gynecologist (female doctor):____________________ Phone:____________________

Breast doctor:____________________ Phone:____________________

10. PSYCHOSOCIAL (mental/social)

Check yes or no:

History of mental illness	☐ Yes	☐ No	Age when diagnosed: ______
History of alcohol/substance abuse	☐ Yes	☐ No	
Anxiety	☐ Yes	☐ No	
Depression	☐ Yes	☐ No	
Have you ever been incarcerated?	☐ Yes	☐ No	

Psychiatrist/Psychologist (mental/social doctor): ______________________ Phone: ______________

11. ADDITIONAL INFORMATION

Check yes or no:

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: ______________________

Is your spouse/significant other supportive of your decision to donate a kidney? ☐ Yes ☐ No

Is your employer willing to give you time off for the evaluation and recovery after donating? ☐ Yes ☐ No

12. FAMILY HISTORY

	Current Age	Medical Problems	Cause of death and Age at death (if no longer living)
Father			
Mother			
Brothers			
Sisters			
Sons			
Daughters			

13. HEALTH HABITS

Check yes or no:

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

Have you ever smoked? ☐ Yes ☐ No Packs per day: ________ Quit date: __________

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? ______ Coffee cups per day: ____________

Tea cups per day: ____________ Caffeinated beverages per day: ____________

Amount of alcohol daily: ____________

Completion of this routine health survey is required in order to be considered as a potential living donor.

I, ____, give my permission to be contacted by Texas Health Harris Methodist Hospital Kidney Transplant Program to receive more information about living donation.

☐ Yes I do ☐ No I do not give my permission to have my blood type and tissue typing lab work drawn as part of the initial screening to be a potential living kidney donor.

☐ Yes I do ☐ No I do not give my permission to allow the transplant program to let the potential recipient know that I have submitted this application. No health information will be shared with your potential recipient.

I understand that by giving my permission to be contacted and/or have screening labs drawn required no furtner commitment to proceed with evaluation of living donation

Potential Donor Name: ______________________________ Date: ____________________