DONOR – Living Donor Application / Health History

If you wish to be considered as a Living Donor, please complete this application and return by mail, fax, or e-mail to:

Texas Health Harris Methodist Hospital Fort Worth
Kidney Transplant Program
1301 Pennsylvania Avenue
Fort Worth, Texas 76104

For questions, please call **817-250-2443** or **800-411-2443**
Fax: **817-250-5136** Email**: THFWKidneyTransplant@TexasHealth.org**

Kidney Transplant Program

DONOR - Living Donation Application / Health History

Last Name ______________________ First Name ______________________

Middle Name or Initial ______________________ Maiden Name ______________________

Date of Birth ______________ Gender Male Female Age ________ Race ______________

Address ______________________ Apartment # ______________

County / City / State / Zip / ______________________________

Home Phone ______________________ Work Phone ______________________

Email Address ______________________ Cell Phone ______________________

Emergency contact ______________________

Are you a U.S. Citizen Yes No SS# ______________________

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

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 ______________________

Are you working: Full time Part time Self-employed 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 would be able to help you around the time of surgery ______________

Name and address of your personal physician Dr. ______________________________

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 Rheumatic Fever Yes No
Mononucleosis Yes No
Do you travel outside the United States Yes No If yes, where and when______________________

____

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 any that apply to you…

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) ______________________ Telephone # ______________________

2. **EYE, EAR, NOSE, AND THROAT** Check any that apply to you…

Blindness	❑Yes ❑No
Deafness/Hearing Loss	❑Yes ❑No
Sinus infections	❑Yes ❑No

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

____

ENT (Eye, Ear, Nose & Throat Doctor)______________________ Telephone # ______________________

3. **CARDIAC** (Heart) Check any that apply to you…

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

Any additional problems/surgeries/recent testing that you have had related to your heart

____

Cardiologist (Heart Doctor) ______________________ Telephone # ______________________

4. **PULMONARY** (Lungs) Check any that apply to you…

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

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

____

Pulmonologist (Lung Doctor) ______________________ Telephone # ______________________

5. ENDOCRINOLOGY (Diabetes or Thyroid) — Check any that apply to you…

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) ______ Telephone # ______

6. GASTROENTEROLOGY (Abdomen/intestines/liver/stomach) — Check all that apply…

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? ______

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 # ______

7. UROLOGY (Kidney/bladder/ureter/urethra) — Check all that apply…

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,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/recent testing that you have had related to your kidneys, bladder, ureters, and/or urethra

______

Urologist (Doctor for kidney / bladder/ureter/urethra) ______Telephone #______

8. HEMATOLOGY/ONCOLOGY/RHEUMATOLOGY (Blood/Cancer) Check any that apply…

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? ______________________________

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/recent testing that you have had related to your blood problem or cancer ______________________

____

Hematologist/Oncologist/Rheumatologist's Name ______________________________

Telephone # ______________________________

9. GYNECOLOGY (Breasts/Female Organs)

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 you 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/recent testing that you have had related to your female organs ______________________

____

Gynecologist's (Female Doctor) ______________________________ Telephone # ______________________

Breast Doctor's Name ______________________________ Telephone # ______________________

10. PSYCHOSOCIAL (Mental/Social) Check any that apply to you…

History of Mental Illness	❑Yes ❑No
History of Alcohol/Substance Abuse	❑Yes ❑No
Anxiety	❑Yes ❑No
Depression	❑Yes ❑No
Have you ever been incarcerated	❑Yes ❑No

Psychiatrist/Psychologist's Name ______________________________ Telephone # ____________________

11. ADDITIONAL INFORMATION

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/Age at death (If no longer living)
Father			
Mother			
Brothers			
Sisters			
Sons			
Daughters			

13. HEALTH HABITS

Do you currently smoke ❑Yes ❑No Amount _______________

Have you ever smoked ❑Yes ❑No Packs per day __________ Date that you quit ____________________

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

Amount of coffee cups __________ per day

Amount of 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 the 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.

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

Potential donor's signature ____ Date ________________