Transplant Intake Form

Texas Health Harris Methodist Hospital® FORT WORTH

Name _____ Date of Birth _____ Age _____

Medication Allergies _____

Primary Care Physician _____ Physician Phone Number _____

Current Nephrologist (Kidney Doctor) _____

Potential Living Donors ❑ Yes ❑ No Request information about Living Donation? ❑ Yes ❑ No

What caused your kidney disease? _____

Are you listed at another transplant center? ❑ Yes ❑ No If yes, where? _____

Do you urinate? ❑ Yes ❑ No If yes, more than one cup per day ❑ Yes ❑ No

Medical History

Select YES if you currently have the condition. Select HX if you have had the condition in the past. Select NO if you have never had the condition.

Seizures	❑ Yes ❑ HX ❑ No	Amputations	❑ Yes ❑ HX ❑ No	Frequent bladder infections	❑ Yes ❑ HX ❑ No
Stroke or CVA	❑ Yes ❑ HX ❑ No	TB/Tuberculosis	❑ Yes ❑ HX ❑ No	Urinary Incontinence	❑ Yes ❑ HX ❑ No
Blindness	❑ Yes ❑ HX ❑ No	Asthma	❑ Yes ❑ HX ❑ No	Kidney Stones	❑ Yes ❑ HX ❑ No
Hearing Loss	❑ Yes ❑ HX ❑ No	Chronic Obstructive Pulmonary Disease (COPD)	❑ Yes ❑ HX ❑ No	Peripheral Vascular Disease	❑ Yes ❑ HX ❑ No
Sinus Infections	❑ Yes ❑ HX ❑ No	CPAP/BIPAP	❑ Yes ❑ HX ❑ No	Bleeding Problems	❑ Yes ❑ HX ❑ No
High Blood Pressure	❑ Yes ❑ HX ❑ No	Lung Masses/Nodule	❑ Yes ❑ HX ❑ No	Blood Clots in legs or lungs	❑ Yes ❑ HX ❑ No
Pacemaker	❑ Yes ❑ HX ❑ No	Home Oxygen	❑ Yes ❑ HX ❑ No	Blood Transfusions How many? _____ Date of last Transfusion:	❑ Yes ❑ HX ❑ No _____/_____/_____
Heart Attack	❑ Yes ❑ HX ❑ No	Diabetes Type of Diabetes:	❑ Yes ❑ HX ❑ No ❑ 1 ❑ 2 ❑ UNKN	Anxiety or Depression	❑ Yes ❑ HX ❑ No
Heart Rhythm Issue	❑ Yes ❑ HX ❑ No	Age of Diabetes Diagnosis:	_____		
Vascular Heart Disease	❑ Yes ❑ HX ❑ No	Thyroid Issues	❑ Yes ❑ HX ❑ No	Psychiatric Illness Describe:	❑ Yes ❑ HX ❑ No
Sores on Feet	❑ Yes ❑ HX ❑ No	Stomach/Intestines Ulcers	❑ Yes ❑ HX ❑ No	Enlarged Prostate	❑ Yes ❑ HX ❑ No ❑ N/A
Gangrene	❑ Yes ❑ HX ❑ No	Blood in Stools or Vomit	❑ Yes ❑ HX ❑ No		

Procedure/Surgical History

If you have had a procedure/surgery listed below, check YES. Please also include information about the surgery.

PROCEDURE	YES/NO	DATE	AGE	DETAILS	LOCATION TO RECEIVE RECORDS
Removal of skin lesion or mole	❑ Yes ❑ No				
CT or MRI of head	❑ Yes ❑ No				
Spinal surgery	❑ Yes ❑ No			Specify Level of Spine: ❑ C 1-7 ❑ T 1-12 ❑ L1-5 ❑ S 1-5	
Neck surgery	❑ Yes ❑ No			Name/Type of procedure:	
Stents	❑ Yes ❑ No			Location:	
EGD	❑ Yes ❑ No				

Procedure/Surgical History *continued*

If you have had a procedure/surgery listed below, check YES. Please also include information about the surgery.

PROCEDURE	YES/NO	DATE	AGE	DETAILS	LOCATION TO RECEIVE RECORDS
Echocardiogram (Ultrasound of the heart)	❑ Yes ❑ No				
Cardiac stress test	❑ Yes ❑ No				
CABG (Coronary Artery Bypass Graft)	❑ Yes ❑ No			How many vessels:	
Surgery to increase blood flow to arms or legs	❑ Yes ❑ No			Type and location of surgery:	
Chest/Lung surgery	❑ Yes ❑ No				
Colon surgery	❑ Yes ❑ No				
CT or MRI of abdomen	❑ Yes ❑ No				
Bladder surgery	❑ Yes ❑ No				
Bone marrow biopsy	❑ Yes ❑ No				
Joint surgery	❑ Yes ❑ No			Type and location of surgery:	
Breast biopsy or surgery	❑ Yes ❑ No			Results:	
Hysterectomy	❑ Yes ❑ No			❑ Full ❑ Partial Reason:	

Other Surgeries

List any other surgeries or procedures you have had. Please also include information about the surgery.

PROCEDURE	DATE	AGE	DETAILS	LOCATION TO RECEIVE RECORDS

Cancer History

Please indicate if you have had any of the following cancers.

CANCER	YES/NO	TYPE/LOCATION	TREATMENT
Skin	❑ Yes ❑ No	❑ Basal Cell ❑ Squamos Cell ❑ Squamos Cell Location:	Treatment: Last Treatment Date: Name of Physician: Location of Records:

Cancer History *continued*

Please indicate if you have had any of the following cancers.

CANCER	YES/NO	TYPE/LOCATION	TREATMENT
Kidney	❑ Yes ❑ No	❑ Left ❑ Right	Treatment: Last Treatment Date: Name of Physician: Location of Records:
Liver	❑ Yes ❑ No		Treatment: Last Treatment Date: Name of Physician: Location of Records:
Colon	❑ Yes ❑ No		Treatment: Last Treatment Date: Name of Physician: Location of Records:
Prostate	❑ Yes ❑ No		Treatment: Last Treatment Date: Name of Physician: Location of Records:
Breast	❑ Yes ❑ No		Treatment: Last Treatment Date: Name of Physician: Location of Records:

Other Cancer

Please list any other cancers not mentioned above.

CANCER	TYPE/LOCATION	TREATMENT	PHYSICIAN/RECORDS
		Treatment: Last Treatment Date:	Name of Physician: Location of Records:
		Treatment: Last Treatment Date:	Name of Physician: Location of Records:

Infectious Diseases

Select YES if you currently have the infection. Select HX if you have had the infection in the past. Select NO if you have never had the infection.

HIV/AIDS	❑ Yes ❑ HX ❑ No	**Hepatitis C**	❑ Yes ❑ HX ❑ No	**Sexually Transmitted Disease (STD)**	❑ Yes ❑ HX ❑ No Type:
Hepatitis B	❑ Yes ❑ HX ❑ No	**Tuberculosis**	❑ Yes ❑ HX ❑ No	**Other:**	❑ Yes ❑ HX

Vaccination/Immunization History

Hepatitis B Series	❑ Yes Date Received: ❑ No	**COVID-19 Series**	❑ Yes Type: ❑ PFIZER ❑ MODERNA ❑ OTHER Date of 1st Vaccine: _____ Date of 2nd Vaccine: _____ ❑ No

Social/Functional Questionnaire

Can you walk a mile and climb 2 flights of stairs?	❑ Yes ❑ No
Are you able to clean your home by yourself?	❑ Yes ❑ No
Are you able to give yourself a bath or shower	❑ Yes ❑ No
Are you able to dress yourself?	❑ Yes ❑ No
Are you able to use the bathroom by yourself?	❑ Yes ❑ No
Can you walk without the assistance of a walker, cane, wheelchair, or another person?	❑ Yes ❑ No
Do you ever urinate or have a bowel movement before you make it to the restroom?	❑ Yes ❑ No
Are you able to prepare your own meals?	❑ Yes ❑ No
Do you organize and take your own daily medications?	❑ Yes ❑ No
Are you able to drive a car?	❑ Yes ❑ No
Are you able to read and write?	❑ Yes ❑ No
Do you exercise? Type: How long: How often:	❑ Yes ❑ No
Have you ever traveled outside the United States? When: Where:	❑ Yes ❑ No

What is your highest level of education? ❑ None ❑ Grade School ❑ High School GED ❑ Associate/Bachelor's Degree ❑ Post College Graduate

Current living arrangements? ❑ Home/Apartment ❑ Nursing Home ❑ Assisted Living

Who lives with you?

Who will be your support person after surgery?

Do you smoke or use any nicotine products? Type: How much: How often:	❑ Yes ❑ HX ❑ No
Do you drink alcohol? Type: How much: How often:	❑ Yes ❑ HX ❑ No
Do you use any illegal drugs? Type: How much: How often:	❑ Yes ❑ HX ❑ No

Health Maintenance

EXAM	DATE OF LAST EXAM	PHYSICIAN WHO COMPLETED LAST EXAM	OFFICE/HOSPITAL TO REQUEST RESULTS	FREQUENCY NEEDED FOR TRANSPLANT LISTING
Dental				Yearly
Colonoscopy				Screening at age 45, then per GI recommendations
Mammogram				Screening at age 40, then yearly after age 45
Pap Smear				Every 3 years after becoming sexually active

*** Please call your physician office to make an appointment to complete any testing that has not been performed within the frequency required. This will help speed up the transplant evaluation process.**

Physician Team

Please list name of any physicians you have seen in the following specialties

Cardiology		**Infectious Disease**	
Dermatology		**Gastroenterology**	
Neurology		**Psychiatry**	