WVU Medicine

Living Kidney Donor History and Health Questionnaire

PHONE: 304-974-3004 FAX: 304-598-4899 PO Box 8301, Morgantown, WV 26506-8012

Please answer the following questions to the best of your knowledge. If you are unsure, leave those questions blank.

PATIENT INFORMATION

Name: _____ DOB: ____/____/____

Preferred Name/Nickname: _____ E-mail: _____

Address: _____

Home Phone Number: _____ Cell Phone Number: _____

Gender/identity: _____ Height: _____ Weight (pounds): _____

Marital Status:

- ☐ **Single**
- ☐ **Married**
- ☐ **Divorced**
- ☐ **Separated**
- ☐ **Life partner**
- ☐ **Widowed**

Do you have any children? ☐ **Yes** ☐ **No**

If yes, how many? _____ Ages: _____

Do any of your children have health problems? ☐ **Yes** ☐ **No**

If yes, please explain: _____

Who would be able to help you after surgery? _____

DEMOGRAPHICS

Citizenship:

- ☐ **U.S. Citizen**
- ☐ **Non- U.S. Citizen/U.S. Resident**
- ☐ **Non-U.S. Citizen/U.S. Resident, Traveled to the U.S. for Reason other than donation**
- ☐ **Non-U.S. Citizen/U.S. Resident, Traveled to the U.S. for donation**
- ☐ **Country of Permanent Residence if not the U.S.:** _____
- **Year of Entry into the U.S.:** _____

Highest Education Level:

- ☐ **Grade School (0-8)**
- ☐ **High School (9-12) or GED**
- ☐ **Attended college/technical school**
- ☐ **Associate/Bachelor's Degree**
- ☐ **Post-college Graduate Degree**

Employment Status:
Are you currently working for income? ☐ **Yes** ☐ **No**

If yes:

- ☐ **Working full time**
- ☐ **Working part time by choice**
- ☐ **Working part time because of disability**
- ☐ **Working part time due to inability to find full-time work**

If no:

- ☐ **Disability (please explain):** _____
- ☐ **Inability to find work**
- ☐ **Student**
- ☐ **Retired**
- ☐ **By choice (please explain):** _____

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DEMOGRAPHICS - CONTINUED

Name of employer _____ Type of Job _____ Years with employer ___

Does your employer offer time off for the evaluation and recovery following kidney donation? ☐ **Yes** ☐ **No** ☐ **Unknown**

Do your religious beliefs permit you to accept blood products if needed? ☐ **Yes** ☐ **No**

If no, please explain: _____

Name of your Primary Care Physician or Practice: _____

Address: _____

Phone Number: _____ Fax Number: _____

Have you had a physical in the last 12 months? ☐ **Yes – date:** _____/_____/_____ ☐ **No**

What is your blood type?

☐ **A** ☐ **AB** ☐ **Unsure**
☐ **B** ☐ **O**

Ethnicity/Race (select all that apply):

☐ White/Caucasian

American Indian or Alaska Native

☐ **American Indian** ☐ **Alaska Indian** ☐ **American Indian or Alaska Native: not specified/unknown**
☐ **Eskimo** ☐ **American Indian or Alaska Native: other**
☐ **Aleutian**

Asian

☐ **Asian Indian/Indian Sub-Continent** ☐ **Japanese** ☐ **Asian: Other**
☐ **Chinese** ☐ **Korean** ☐ **Asian: Not Specified**
☐ **Filipino** ☐ **Vietnamese**

Black or African American

☐ **African American** ☐ **West Indian** ☐ **Black or African American: Other**
☐ **African (Continental)** ☐ **Haitian** ☐ **Black or African American: Not Specified/Unknown**

Hispanic/Latino

☐ **Mexican** ☐ **Puerto Rican (Island)** ☐ **Hispanic/Latino: Other**
☐ **Puerto Rican (Mainland)** ☐ **Cuban** ☐ **Hispanic/Latino: Not Specified/ Unknown**

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MEDICAL HISTORY

Have you ever been treated for the following conditions?

	Never	Treated in Past	Currently Treated	Comments
Diabetes				
Gestational Diabetes				
Neurological Disease/Seizures				
Heart Disease/Heart Attack				
Hypertension/High Blood Pressure				
Anemia (Low blood count)				
Stroke				
Deep Vein Thrombosis (DVT)/Blood Clot				
Lung Disease/Asthma				
COPD/Emphysema				
Blood Clot in Lungs/Pulmonary Embolism (PE)				
Liver Disease/Hepatitis/Jaundice				
Excessive Bleeding				
GI Disease/Crohn's/Ulcers				
Kidney Disease/Bladder Infections/ UTI's				
Kidney Injury or Dialysis				
Kidney Stones				
Blood or Protein in Urine				
Autoimmune Kidney Disease/Lupus				
Autoimmune Disease				
Cancer (including Skin Cancer				
Infections (TB/HIV/AIDS/Hep C.)				
Gout				
Chronic Back Pain				

Please add any additional medical problems not noted above – use the back of the page if needed

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MEDICATION HISTORY

Please complete table below to include any prescribed medications and over-the-counter medications.

Medication Name	Dose	Frequency	Why do you take it?

Please make sure to include any use of pain medications, such as Ibuprofen (Advil, Motrin®), Naproxen (Aleve®)

Please complete table below to include any prescribed medications and over-the-counter medications.

Vitamin or Supplement	Dose	Frequency	Why do you take it?

VACCINATION HISTORY

Please list any vaccines that you have received (i.e.: flu vaccine, pneumonia vaccine, shingles, COVID-19, etc.).

Vaccine	Date	Vaccine	Date

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ALLERGY HISTORY

Please list any allergies you have to medications or foods.

Allergen	Reaction

SURGICAL HISTORY

Please list any surgeries and/or procedures you had and the facility where they were performed.

Date	Surgery	Location	Why

SOCIAL HISTORY

Alcohol:

☐ **Yes - amount consumed in 1 week:** _____

☐ **No**

☐ **Never**

Tobacco:

☐ **Never smoked**

☐ **Smoker**

- **What do you smoke?** _____
- **How much do you smoke?** _____

☐ **Former smoker**

- **Quit date:** _____
- **How long did you smoke?** _____
- **How much did you smoke per day?** _____

Smokeless tobacco use:

☐ **Never**

☐ **Current everyday user**

- **What do you use?** _____
- **How much do you use?** _____

☐ **Former user**

- **Quit date:** _____
- **How long did you smoke?** _____
- **How much did you smoke per day?** _____

Illegal drugs:

☐ **Never**

☐ **Using**

- **What** _____
- **Route** _____
- **How much** _____

☐ **Former**

- **Quit date** _____
- **What** _____
- **How long did you use?** _____
- **How much did you use per day?** _____

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SOCIAL HISTORY - CONTINUED

Have you ever participated in a drug or alcohol rehabilitation program? ☐ Yes ☐ No

If yes, please explain: _____

Have you ever been under the care of a mental health professional? ☐ Yes ☐ No

If yes, please explain: _____

Do you have any tattoos or body piercings? ☐ Yes ☐ No

If yes, how many tattoos: _____ Date of last one: _____ How many piercings: _____Date of last one: _____

Have you ever been in jail? ☐ Yes ☐ No

If yes ☐ When: _____ ☐ How long: _____

FAMILY HISTORY

Please list any medical history for the following family members. If medical history is not known, please leave blank.

☐ **I am adopted**

Family Member	Medical History	Alive or Deceased
Mother		
Father		
Siblings		
Children		
Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Paternal Grandfather		

FEMALE SCREENING

Pregnancy

Number of deliveries: _____

Number of abortions: _____

Number of miscarriages: _____

Do you plan on having more children? ☐ Yes ☐ No

Are you currently using birth control? ☐ Yes ☐ No

If yes, what form:

_____

Menstrual Cycle

Last menses/period:

_____

Are you post-menopausal? ☐ Yes ☐ No

Testing

Last pap smear_____

Any abnormal pap smear results?

_____

Date of last mammogram:

_____

Any abnormal mammogram findings?

_____

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MALE SCREENING

Do you have prostate problems? ☐ Yes ☐ No

Do you have regular prostate exams? ☐ Yes ☐ No If yes, date of last exam: _____/_____/_____

Have you ever been diagnosed with testicular cancer? ☐ Yes ☐ No

If yes, date diagnosed: _____/_____/_____ Date of last PSA test: _____/_____/_____

HEALTH INSURANCE

Health insurance is not required to be a Living Kidney Donor as all testing to determine candidacy, appointments, surgery, and hospital stay are covered by the recipient's insurance. During the testing, there is a potential for an unexpected medical finding at which point any additional tests or consults needed then bill to your insurance provider. In addition, your follow-up will be covered for 2 years post-donation to monitor your kidney function with the annual requirements then moving to your local provider/insurer.

Do you currently have health insurance? ☐ Yes ☐ No

If yes: Insurance provider name: _____ Identification number _____

RECIPIENT

Intended recipient's name: _____

Your relationship to recipient:

- ☐ Parent
- ☐ Child
- ☐ Identical twin
- ☐ Full sibling
- ☐ Half sibling
- ☐ Spouse
- ☐ Life partner
- ☐ Secondary Family (Aunt/Uncle/Cousin)
- ☐ Friend
- ☐ Co-worker
- ☐ Anonymous/altruistic
- ☐ Other: _____

Are you feeling pressured or forced into being a donor? ☐ Yes ☐ No

If yes - please explain _____

Are you being offered any compensation for being a donor? ☐ Yes ☐ No

If yes - please explain: _____

Do you have any concerns about the recipient's commitment to taking care of the transplanted organ? ☐ Yes ☐ No

My signature below acknowledges that I have completed this form and that the information provided is as accurate and detailed as possible to the best of my knowledge.

Signature: _____ Date: _____/_____/_____

Instructions for Form Return:
Living Kidney Donor Program
Attn: Living Donor Coordinator
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Phone: 304-974-3004
Fax: 304-598-4899