DONOR DEMOGRAPHICS FORM

Referral Date: ______________________ Evaluation (PTE) Date: ______________________

☐ "Donating Your Kidney" booklet given.

NAME: ______________________ Date of Birth: ______________________

Address: ______________________ Social Security: ______________________

______________________ Gender: Male Female

______________________ Race: ______________________

Telephone Number: ______________________ Height: ______________________

Cell Number: ______________________ Weight: ______________________

Work Number: ______________________ Is it alright to call you at work? ______________________

E-Mail Address: ______________________

Blood Type: ______________________

Blood Pressure Reading: ______________________

Donor For (Name): ______________________ Relationship to Recipient: ______________________

Have you ever been told you have or been treated for:

High Blood Pressure Yes No

Diabetes Yes No

Stroke or Heart Attack Yes No

WOMEN: Have you ever had any problems during pregnancy?

____ High Blood Pressure _____ Gestational Diabetes ____ Other –explain: ______________________

Date of Last Pap Smear: ______________________ Where: ______________________

Date of Last Mammogram: ______________________ Where: ______________________

Does Anyone in Your **Family** Have Any of The Following? :

Stroke Yes No
If yes, who? ______________________
Heart attack Yes No
If yes, who? ______________________
Cancer Yes No
If yes, who? ______________________
Diabetes Yes No
If yes, who? ______________________
High blood pressure Yes No
If yes, who? ______________________

Do **You** Have Any of The Following? :

Cardiac:

Chest pain	Yes	No
Shortness of breath	Yes	No
Swelling of legs/arms	Yes	No

Renal:

Urinary tract infection	Yes	No
Kidney stones	Yes	No

GI:

Nausea	Yes	No
Vomiting	Yes	No
Constipation	Yes	No
Diarrhea	Yes	No
Heartburn	Yes	No
Ulcers	Yes	No
Rectal bleeding	Yes	No
Gallbladder problems	Yes	No
Jaundice	Yes	No

Pulmonary:

Cough	Yes	No
Bronchitis	Yes	No
Pneumonia	Yes	No

Neurological:

Dizziness/blackouts	Yes	No
Headaches	Yes	No
Blurry vision	Yes	No

Mental:

Depression	Yes	No
Mental disorders	Yes	No

Have **You** Had Any of These Conditions? :

Cancer	Yes	No
HIV	Yes	No
Hepatitis	Yes	No
Thyroid problems	Yes	No
Tuberculosis	Yes	No
Asthma	Yes	No

Have you ever had a blood transfusion? Yes No

Do you have any religious beliefs that would prevent you from receiving blood transfusions? Yes No

Have you ever had a colonoscopy? Yes No

If yes, When? ______________________ Where? ______________________

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Have You Ever Been Hospitalized? Yes No

If yes, when and for what? ____

____

Any Surgeries: Yes No

If yes, what type and when? ____

____

Do You Smoke? Yes No

If yes, how much ______/day For how many years? ____________________
If no, did you use to smoke? Yes No
If yes, when did you quit? ____

Do You Drink Alcohol? Yes No

If yes, how much? _____/day ______/week Since when? ____________________
If no, did you use to drink? Yes No
If yes, when did you quit? ____

Do You Use Recreational Drugs? Yes No

If yes, type and quantity: ____
If no, have you ever used drugs? Yes No
If yes, when was last time? ____

Family History:

Marital Status: Married Divorced Separated Widowed Single

Any Children? Yes No

If yes, ages: ____

Are you employed? Yes No

If yes, occupation: ____

If no, when did you last work? ____

Check highest level of education completed:

____None ____Grade School (0-8) ____High School (9-12) ____Attended College/Technical School

____ Associate/Bachelor Degree ____ Post-College Graduate Degree

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Are your parents still living? Yes No

If yes, ages: Mother: ________ Father: _________

Do they have any medical problems? : ______________________________________

If deceased, cause of death: ____

Do you have any brothers or sisters? : Yes No

If yes, ages: ____

Do they have any medical problems? :______________________________________

If deceased, cause of death: ____

Are you taking any medication? : Yes No

If yes, list types: ____

____

Any Allergies: Yes No

If yes, please list: ____

____

Are there any conditions, medical or otherwise, that we should be aware of that were not covered? Yes No

If yes, list: ____

____

Primary Care Physician (Family Doctor) ___________________________________

Phone: _____________________________________

Address: ___________________________________

Transplant Office Use Only:

Relationship to Recipient ________________________

Recipient Insurance ________________________

Financial Clearance ________________________

Recipient ABO ________ Recipient PRA __________

Recipient Status ___________________________ Re-Transplant ___________________________