Transplant Institute
THE GEORGE WASHINGTON UNIVERSITY HOSPITAL

Living Donor Kidney Medical and Behavioral Questionnaire

Referral Date: _____

Last Name: _____ First Name: _____

Middle Initial: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Other Phone: _____

Email Address: _____

Date of Birth: _____ Social Security Number: _____ Sex: _____

Marital Status: _____ Race/Ethnicity: _____ Religion: _____

Preferred Language: _____ Where were you born: _____

Where did you grow up: What is your country of citizenship:

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____ Relationship to you: _____

Emergency Contact Phone Number: _____ Secondary Phone Number (not req): _____

Emergency Contact Address

PHYSICIAN INFORMATION

Primary Care Doctor: Phone Number:

POTENTIAL RECIPIENT INFORMATION

Last Name: _____ First Name: _____

Donor's Relationship to Recipient:

HIGHEST LEVEL OF EDUCATION COMPLETED

Grade School (0-8) ☐	High School (9-12) ☐	College/Technical School ☐
Associate Bachelor Degree ☐	Post Graduate Degree ☐	

Are you currently working? YES ☐ NO ☐ Retired ☐

If yes Full - Time ☐ Part - Time ☐

Occupation: _____

Name of Employer:

MEDICAL HISTORY PART 1

Height: _____ Weight: _____ BMI: _____

Blood Type (If Known): _____

Medications/Dosages: _____

Supplements - Vitamins, Herbal, etc.: _____

Allergies:

MEDICAL HISTORY PART 2

Do you have or have you ever had any of the following? Please answer YES or NO. If YES, please explain in the additional details section

	Yes	No
Diabetes	☐	☐
High Blood Pressure	☐	☐
High Cholesterol	☐	☐
Lung Disease	☐	☐
Heart Disease	☐	☐
Cancer	☐	☐
Kidney Stones	☐	☐
Asthma	☐	☐
Blood Transfusion	☐	☐
Urinary Tract Infection (UTI)	☐	☐
Depression	☐	☐
Psychiatric Disorder	☐	☐

	Yes	No
Hepatitis	☐	☐
Lupus	☐	☐
Arthritis	☐	☐
Intestine Issues	☐	☐
Stomach Issues	☐	☐
Sickle Cell	☐	☐
Blood Clots	☐	☐
Anemia	☐	☐
Seizures	☐	☐
Kidney or Bladder Infection	☐	☐
Anxiety/Panic Attach	☐	☐

FEMALES		
	Yes	**No**
Abnormal PAP smear	☐	☐
Abnormal Mammogram	☐	☐

MALES		
	Yes	**No**
Elevated PSA	☐	☐

Additional Details: _____

Other Illness:

MEDICAL HISTORY PART 3 – CURRENT SYMPTOMS

	Yes	No
Difficulty Breathing	☐	☐
Leg Swelling	☐	☐
Unexplained weight loss	☐	☐
Nausea/Vomiting	☐	☐
Cough	☐	☐
Pain in Legs	☐	☐

	Yes	No
Chest Pain	☐	☐
Headache	☐	☐
Pain in legs	☐	☐
Diarrhea	☐	☐
Fever	☐	☐
Stiff Joints	☐	☐

Please list any surgeries/operations and the dates:

Have you ever been hospitalized for any reason other than the above surgery?

FEMALE DONORS

Number of Pregnancies: _____ Number of Live Births: _____

Complications during pregnancy:

Gestational Diabetes: ☐ High Blood Pressure: ☐

Other Problems During Pregnancy:

FAMILY HISTORY

	Yes	No	Relative		Yes	No	Relative
High Blood Pressure	☐	☐		Kidney Disease	☐	☐	
Diabetes	☐	☐		Kidney Stones	☐	☐	
Heart Attack or Stroke	☐	☐		Kidney Cancer	☐	☐	
Cancer	☐	☐		Type of Cancer	☐	☐	

TOBACCO PRODUCTS

	Yes	No			Yes	No
Cigarettes	☐	☐		Current	☐	☐
Other	☐	☐		For how long?	☐	☐

ALCOHOL

Yes	☐	No	☐	
How Much?	/			
What Type?				
For How Long?				

NON-PRESCRIPTION DRUGS OR OTHER SUBSTANCES (MARIJUANA, COCAINE, STEROIDS, INHALANTS):

Yes	☐	No	☐	Date of Last Use:	
If Yes, What Type and Route:					

In the past have you received a tattoo, ear/body piercing, or acupuncture? Yes ☐ No ☐
If yes; when, where, by whom and how?

VACCINATIONS

In the past 12 months have you been vaccinated or immunized for any reason? Yes ☐ No ☐
If yes; what type?

Have you been vaccinated for Hepatitis B? Yes ☐ No ☐

Have you been vaccinated for small pox in the last 8 weeks? Yes ☐ No ☐
If yes; when? _____

Have you recently had close contact with a recipient of the small pox vaccination? Yes ☐ No ☐
If yes; when?

Have you experienced skin infections (leprosy, eczema, dermatitis, inflammatory skin disease or abrasions? If yes; type and when?	Yes ☐	No ☐
Have you ever been exposed to any toxic substances (lead, pesticides, or other) If yes; please explain?	Yes ☐	No ☐
Have you ever been tested for HIV?	Yes ☐	No ☐
Have you ever had a positive test for HIV?	Yes ☐	No ☐
Person completing this form (First and Last Name):		
Signature of person completing this form:		
Date:		

LIVING DONOR CENTER FOR DISEASE AND CONTROL (CDC) RISK ASSESSEMENT		
Have you ever received human-derived clotting factor concentrates for hemophilia or related clotting disorders?	Yes ☐	No ☐
Were you exposed to known or suspected viral hepatitis or HIV infected blood through accidental needle sticks or through contact with an open wound, non-intact skin or mucous membrane in the past 12 months? If yes; please explain?	Yes ☐	No ☐
Were you an inmate of a correctional system/jail, of have been released from a correctional system/jail within the past 12 months? If yes; please specify when and for how long?	Yes ☐	No ☐

MALE DONORS		
Have you had sex with another male in the past 5 years?	Yes ☐	No ☐
In the past 12 months have you been treated for any sexually transmitted diseases (syphilis, gonorrhea, herpes, chlamydia, trichomonas, or venereal warts)?	Yes ☐	No ☐
Have you engaged in sex for exchange of money or drugs in the past 5 years?	Yes ☐	No ☐
Have you had sex in the past 12 months with any person known or suspected of having viral hepatitis or HIV infection, or any person described above?	Yes ☐	No ☐
Have you traveled outside of the U.S. in the past 3 years?	Yes ☐	No ☐
If so, when and where?		

Having answered the above questions about medical conditions and behavioral risk factors, do you have any concerns that would make you think you should not proceed with organ donation?	Yes ☐	No ☐
If yes, please explain your concerns?		

By signing this form, I attest the above facts are true and accurate to the best of my knowledge.

Patient Signature: _____ **Date:** _____

Patient Name (Printed) _____