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 ☐

Are you currently insured? YES ☐ NO ☐ If yes, provide name of insurance company: _____

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		Yes	No
Diabetes	☐	☐	Hepatitis	☐	☐
High Blood Pressure	☐	☐	Lupus	☐	☐
High Cholesterol	☐	☐	Arthritis	☐	☐
Lung Disease	☐	☐	Intestine Issues	☐	☐
Heart Disease	☐	☐	Stomach Issues	☐	☐
Cancer	☐	☐	Sickle Cell	☐	☐
Kidney Stones	☐	☐	Blood Clots	☐	☐
Asthma	☐	☐	Anemia	☐	☐
Blood Transfusion	☐	☐	Seizures	☐	☐
Urinary Tract Infection (UTI)	☐	☐	Kidney or Bladder Infection	☐	☐
Depression	☐	☐	Anxiety/Panic Attach	☐	☐
Psychiatric Disorder	☐	☐			

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		Yes	No
Difficulty Breathing	☐	☐	Chest Pain	☐	☐
Leg Swelling	☐	☐	Headache	☐	☐
Unexplained weight loss	☐	☐	Pain in legs	☐	☐
Nausea/Vomiting	☐	☐	Diarrhea	☐	☐
Cough	☐	☐	Fever	☐	☐
Pain in Legs	☐	☐	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: _____

Are you currently taking birth control? YES ☐ NO ☐

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 ☐
In the past five years have you used a needle to inject drugs into your veins, muscle, or under your skin for non-medical use?	Yes ☐	No ☐
Have you lived outside the United States?	Yes ☐	No ☐
Have you had a recent tick or mosquito bite?	Yes ☐	No ☐
Do you work with animals?	Yes ☐	No ☐
Are you a hunter?	Yes ☐	No ☐
Have you had a recent exposure to an infected patient in the hospital or nursing home?	Yes ☐	No ☐
Any travel outside of the U.S. in the last year? If yes; please specify when and where:	Yes ☐	No ☐

PHS Guidelines		
People who have had sex with a person known or suspected to have HIV, HBV, or HCV infection in the preceding 12 months	Yes ☐	No ☐
Men who have had sex with men (MSM) in the preceding 12 months	Yes ☐	No ☐
Women who have had sex with a man with a history of MSM behavior in the preceding 12 months	Yes ☐	No ☐
People who have had sex in exchange for money or drugs in the preceding 12 months	Yes ☐	No ☐
People who have had sex with a person who had sex in exchange for money or drugs in the preceding 12months	Yes ☐	No ☐
People who have had sex with a person who injected drugs by intravenous, intramuscular, orsubcutaneous route for nonmedical reasons in the preceding 12 months	Yes ☐	No ☐
People who have had sex with a person who had sex in exchange for money or drugs in the preceding 12months	Yes ☐	No ☐
People who have been in lockup, jail, prison, or a juvenile correctional facility for more than 72 consecutivehours in the preceding 12 months	Yes ■	No ☐
People who have been newly diagnosed with, or have been treated for, syphilis, gonorrhea, Chlamydia, orgenital ulcers in the preceding 12 months	Yes ☐	No ☐
People who have been on hemodialysis in the preceding 12 months	Yes ☐	No ☐
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 ☐

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) _____