

Iowa Methodist Transplant Center Kidney Recipient Health History Form

Personal Information

Full Name: _____ Male Female
Date of Birth: _____ Social Security Number: _____
Mailing Address: _____
City: _____ State: _____ Zip Code: _____
Home Telephone: _____ Cell phone: _____ Work phone: _____
Email address: _____
Race: _____ Place of Birth: _____ Are you a US Citizen? Yes No

Advance Directives

What is your CODE status? **FULL** or **DNR (Do Not Resuscitate)** (please circle one)
Are you willing to accept blood products? _____ Yes _____ No
Do you have a Durable Power of Attorney? _____ Yes* _____ No
Do you have a Living Will? _____ Yes* _____ No

*Please be prepared to provide a copy.

Emergency Contacts

Name: _____ **Telephone Number:** _____
Name: _____ **Telephone Number:** _____
Name: _____ **Telephone Number:** _____
Name: _____ **Telephone Number:** _____

Health Care Providers

 Please provide a list of all of your healthcare providers:

Kidney Doctor: _____
Family Doctor: _____
Heart Doctor: _____
Diabetes Doctor: _____
Other Doctor: _____

Allergy History

Medication allergies: _____

Food or Environmental allergies: _____

Medical History Please check if you have any of the following conditions/symptoms:

- | | | |
|---|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> Bladder problems |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Hearing difficulties | <input type="checkbox"/> Kidney infections |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Vision difficulties | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Lung disease | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Sexually transmitted disease | <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Chronic pain |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Sleeping difficulties | <input type="checkbox"/> Depression/Anxiety |
| <input type="checkbox"/> Shingles | <input type="checkbox"/> Cancer | <input type="checkbox"/> Blood transfusions |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Teeth or gum problems | <input type="checkbox"/> Previous transplant |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Seizure Disorder | Dialysis Start Date: _____ |

Immunization and Preventative Health History When did you last have the following:

Tetanus _____ Pneumonia _____ Flu _____ Hepatitis A _____ Hepatitis B _____
 Dental Exam _____ Eye Exam _____ Colonoscopy _____
 (Women Only: Mammogram _____ Pap smear _____)

Surgeries/Injuries Please list any surgeries/injuries:

Social History

Marital Status: Single Married Divorced Widowed
 Spouse/Significant Other's name: _____ Telephone: _____
 Maiden Name or any other name under which records may be kept: _____
 What is your highest level of education completed _____
 Are you currently working? Yes No If Yes, Full time or Part time?
 Occupation _____ Employer _____
 Tobacco Use: _____ No _____ Yes, how much/how long _____
 Alcohol Use: _____ No _____ Yes, how much/how often _____
 Recreational Drug Use: _____ No _____ Yes, how much/how often _____

Can you perform your daily activities independently? _____ No _____ Yes If No, please explain _____

Do you exercise regularly? _____

<u>Family History</u>	<u>Age</u>	<u>Current Health Status/Cause of Death</u>
Father	_____	_____
Mother	_____	_____
Spouse	_____	_____
<input type="checkbox"/> Brother or <input type="checkbox"/> Sister	_____	_____
<input type="checkbox"/> Brother or <input type="checkbox"/> Sister	_____	_____
<input type="checkbox"/> Brother or <input type="checkbox"/> Sister	_____	_____
<input type="checkbox"/> Brother or <input type="checkbox"/> Sister	_____	_____
<input type="checkbox"/> Brother or <input type="checkbox"/> Sister	_____	_____
<input type="checkbox"/> Male or <input type="checkbox"/> Female Child	_____	_____
<input type="checkbox"/> Male or <input type="checkbox"/> Female Child	_____	_____
<input type="checkbox"/> Male or <input type="checkbox"/> Female Child	_____	_____
<input type="checkbox"/> Male or <input type="checkbox"/> Female Child	_____	_____

(Please indicate if you or other family members are adopted.)

Do you know of anyone who may be interested in donating a kidney to you? _____ Yes _____ No

Have you ever received a blood transfusion? _____ Yes _____ No. If you answer yes to this question when did you receive blood and how many units did you receive _____

Additional

Is there any additional information that you feel is important for us to know about your medical history or current situation? _____

- Please bring the following to your evaluation:**
- ✓ **Informed Consent**
 - ✓ **Completed Kidney Recipient Health History Form**
 - ✓ **Insurance Cards**
 - ✓ **List of Medications**
 - ✓ **Copy of Durable Power of Attorney and/or Living Will**
- (The Transplant Center will make copies for you if necessary.)**