UnityPoint Health
Des Moines

Iowa Methodist Medical Center
Transplant Center
1215 Pleasant Street, Suite 506
Des Moines, IA 50309
515-241-4044 Phone
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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:

___ Diabetes
___ High blood pressure
___ High cholesterol
___ Lung disease
___ Sexually transmitted disease
___ Chicken pox
___ Shingles
___ Heart attack
___ Stroke
___ Peripheral Vascular Disease
___ Hearing difficulties
___ Vision difficulties
___ Thyroid problems
___ Bleeding disorder
___ Sleeping difficulties
___ Cancer
___ Teeth or gum problems
___ Seizure Disorder
___ Bladder problems
___ Kidney infections
___ Kidney stones
___ Liver disease
___ Chronic pain
___ Depression/Anxiety
___ Blood transfusions
___ Previous transplant

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? _____

Family History	**Age**	**Current Health Status/Cause of Death**
Father	_____	_____
Mother	_____	_____
Spouse	_____	_____
□ Brother or □ Sister	_____	_____
□ Brother or □ Sister	_____	_____
□ Brother or □ Sister	_____	_____
□ Brother or □ Sister	_____	_____
□ Brother or □ Sister	_____	_____
□ Male or □ Female Child	_____	_____
□ Male or □ Female Child	_____	_____
□ Male or □ Female Child	_____	_____
□ Male or □ 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.)