UnityPoint Health
Des Moines

Iowa Methodist Transplant Center

Iowa Methodist Transplant Center
Iowa Methodist Medical Center
1215 Pleasant Street, Suite 506
Des Moines, IA 50309
Phone: 515-241-4044
Fax: 515-241-4100

Kidney Transplant Health History Form

Personal Information:

Full Name: ______________________________________ ☐ Male ☐ Female

Date of Birth: ___________________ Social Security Number: _______________________

Mailing Address: ____

Zip Code: ______________________ City: ________________________ State: _________________________

Home Phone: _______________________ Cell Phone: __________________________ Work Phone: ________________

Email Address: ____

☐**It is ok to leave a message via phone numbers provided.** **Preferred method of contact** __________________

Designated Support Person/ One Must Be Present at Evaluation/ Check box if ok to contact / Leave Messages:

Name/Relationship: __________________________________ Phone Number: ____________________________ ☐

Emergency Contacts / Check box if it is ok to talk / Leave a Message With Contacts Listed Below:

Name/Relationship: __________________________________ Phone Number: ____________________________ ☐

Name/Relationship: __________________________________ Phone Number: ____________________________ ☐

Name/Relationship: __________________________________ Phone Number: ____________________________ ☐

Social History:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐Widowed ☐ Life Partner

Advanced Directives:

Code Status: ☐ Full Code ☐Do Not Resuscitate If Durable Power of Attorney for Health Care Bring to Evaluation

Dialysis:

Currently on Dialysis: ☐ Yes ☐ No Type: ☐ Hemo ☐ PD If PD, Cycler or Manual Days: M T W Th F S Sun

Dialysis Unit: ________________________ Dialysis Start Date: ___________________________

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Allergies/ Check box if No Allergies:

Drug Allergies: ____ ☐

Food/ Environmental Allergies: ____ ☐

Immunizations/ Preventative Health – Add the Date if known:

Tetanus: ______ Pneumonia: ______ Flu: ______ Hepatitis A: ______ TB: _______

Dental Exam: _____ Colonoscopy: ______ Women Only: Pap: ______ Mammo: ______

Number of Pregnancies: _______

General Questions:

Highest Education Completed: _________________________ Occupation: ______________________________

Currently Working: ☐ Yes ☐ No If Yes, ☐ Full Time ☐ Part Time US Citizen ☐ Yes ☐ No

Race: ________________ Place of Birth: _________________ Religious Preference: ________________________

Tobacco Use/History of Tobacco Use: ☐ Yes ☐ No If Yes, how long/ packs per day: ___________________________

Do you use E-Cigarettes: ☐ Yes ☐ No

Recreational Drug Use: ☐ Yes ☐ No If yes: ____

Alcohol Use/ History of Alcohol Abuse: ☐ Yes ☐ No If Yes explain: ______________________________________

Can you perform daily activities independently: ☐ Yes ☐ No If No explain: ________________________________

Exercise Regularly ☐ Yes ☐ No Hobbies/ Interest: ____

Willing to Accept Blood Products: ☐ Yes ☐ No If No explain: ____

Height ____________ Weight____________

Revised date: 05/22/2017, 4/4/2018

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Family History / Please Indicate if you or other family members have been adopted

Age/Current Health Status/ Cause Of Death

Father ______________________________________

Mother ______________________________________

Sibling (M/F) _________________________________

Sibling (M/F) _________________________________

Sibling (M/F) __________________________________

Sibling (M/F) ____________________________________

Age/Current Health Status/Cause Of Death

Child (M/F) _____________________________________

Child (M/F) _____________________________________

Child (M/F) _____________________________________

Child (M/F) _____________________________________

Medical/ Surgical / Check if You Have any of the Following:

☐ High Blood Pressure	☐ Peripheral Disease	☐ Kidney Infection	☐ Diabetes, age diagnosed____
☐ Bladder Problems	☐ Kidney Stones	☐ Thyroid Disorder	☐ Bleeding Disorder High
☐ Cholesterol	☐ Vision Difficulties	☐ Chronic Pain	☐ Hearing Difficulties
☐ Lung Disease	☐ Liver Disease	☐ Heart Disease	☐ Sleeping Difficulties
☐ Heart Attack	☐ Depression/ Anxiety	☐ Chicken Pox	☐ Sexually Transmitted Disease
☐ Shingles	☐ Stroke	☐ Cancer	
☐ Seizure Disorder	☐ Teeth or Gum Problems	☐ Other: ______________________	

Surgeries/ Injuries: ____

____

- ☐ Previous Blood Transfusions: If Yes, Where and When: ______________________________
- ☐ Previous Transplant: If Yes, Where and When: ___________________________________
- ☐ Multiple Listed for Transplant; If Yes, Where: ___________________________________

If you have anyone interested in being a living donor, please have him or her call our office. Many times people think they are not a candidate to donate for one reason or another. It is best to direct them to our office and we can help answer any questions or concerns they may have.

Patient Signature: ________________________________ Date: _______________