Corewell Health™ corewellhealth.org

William Beaumont University Hospital Kidney Transplant Program
Confidential Living Donor Medical History Questionnaire

Today's Date: _____

Recipient's Name: _____

Your relationship to recipient: _____

Are you blood related to recipient? YES NO

Please complete this form giving specific information whenever possible.
Return this questionnaire and the Donor Consent for Initial Blood Work in the enclosed self-addressed stamped envelope.
This information will be reviewed by the Transplant Team. The Transplant Nurse Coordinator will call you with more information about the next step. Please feel free to call us at 248-551-1033 or 1-800-253-5592, if you have any questions.
The enclosed booklet will provide you with general information about being a potential living organ donor. Please read the information carefully. If you have any questions, please call the transplant center.

Your Name: _____Date of Birth:_____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Other Phone: _____ Email address: _____

Best day and time to be reached: _____

Are you working? Full Time_____ Part Time _____Retired _____ Not Employed _____

If yes, what type of work do you do? _____

Height _____ Weight _____ Race/Ethnicity _____

Marital Status: Single Married Divorced Separated Widowed

Number of children and their ages: _____

Do you know your blood type? _____ If yes, circle: A B AB O

On a scale of 1-10 (with 10 being very willing to donate and 1 not willing to donate at all) how do you feel about being an organ donor?

1 2 3 4 5 6 7 8 9 10

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Please list all medications, over-the-counter medications, and herbal supplements you are taking. Include dosage and frequency of use.

Medication/Supplement	Dose	How often do you take this?

Do you have allergies (medications/foods/seasonal)? YES NO

If yes, list allergies and reaction(s).

_____

_____

Have you ever had a reaction to iodine (CT Dye) YES NO
If you have asthma, a special medication protocol will be required for CT studies.

Please list any surgeries that you have had and the date(s) completed.

Type of Surgery	Date

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Have you ever had or been treated for any of the following problems?

Issue	Yes	No	Comments
High Blood Pressure			
Diabetes			If yes, Type:
Pregnancy Complications			
Kidney Infection			
Kidney Stones			
Bladder Infection			
Cancer			If yes, Type:
Heart Disease/Heart Attack			
Stroke			
Blood Clot			
Lung Disease/Asthma/COPD			
Liver Disease			
Hepatitis			
Arthritis			
Lupus			
Tuberculosis			
Bleeding Issues			
Anemia			
Received Blood Transfusions			If yes, how many and when:
Use/Used Tobacco			If yes, list type and quantity:
Use/Used Alcohol			If yes, list type and quantity:
Use/Used Recreational Drugs			If yes, list type and quantity:
Tattoos/Body Piercings			If yes, professionally done?:
Treatment for Mental Illness			

If you answered yes to any of the questions above, please describe your illness/condition. Include number of times you were treated and/or how long you were ill.

_____
_____
_____
_____

Signature _____ Date_____

Thank you!