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| http://mcintranet.musc.edu/communications/logos/transplant/HEA_TRANSPLANT_4C.jpg | MUSC Transplant Program162 Ashley Ave., MSC 586Charleston, SC 29425 | Phone: (843) 792-1594Fax: (843) 876-2968Email: LiveDonor@musc.edu |

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| Living Donor Patient Health History Form |
| **Transplant Office Use Only:**  | Donor MRN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Recipient MRN: \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | State: \_\_\_\_\_\_\_\_\_\_ | Zip: \_\_\_\_\_\_\_\_\_\_\_\_ |
| Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Primary Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Work Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| □ Male  | □ Female | Height (in): \_\_\_\_\_\_\_\_\_\_ | Weight (lbs): \_\_\_\_\_\_\_\_ | BMI: ­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Blood Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Marital Status:** | □ Married | □ Divorced | □ Separated | □ Widowed | □ Single |
| **Highest Level of Education:** | □ None | □ Grade School (0-8) | □ High School (9-12) |
|  | □ Technical School  | □ Associate/Bachelor | □ Post-Graduate |
| **Are you employed?** | Yes | No |  |
|  If yes, occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  If no, when did you last work? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Citizenship**  |
| □ U.S. Citizen | □ Resident Alien | □ Non-Resident Alien | Year Entered U.S.: \_\_\_\_ |

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| **Ethnicity**  |
| □ White | □ Black/African American | □ American Indian/Alaska Native | □ Hispanic/Latino |
| □ Asian | □ Hawaiian/Pacific Islander | □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

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| **Recipient Relationship** |
| Recipient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Relationship to Recipient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Family History (please circle)** |
|  | **Alive?** | **If yes, Age** | **If no, Cause of Death** | **Known Medical History** |
| **Mother** | YesNo | \_\_\_\_\_years |  | Heart Condition High Blood PressureStroke/Brain Bleed | Diabetes Blood Clots |
| **Father** | YesNo | \_\_\_\_\_years |  | Heart Condition High Blood PressureStroke/Brain Bleed | Diabetes Blood Clots |
| **Siblings** | YesNo | \_\_\_\_\_years\_\_\_\_\_years\_\_\_\_\_years |  | Heart ConditionHigh Blood PressureStroke/Brain Bleed | Diabetes Blood Clots |
| **Other:****­\_\_\_\_\_\_\_\_\_\_** | YesNo | \_\_\_\_\_years |  | Heart ConditionHigh Blood PressureStroke/Brain Bleed | Diabetes Blood Clots |

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| **Social History (please circle)** |
|  | **Cigarettes** | **Alcohol** | **Recreational Drugs** |
| Do you currently use? | Yes | No | Yes | No | Yes | No |
| Have you in the past? | Yes | No | Yes | No | Yes | No |
| If yes, how much? | \_\_\_\_\_ per day | \_\_\_\_\_ drinks per week | \_\_\_\_\_ per week |
| If no, date you quit? | \_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ |

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| **Medical History** |
| **List of medications you are taking**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Allergies**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **For women:** | Number of Children: \_\_\_\_ | Ages of Children: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | □ Gestational Diabetes | □ Pregnancy-induced High Blood Pressure |
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| **Do You Have, or Have You Had Any of these Conditions?** |
| □ Anemia | □ Heart murmur | □ Rectal bleeding |
| □ Arthritis | □ Heart problems | □ Seizures |
| □ Asthma | □ Heartburn | □ Shortness of breath |
| □ Blood clot | □ Hepatitis | □ Sickle cell |
| □ Blood disorder | □ High blood pressure | □ Skin cancer |
| □ Blood transfusion | □ HIV | □ Sores or lumps on skin |
| □ Cancer | □ Jaundice | □ Stroke |
| □ Chest pain | □ Kidney stones | □ Swelling of legs/arms |
| □ Colon problems | □ Liver problems | □ Thyroid disease |
| □ Constipation | □ Mental disorders | □ Tuberculosis |
| □ COPD/Emphysema | □ Migraines | □ Ulcers in stomach |
| □ Depression | □ Nausea | □ Ulcers to feet |
| □ Diabetes | □ Ovary problems | □ Urinary tract infection |
| □ Diarrhea | □ Persistent skin rash | □ Vision problems |
| □ Gallbladder problems | □ Pneumonia | □ Vomiting |
| □ Gout | □ Prostate problems | □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| **When was your last procedure?** |
|  | **Month/Year** | **Not Applicable** | **Abnormal?** | **Location** |
| Colonoscopy | \_\_\_\_\_/\_\_\_\_\_ | N/A | Yes | No | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| PAP Smear | \_\_\_\_\_/\_\_\_\_\_ | N/A | Yes | No | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Mammogram | \_\_\_\_\_/\_\_\_\_\_ | N/A | Yes | No | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| PSA (Prostate test) | \_\_\_\_\_/\_\_\_\_\_ | N/A | Yes | No | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Physician Information** |
| **Do you currently see any of the following?** |
| **Gynecologist** | Yes | No |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Primary Care Physician** | Yes | No |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Any Other Specialists?** |  |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

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| **Signature** |
| **I certify that the information provided above is true and accurate.** |
| Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Transplant Office Use Only** |
| Recipient ABO: \_\_\_\_\_\_\_ | Recipient PRA: \_\_\_\_\_\_\_ | Recipient Age: \_\_\_\_\_\_\_ | Dx: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Relationship to Recipient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Recipient Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Financial Clearance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Recipient Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Re-Transplant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |