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| http://mcintranet.musc.edu/communications/logos/transplant/HEA_TRANSPLANT_4C.jpg | MUSC Transplant Program  162 Ashley Ave., MSC 586  Charleston, SC 29425 | Phone: (843) 792-1594  Fax: (843) 876-2968  Email: 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** | Yes  No | \_\_\_\_\_years |  | Heart Condition  High Blood Pressure  Stroke/Brain Bleed | Diabetes  Blood Clots |
| **Father** | Yes  No | \_\_\_\_\_years |  | Heart Condition  High Blood Pressure  Stroke/Brain Bleed | Diabetes  Blood Clots |
| **Siblings** | Yes  No | \_\_\_\_\_years  \_\_\_\_\_years  \_\_\_\_\_years |  | Heart Condition  High Blood Pressure  Stroke/Brain Bleed | Diabetes  Blood Clots |
| **Other:**  **­\_\_\_\_\_\_\_\_\_\_** | Yes  No | \_\_\_\_\_years |  | Heart Condition  High Blood Pressure  Stroke/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 | | | | | |
|  | | | | | | | | | |
| **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |