THE UNIVERSITY OF TOLEDO MEDICAL CENTER

Potential Living Kidney Donor Medical History Screening Form

Name: _____ Date: _____

Address:_____
(Street & Apt #) (City) (State) (Zip Code)

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____ Ext.: _____

Email Address: _____ Employment: Full-time Part-time

Date of Birth: ____/_____/_____ Age: _____ Years SS#: _____-_____-_____ Sex: Male Female

Height: _____ Ft. _____In. Weight: _____Lbs. Marital Status: Single Married Divorced Separated Widowed

Highest level of education: High school Technical school Some College College Degree Other: _____

Do you have health Insurance? Yes No Dental Insurance? Yes No Do you follow with a dentist routinely? Yes No

PERSONAL HISTORY

Number of Children: _____ Health of Children: _____

Females Only: Did you experience gestational diabetes with any of your pregnancies? YES -- ALL / SOME NO

Are you (circle one)? Premenopausal Postmenopausal Surgical Sterilization

What is your preferred over the counter pain medication? Tylenol Motrin/Ibuprofen Aspirin Other: _____

Do you know your blood type? A B O Unknown Allergies: _____

Name / Contact of Family Physician: _____
(Name) (Contact Number)

Please review following conditions and circle any you have been treated for in the or are currently being treated for then provide additional details at end of form.

Neurological Issues (TIA, Stroke, Seizures) Autoimmune Issues (Lupus, Crohns, RA) Heart Issues Lung Issues

Hypertension Diabetes/Pre-diabetes Blood Disorders (Anemia) STD (Herpes, HIV) Liver Disease (Hepatitis)

Cancer Tuberculosis (positive/exposure, jail time, lived outside US for 3 months+) Psychological Issues

Bladder Infection Kidney Infection Kidney Stones

If you have a known history of hypertension, what is your typical BP? _____

Do you smoke: NO YES-How much:_____ How long:_____ Date Quit:_____

Do you use alcohol: NO YES-How much:_____ How Often:_____ How long:_____

Drug use-current or past: NO YES-What drug(s):_____

How often/much:_____ Last used / Quit:_____

Do you exercise routinely: NO YES-How often_____

Medications:	
Past Medical History:	
Past Surgical History:	

FAMILY HISTORY: Please review following conditions and circle any that your family members (parents, siblings, etc.) have been or are currently being treated for:

Cancer Lung Issues Diabetes Cardiac Issues Hypertension Kidney Issues Blood Disorders Stroke

Psychological Other:_____

Why do you want to be a kidney donor?_____

_____

Recipient Name:_____ Relationship:_____

Please give additional information on conditions you have been treated for or are currently under treatment for:

_____

_____

_____

_____

_____

_____

FOR LIVING DONOR COORDINATOR:

- Female donor educated on cessation of birth control or hormone replacement therapy
- All donors educated on discontinuing or non-usage of NSAIDS
- All donors educated on drug screen performed on all donors regardless of reported use or non-usage of drugs
- All donors educated on Paired Exchange Program and are they interested in program if unable to donate to intended recipient Yes No
- LABS