

Donor Health History

Name: _____ DOB: ____ / ____ / ____
(As written on your health card) Day Month Year

Marital Status: Married/Single/Divorced/Widowed/Other

Sex: Male / Female

Organ you wish to donate: Liver / Kidney

Weight: _____ lbs or _____ kg Height: _____ in or _____ cm

BMI (WE WILL COMPLETE FOR YOU) _____

Address: _____
_____ (City) _____ (Province) _____ (Postal Code)

Telephone: (____) ____ - _____ E-Mail Address: _____

Occupation: _____

Work Telephone: (____) ____ - _____ Can we contact you at work? Yes: No:

Health Card Number: _____

Family Doctor: _____ Tel. (____) ____ - _____

Address: _____

Please indicate the name of the recipient to whom you wish to direct your donation:

Please indicate your relationship to the recipient:

Medical History:

These questions are used to gather important information about your health and lifestyle that might impact on your potential to become a living donor. This information will be used by the health care professionals on our team to determine your overall well being. All information on this questionnaire is kept strictly confidential. Please submit this form along with a copy of your blood type to the assessment office.

YES NO

GENERAL HEALTH

Have you ever had any abdominal surgery? (gallbladder, appendix, bowel)
What? _____

Have you ever had any other surgery?
If yes, what? _____

Did you have any problems after surgery/anaesthetic
If yes, what were the problems? _____

Have you had any hospitalization for other reasons?
If yes, when and why? _____
Name of Hospital _____

Do you routinely take any medications (including over the counter)
If yes, list: _____

Do you have any allergies?
If yes, to what? _____
Reaction? _____

Do you currently or have you ever smoked cigarettes?
How many per day? _____ For how long? _____ years
When did you quit? _____

Do you drink alcohol?
How much per day? _____ For how long? _____ years

LIVER HEALTH

Have you ever had jaundice (yellow skin)?

Have you ever had a liver problem?

Have you ever had an inflamed liver - hepatitis

Is there a family history of liver problems?

If yes, what? _____

CANCER HISTORY

Have you had cancer?

Type: _____ When? _____

Treatment: Radiation: _____ Chemo: _____ Surgery: _____ Other: _____

INFECTION RISKS (including exposures or risk factors for "AIDS" or sexually transmitted diseases)

YES NO

Do you have a chronic infection of any type?

If yes, what? _____ When? _____

Have you ever received a blood transfusion or other blood product?

If yes, type? _____ When? _____

Have you ever had a tattoo, body piercing or acupuncture?

If yes what? _____

When? _____

The name of the establishment: _____

Do you currently use or have you used recreational or street drugs in the past 5 years? (ie marijuana/IV drugs/cocaine/LSD/hash/etc)

If yes, what and when? _____

Have you had any recent unexplained weight loss?

Have you been treated for any infection in the past 12 months?

Have you ever tested positive for HIV?

Have you had unprotected 'casual sex' in the last 5 years (which is a risk factor for HIV or sexually transmitted diseases)?

Have you or do you have sex with multiple partners?

Have you or do you have sex with anybody who would have answered yes to the previous 6 questions?

Where were you born? _____

Where were you immunized? _____

Have you had any recent vaccinations? 0 0
If yes, what? _____

Have you been vaccinated for Hepatitis B? 0 0
If yes, when or at what age? _____

Have you traveled outside North America in the past 3 years? 0 0
If yes, where? _____

NEURO/PSYCHO/SOCIAL

Do you have a seizure disorder/epilepsy? **YES** **NO**
 0

Have you ever had a stroke/transient ischemic attack? 0

Have you ever had treatment for depression? 0 0
Treatment: _____

Have you ever had treatment for a psychiatric problem? 0 0
Treatment: _____

CARDIOVASCULAR

Do you have a history of heart disease or chest pain? 0 0
If yes, elaborate: _____

Have you ever had high blood pressure? 0 0
If yes, when? _____
Type of treatment: _____

Have you had a heart attack? 0 0
If yes, when? _____

Have you ever had rheumatic fever, or been told you have a heart murmur? 0 0
If yes, when? _____

Do you and/or a family member have hemophilia or a clotting problem? 0 0
If yes, what? _____

Have you or any of your family members had a problem with excessive bleeding? 0 0
If yes, when? _____

Have you had excessive bleeding with any surgery or dental extractions? 0 0
If yes, when? _____

Have you and/or a family member ever had a blood clot in your lungs or legs?

RESPIRATORY

Have you ever had any lung disease such as asthma or emphysema?
If yes, what? _____ When? _____
Any treatment? _____

Have you ever been exposed to someone with tuberculosis or had a positive TB skin test yourself?

Do you routinely use any inhalers or take medications to help your breathing?
If yes, what? _____

Do you have sleep apnea or use a CPAP machine?

GASTROINTESTINAL

Do you have any stomach or intestinal problems?
If yes, what? _____


Have you ever had gallbladder problems or gallstones?

Have you ever had a colonoscopy or gastroscopy?

GENITOURINARY

Have you ever had problems with your kidneys (such as infections or stones)?
If yes, what? _____ When: _____

Have you ever had any problems with your bladder (such as infections, incontinence or difficulty voiding)?

 Do you have any problems related to an enlarged prostate?
If yes, what? _____

Have you ever had a gynecologic problem?
Date of last PAP smear: _____
Date of last breast exam or mammogram: _____

Did you experience any problems with pregnancies or deliveries (such as high blood pressure, toxemia or blood sugar)?
If yes, what? _____

ENDOCRINE

Do you have diabetes?	<input type="radio"/>	<input type="radio"/>
Do you have a family history of diabetes?		<input type="radio"/>
<input type="radio"/>		
Have you ever had increased blood sugars, i.e., with pregnancy?	<input type="radio"/>	<input type="radio"/>
Have you ever been diagnosed with thyroid disease?	<input type="radio"/>	<input type="radio"/>

OTHER

1. Is there any other health information that we should know?

YES NO

I have answered these questions to the best of my ability and have read the living donor transplantation information for donors manual.

Signature: _____

Date: _____