Living Donor Transplant Program
Donor Health History Form

FOR LIVING LIVER DONORS, **PLEASE SUBMIT A COPY OF YOUR BLOOD TYPE** TO THE OFFICE WITH YOUR FORM. HEALTH HISTORY FORMS CANNOT BE PROCESSED WITHOUT A BLOOD TYPE.

For office use only:

Date Received: _____ Date Entered in OTTR: _____
dd/mmm/yyyy *dd/mmm/yyyy*

Date ABO Received: _____ Date Reviewed: _____
dd/mmm/yyyy *dd/mmm/yyyy*

Donor: MRN _____ TGLN:_____ ABO _____

Recipient: MRN _____ TGLN:_____ ABO _____

DEMOGRAPHICS: Please complete the questionnaire in pen and its entirety in order to be processed

First Name(Legal):	Middle Name (Legal):	Surname (Legal):

Preferred Name (if applicable):	Date of Birth: _____/_____/_____ dd mmm yyyy	Age:
Provincial Health Card Number: □ N/A	Health Insurance Card Expiry Date: □ N/A _____/_____/_____ yyyy mm dd	
Marital Status: *(Please Circle)* Married / Single / Divorced / Widowed / Other:	Blood Type: A / B / AB / O Positive / Negative I have attached a copy of my blood type ☐	

Sex: Male / Female	Height: _____ in / cm	Weight: _____ lbs / kg	***Office use only*** BMI:

Country of Birth:	Citizenship:	Race/Ethnicity:

Spoken language(s):	Preferred Language:

Street # and Name *Apt #* *City* *Province* *Postal Code*
Address:

Home Telephone: ( )	Cell Telephone: ( )
Email Address:	
Work Telephone: ( ) Can we contact you at work? □ Yes □ No	How do you prefer to be contacted?
Family Doctor:	Family Doctor Telephone: ( )

Street # and Name *Unit #* *City* *Province* *Postal Code*
Address:

Please print your full name in the indicated section at the top of <u>each page</u> of this questionnaire

Name :

Do you have an **intended recipient** *(someone you want to donate to)?* **If Yes,** what is the recipient's name?_____ How do you know the recipient? _____	☐ Yes ☐ No	***Office use only*** MRN ABO
Have you discussed your wish to donate with the intended recipient?	□ Yes □ No □ N/A	
Why do you wish to donate?		

Medical History Section: 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 <u>strictly confidential</u>.

GENERAL HEALTH:		
1.	Have you ever had any abdominal surgery? (gallbladder, appendix, bowel) **If yes,** what type, when? ……	☐ Yes ☐ No
2.	Have you ever had any other surgery? **If yes,** what and when? ……	☐ Yes ☐ No
3.	Did you have any problems after surgery/anesthetic? **If yes,** what were the problems? ……	☐ Yes ☐ No
4.	Have you had any hospitalization for other reasons? **If yes,** when and why? …… Name of Hospital: ……	☐ Yes ☐ No
5.	Do you routinely take any medications (including prescriptions, over the counter(OTC), vitamins and herbal supplements)? **If yes,** list: …… ……	☐ Yes ☐ No
6.	Do you have any allergies? **If yes,** to what? …… **If yes,** what type of reaction and symptoms do you have? …… **If yes,** do you carry an EpiPen? ☐ Yes ☐ No	☐ Yes ☐ No

Name :

7.	Do you currently smoke or have you ever smoked tobacco products? **If yes,** what type (cigarettes, pipe, cigarillos, cigars)? **(indicate)** How many ? …… per day/week/month/year **(circle one)** Since when?…… If you have quit, when did you quit? ……	☐ Yes ☐ No
8.	Do you drink alcohol? **If yes**, how many drinks *per week* (1 drink = 1 bottle of beer, 1 glass of wine or 1 ½ oz of spirits)? …….. Since when? ……	☐ Yes ☐ No
LIVER HEALTH		
9.	Have you ever had jaundice (yellow skin)? **If yes,** when? ……	☐ Yes ☐ No
10.	Have you ever had a liver problem? **If yes,** what and when? ……	☐ Yes ☐ No
11.	Is there a family history of liver problems? **If yes,** what? ……	☐ Yes ☐ No
CANCER HISTORY		
12.	Have you had cancer? **If yes,** Type? …… When? …… Treatment: Radiation ☐ Chemo ☐ Surgery ☐ Other:	☐ Yes ☐ No **
13.	Do you have a family history of cancer? **If yes,** who? …… What type of cancer? ……	☐ Yes ☐ No

Name :

INFECTION RISKS		
14.	Have you ever received a blood transfusion or other blood product? **If yes,** type? …… When? …….	☐ Yes ☐ No
15.	Have you, in the last 12 months, had a tattoo, ear piercing, or body piercing, in which sterile procedures were not used (e.g. contaminated instruments and/or ink were used, or shared instruments that had not been sterilized between uses were used)? **If yes,** what? …… When? ……	☐ Yes ☐ No **
16.	Do you have a chronic infection of any type? **If yes,** what and when? ……	☐ Yes ☐ No
17.	Have you ever had a communicable disease (such as Mono)? **If yes,** what and when? ……	☐ Yes ☐ No
18.	Do you have or have you ever had any history of syphilis? **If yes,** when? ……	☐ Yes ☐ No **
19.	In the past 12 months have you had close contact with another person having clinically active viral hepatitis (e.g. living in the same household, where sharing of kitchen and bathroom facilities occurs regularly?)	☐ Yes ☐ No **
20.	In the past six months have you been bitten by an animal? **If yes,** please describe: …… …… Were you treated as if the animal was rabid or diagnosed with rabies?	☐ Yes ☐ No ☐ Yes ☐ No **

Name :

21.	Do you currently use or have you ever used nonmedical or recreational/ street drugs (ingested, inhaled, subcutaneous, intramuscular or intravenous drugs e.g. LSD, marijuana, hash, cocaine)? **If yes,** what is your **current** consumption?…… **If not current,** what was your consumption previously (product, frequency and time period)?…… Have you ever had treatment for this? **If yes,** what treatment and when? ……..	☐ Yes ☐ No ☐ Yes ☐ No **
22.	Have you been treated for any infection in the past 12 months? **If yes,** what? ……. When? ……	☐ Yes ☐ No
23.	Have you ever tested positive for HIV? **If yes,** when? …….	☐ Yes ☐ No
24.	Have you had any recent vaccinations? **If yes,** what and when? ……	☐ Yes ☐ No
25.	Have you been vaccinated for Hepatitis B? **If yes,** when or at what age? ……	☐ Yes ☐ No
26.	Have you ever been suspected of having West Nile Virus or been diagnosed with West Nile Virus? **If yes,** when? …….	☐ Yes ☐ No
27.	Within the last **6 months** have you traveled to other parts of Canada, or any where outside of Canada (including the US)? **If yes,** where? ……When?……. Office use only: Review current travel health notices - http://www.phac-aspc.gc.ca/tmp-pmv/notices-avis/index-eng.php If traveling to a WNV endemic area, during non WNV testing season - http://www.cdc.gov/westnile/index.html http://www.phac-aspc.gc.ca/wnv-vwn/index-eng.php	☐ Yes ☐ No
28.	Have you ever lived outside of Canada? **If yes,** where? ……When?……	☐ Yes ☐ No

Name :

29.	Have you ever received human growth hormone? **If yes,** was it prior to 1986 within Canada or the US OR at any time outside Canada or the US?	☐ Yes ☐ No ☐ Yes ☐ No **
30.	Have you ever received dura mater?	☐ Yes ☐ No **
NEUROLOGICAL/PSYCHOLOGICAL		
31.	Do you have a seizure disorder/epilepsy? Please provide details. ……	☐ Yes ☐ No
32.	Have you ever had a stroke/transient ischemic attack (TIA)? If yes when? ……	☐ Yes ☐ No
33.	Have you been diagnosed with or been investigated for any degenerative neurological diseases such as dementia, Alzheimer's, Creutzfeldt-Jakob (CJD) disease (Mad Cow), brain tumours, Parkinson's disease, Lou Gehrig's, Multiple Sclerosis? **If yes,** what and when? ……	☐ Yes ☐ No **
34.	Have you ever had treatment for depression? When? …… Treatment: ……	☐ Yes ☐ No
35.	Have you ever had treatment for a psychiatric problem? When? …… Treatment: ……	☐ Yes ☐ No
CARDIOVASCULAR		
36.	Do you have a history of heart disease or chest pain? **If yes,** elaborate: ……	☐ Yes ☐ No
37.	Have you ever had high blood pressure? **If yes,** when and type of treatment? ……	☐ Yes ☐ No

Name :

38.	Have you ever had a heart attack? **If yes,** when? ……	☐ Yes ☐ No
39.	Have you ever had rheumatic fever, or been told you have a heart murmur? **If yes,** when? ……	☐ Yes ☐ No
40.	Have you ever had palpitations or been told that you have a heart arrhythmia? **If yes,** when? ……	☐ Yes ☐ No
HEMATOLOGY/BLOOD		
41.	Do you and/or a family member have hemophilia or a clotting problem? **If yes,** what? ……	☐ Yes ☐ No
42.	Have you ever received human-derived clotting factor concentrates? **If yes,** when? ……	☐ Yes ☐ No **
43.	Have you or any of your family members had a problem with excessive bleeding? **If yes,** when? ……	☐ Yes ☐ No
44.	Have you had excessive bleeding with any surgery or dental extractions? **If yes,** when? ……	☐ Yes ☐ No
45.	Have you and/or a family member ever had a blood clot in your lungs or legs? **If yes,** what? …… When? ……	☐ Yes ☐ No
RESPIRATORY		
46.	Have you ever had any lung disease such as asthma or emphysema? **If yes,** what? …… When? …… Any treatment? ……	☐ Yes ☐ No

Name:

47.	Have you ever been exposed to someone with tuberculosis or had a positive TB skin test yourself? **If yes,** when? ……	☐ Yes ☐ No
48.	Do you routinely use any inhalers or take medications to help your breathing? **If yes,** what? ……	☐ Yes ☐ No
49.	Have you ever been suspected of having SARS (Severe Acute Respiratory Syndrome) or been diagnosed with SARS? **If yes,** when? ……	☐ Yes ☐ No
50.	Do you have sleep apnea or use a CPAP machine? **If yes,** please describe: ……	☐ Yes ☐ No
GASTROINTESTINAL		
51.	Do you have any stomach or intestinal problems? **If yes,** what? ……	☐ Yes ☐ No
52.	Have you ever had gallbladder problems or gallstones? **If yes,** when? ……	☐ Yes ☐ No
53.	Have you ever had a colonoscopy or gastroscopy? **If yes,** when? ……	☐ Yes ☐ No
GENITOURINARY		
54.	Have you ever had problems with your kidneys (such as infections or stones)? **If yes,** what and when? ……	☐ Yes ☐ No
55.	Have you ever had any problems with your bladder (such as infections, incontinence or difficulty voiding)? **If yes,** please describe. …… When? ……	☐ Yes ☐ No

Name:

56.	**For MEN only:** Do you have any problems related to an enlarged prostate? **If yes,** what? ……..	☐ Yes ☐ No ☐ N/A
57.	**For FEMALES only :** Date of Last Menstrual Period: ……. Date of last PAP smear …….. ☐ N/A Date of last breast exam or mammogram: …….. ☐ N/A	☐ N/A
58.	**For FEMALES only:** Have you ever had a gynecologic problem? **If yes,** what? ……..	☐ Yes ☐ No ☐ N/A
59.	**For FEMALES only: Have you had any pregnancies?** **If yes,** did you experience any problems with your pregnancies or deliveries (such as high blood pressure, toxemia or high blood sugar)? **If yes,** please describe? ……	☐ Yes ☐ No ☐ N/A ☐ Yes ☐ No
60.	**For FEMALES only:** Are you currently trying to become pregnant or do you have plans for future pregnancies?	☐ Yes ☐ No ☐ N/A
ENDOCRINE		
61.	Do you have diabetes? Type? …….. Onset? ……	☐ Yes ☐ No
62.	Do you have a family history of diabetes? **If yes,** who? ……	☐ Yes ☐ No
63.	Have you ever had increased blood sugars (i.e., with pregnancy)? **If yes,** please describe: ……	☐ Yes ☐ No
64.	Have you ever been diagnosed with thyroid disease? **If yes,** what and when? ……	☐ Yes ☐ No
SOCIAL		
65.	Does your family have a history of any serious health issues? (i.e. heart disease, strokes, Creutzfeldt-Jakob (Mad Cow) disease) **If yes,** please outline: ……	☐ Yes ☐ No