

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: _____ <i>dd/mmm/yyyy</i>		Date Entered in OTTR: _____ <i>dd/mmm/yyyy</i>		
Date ABO Received: _____ <i>dd/mmm/yyyy</i>		Date Reviewed: _____ <i>dd/mmm/yyyy</i>		
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: _____/_____/_____ <i>dd mmm yyyy</i>	Age:
Provincial Health Card Number: <input type="checkbox"/> N/A			Health Insurance Card Expiry Date: <input type="checkbox"/> N/A _____/_____/_____ <i>yyyy mm dd</i>	
Marital Status: <i>(Please Circle)</i> Married / Single / Divorced / Widowed / Other:			Blood Type: A / B / AB / O Positive / Negative I have attached a copy of my blood type <input type="checkbox"/>	
Sex: Male / Female	Height: _____ in / cm	Weight: _____ lbs / kg	Office use only BMI:	
Country of Birth:		Citizenship:	Race/Ethnicity:	
Spoken language(s):			Preferred Language:	
<i>Street # and Name Apt # City Province Postal Code</i>				
Address:				
Home Telephone: ()			Cell Telephone: ()	
Email Address:				
Work Telephone: () Can we contact you at work? <input type="checkbox"/> Yes <input type="checkbox"/> No			How do you prefer to be contacted?	
Family Doctor:			Family Doctor Telephone: ()	
<i>Street # and Name Unit # City Province Postal Code</i>				
Address:				

Please print your full name in the indicated section at the top of each page 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? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Office use only MRN ABO
Have you discussed your wish to donate with the intended recipient?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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 strictly confidential.

GENERAL HEALTH:		
1.	Have you ever had any abdominal surgery? (gallbladder, appendix, bowel) If yes , what type, when?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Have you ever had any other surgery? If yes , what and when?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Did you have any problems after surgery/anesthetic? If yes , what were the problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Have you had any hospitalization for other reasons? If yes , when and why? Name of Hospital:	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Do you routinely take any medications (including prescriptions, over the counter(OTC), vitamins and herbal supplements)? If yes , list:	<input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
LIVER HEALTH		
9.	Have you ever had jaundice (yellow skin)? If yes, when?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10.	Have you ever had a liver problem? If yes, what and when?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11.	Is there a family history of liver problems? If yes, what?	<input type="checkbox"/> Yes <input type="checkbox"/> No
CANCER HISTORY		
12.	Have you had cancer? If yes, Type? When? Treatment: Radiation <input type="checkbox"/> Chemo <input type="checkbox"/> Surgery <input type="checkbox"/> Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No <p style="text-align: center;">**</p>
13.	Do you have a family history of cancer? If yes, who? What type of cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Name : _____

INFECTION RISKS		
14.	Have you ever received a blood transfusion or other blood product? If yes, type? When?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No **
16.	Do you have a chronic infection of any type? If yes, what and when?	<input type="checkbox"/> Yes <input type="checkbox"/> No
17.	Have you ever had a communicable disease (such as Mono)? If yes, what and when?	<input type="checkbox"/> Yes <input type="checkbox"/> No
18.	Do you have or have you ever had any history of syphilis? If yes, when?	<input type="checkbox"/> Yes <input type="checkbox"/> 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)?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No **

Name : _____

21.	<p>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)?</p> <p>If yes, what is your current consumption?.....</p> <p>If not current, what was your consumption previously (product, frequency and time period)?.....</p> <p>Have you ever had treatment for this? If yes, what treatment and when? </p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="text-align: center;">**</p>
22.	<p>Have you been treated for any infection in the past 12 months?</p> <p>If yes, what? When?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
23.	<p>Have you ever tested positive for HIV?</p> <p>If yes, when?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
24.	<p>Have you had any recent vaccinations?</p> <p>If yes, what and when?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
25.	<p>Have you been vaccinated for Hepatitis B?</p> <p>If yes, when or at what age?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
26.	<p>Have you ever been suspected of having West Nile Virus or been diagnosed with West Nile Virus?</p> <p>If yes, when?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
27.	<p>Within the last 6 months have you traveled to other parts of Canada, or any where outside of Canada (including the US)?</p> <p>If yes, where?When?.....</p> <p style="background-color: #e0e0e0;">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</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
28.	<p>Have you ever lived outside of Canada?</p> <p>If yes, where?When?.....</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

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?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No **
30.	Have you ever received dura mater?	<input type="checkbox"/> Yes <input type="checkbox"/> No **

NEUROLOGICAL/PSYCHOLOGICAL

31.	Do you have a seizure disorder/epilepsy? Please provide details.	<input type="checkbox"/> Yes <input type="checkbox"/> No
32.	Have you ever had a stroke/transient ischemic attack (TIA)? If yes when?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No **
34.	Have you ever had treatment for depression? When? Treatment:	<input type="checkbox"/> Yes <input type="checkbox"/> No
35.	Have you ever had treatment for a psychiatric problem? When? Treatment:	<input type="checkbox"/> Yes <input type="checkbox"/> No

CARDIOVASCULAR

36.	Do you have a history of heart disease or chest pain? If yes, elaborate:	<input type="checkbox"/> Yes <input type="checkbox"/> No
37.	Have you ever had high blood pressure? If yes, when and type of treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Name :

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

Name: _____

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

