Texas Health Harris Methodist Hospital Fort Worth

Kidney Transplant Program

DONOR
Living Donor Application and Health History

If you wish to be considered as a living donor,
please complete this application and return by mail, fax or email to:

Texas Health Harris Methodist Hospital Fort Worth
Kidney Transplant Program
1325 Pennsylvania Avenue, Suite 450
Fort Worth, Texas 76104

Fax: 817-250-5136
Email: THFWKidneyTransplant@TexasHealth.org

For questions, please call 817-250-2443

Application/Health History

Last name:_____ First name:_____

Middle name or initial:_____ Maiden name:_____

Date of birth:_____ Gender: ☐ Male ☐ Female Age:_____ Race:_____

Street address:_____ Apartment no:_____

County:_____ City:_____ State:_____ Zip:_____

Home phone: (_____)_____ Work phone: (_____)_____

Email address:_____ Cell phone: (_____)_____

Emergency contact:_____ Phone: (_____)_____

Are you a U.S. citizen? ❑ Yes ❑ No Social Security No:_____-_____-_____

Resident Alien/Green Card? ❑ Yes ❑ No Non-resident Alien? ❑ Yes ❑ No

Education: ❑ Grade school (0-8) ❑ High school/GED ❑ College/Tech school ❑ Associate/Bachelor ❑ Post-graduate

Potential donor for:_____

Your relation to the recipient (Please circle specific relation):

Blood related relative: ☐ Child ☐ Parent ☐ Full Sibling ☐ Half Sibling ☐ Identical Twin ☐ Other:

Non biological relative: ☐ Life Partner ☐ Spouse ☐ Other: ☐ None; I do not have a specific person in mind

Are you currently working? ❑ Yes ❑ No May we contact you at work, if needed? ❑ Yes ❑ No

Occupation:_____ Employer:_____

Employment: ❑ Full time ❑ Part time ❑ Self-employed ❑ Unemployed How many hours/day?_____

Do you perform strenuous activities at work? ❑ Yes ❑ No If yes, please explain:_____

Do you have health insurance? ❑ Yes ❑ No

Who will be able to help you around the time of surgery?_____

Name of your personal physician: Dr._____Address:_____

Did you have any serious illnesses as a child? ❑ Yes ❑ No If yes, please explain:_____

Have you had the following?

Mumps ❑ Yes ❑ No

Measles ❑ Yes ❑ No

Chickenpox ❑ Yes ❑ No

Mononucleosis ❑ Yes ❑ No

Rhumatic Fever ❑ Yes ❑ No

Do you travel outside the United States? ❑ Yes ❑ No If yes, where and when:_____

TRNPLT

Texas Health Harris Methodist Hospital FORT WORTH

PATIENT IDENTIFICATION

KIDNEY TRANSPLANT PROGRAM
LIVING DONOR APPLICATION - ENGLISH

Your height is:_____ Your weight is:_____ ❑ lbs. ❑ kg Is this your usual weight? ❑ Yes ❑ No

Please list the name of any medications you take (prescribed and over-the-counter):_____

Allergies:_____

1. NEUROLOGY (brain and spinal cord) Check yes or no:

Headaches	❑ Yes ❑ No
Head injury	❑ Yes ❑ No
Seizures	❑ Yes ❑ No
Back pain	❑ Yes ❑ No

Additional problems/surgeries/any recent testing that you have had related to your brain or spinal cord:_____

Neurologist (brain doctor):_____ Phone:_____

2. EYE, EAR, NOSE AND THROAT Check yes or no:

Blindness	❑ Yes ❑ No
Deafness/Hearing Loss	❑ Yes ❑ No
Sinus infections	❑ Yes ❑ No

Additional problems/surgeries/any recent testing that you have had related to your eyes, ears, nose and/or throat:_____

ENT (eye, ear, nose and throat doctor):_____ Phone:_____

3. CARDIAC (heart) Check yes or no:

High blood pressure	❑ Yes ❑ No
Swollen ankles	❑ Yes ❑ No
Heart disease	❑ Yes ❑ No
Heart attack	❑ Yes ❑ No
Pacemaker	❑ Yes ❑ No
Heart surgery	❑ Yes ❑ No
Heart palpitations	❑ Yes ❑ No

Additional problems/surgeries/any recent testing that you have had related to your heart:_____

Cardiologist (heart doctor):_____ Phone:_____

4. PULMONARY (lungs) Check yes or no:

TB/Tuberculosis	❑ Yes ❑ No
Bronchitis	❑ Yes ❑ No
Asthma	❑ Yes ❑ No
Wheezing	❑ Yes ❑ No
Shortness of breath	❑ Yes ❑ No
History of lung masses/nodules	❑ Yes ❑ No
History of lung cancer	❑ Yes ❑ No

Additional problems/surgeries/any recent testing that you have had related to your lungs:_____

Pulmonologist (lung doctor):_____ Phone:_____

5. ENDOCRINOLOGY (diabetes or thyroid)

	Check yes or no:	
Diabetic	❑ Yes ❑ No	Age when diagnosed:_____
Thyroid problems	❑ Yes ❑ No	
Does anyone in your family have diabetes?	❑ Yes ❑ No	
Does anyone in your family have thyroid problems?	❑ Yes ❑ No	

Endocrinologist (diabetes/thyroid doctor):_____ Phone:_____

6. GASTROENTEROLOGY (abdomen/intestines/liver/stomach)

	Check yes or no:
History of hepatitis	❑ Yes ❑ No
Ulcer in stomach/intestines	❑ Yes ❑ No
History of blood in stools	❑ Yes ❑ No
History of gallstones/gallbladder problems	❑ Yes ❑ No
Diverticulosis	❑ Yes ❑ No
History of vomiting blood	❑ Yes ❑ No
Problems with esophagus	❑ Yes ❑ No
History of diarrhea	❑ Yes ❑ No
History of constipation	❑ Yes ❑ No
Have you ever had a colonoscopy (lower endoscopy) or EGD (upper endoscopy)?	❑ Yes ❑ No

When:_____ Why:_____

Additional problems/surgeries/any recent testing that you have had related to your abdomen, intestines, liver and/or stomach:_____

_____

Gastroenterologist (abdomen, stomach, liver and/or intestines doctor):_____ Phone:_____

7. UROLOGY (kidney/bladder/ureter/urethra)

	Check yes or no:
Frequent bladder infections	❑ Yes ❑ No
Painful urination	❑ Yes ❑ No
Difficult to urinate	❑ Yes ❑ No
Urinate frequently	❑ Yes ❑ No
Lose control of bladder when you cough, laugh or sneeze	❑ Yes ❑ No
History of kidney infections	❑ Yes ❑ No
History of kidney stones	❑ Yes ❑ No
History of enlarged prostate	❑ Yes ❑ No
History of bladder surgeries	❑ Yes ❑ No

If yes, why?_____

Additional problems/surgeries/any recent testing that you have had related to your kidneys, bladder, ureters and/or urethra:_____

_____

Urologist (kidney/bladder/ureter/urethra doctor):_____ Phone:_____

8. HEMATOLOGY/ONCOLOGY/RHEUMATOLOGY

(blood/cancer/arthritis) Check yes or no:

History of bleeding problems ❑ Yes ❑ No

History of difficulty clotting ❑ Yes ❑ No

Frequent bruising ❑ Yes ❑ No

Blood clots in legs or lungs ❑ Yes ❑ No

Frequent nosebleeds ❑ Yes ❑ No

Do you have arthritis? ❑ Yes ❑ No

Do you have muscle or joint pains? ❑ Yes ❑ No

Do you have a history of cancer? ❑ Yes ❑ No

If yes, what type of cancer?_____

When was the cancer diagnosed?_____ What treatment was done?_____

Date of last treatment was:_____

Do you have a family history of any type of cancer? ❑ Yes ❑ No

If yes, what relative and type of cancer?_____

Have you ever had a blood transfusion? ❑ Yes ❑ No

Total number of blood transfusions:_____ When was the last blood transfusion?_____

Additional problems/surgeries/any recent testing that you have had related to your blood problem or cancer:_____

_____

Hematologist/Oncologist/Rheumatologist
(blood/cancer/arthritis doctor): _____ Phone:_____

9. GYNECOLOGY (breasts/female organs)

Check yes or no:

How many times have you been pregnant?_____ How many children do you have?_____

Was your blood pressure elevated while you were pregnant? ❑ Yes ❑ No

Was your blood sugar elevated while you were pregnant? ❑ Yes ❑ No

Have you had a hysterectomy (uterus surgically removed)? ❑ Yes ❑ No

If yes, why?_____

Date of last pap smear:_____

Have you ever had an abnormal pap smear? ❑ Yes ❑ No

If yes, what was wrong?_____

Date of last mammogram:_____

Have you ever had an abnormal mammogram? ❑ Yes ❑ No

If yes, what was wrong?_____

Treatment for abnormal mammogram was:_____

History of breast biopsy ❑ Yes ❑ No

Additional problems/surgeries/any recent testing that you have had related to your your female organs:_____

_____

Gynecologist (female doctor):_____ Phone:_____

Breast doctor:_____ Phone:_____

10. PSYCHOSOCIAL (mental/social)

	Check yes or no:	
History of mental illness	❑ Yes ❑ No	Age when diagnosed:_____
History of alcohol/substance abuse	❑ Yes ❑ No	
Anxiety	❑ Yes ❑ No	
Depression	❑ Yes ❑ No	
Have you ever been incarcerated?	❑ Yes ❑ No	

Psychiatrist/Psychologist (mental/social doctor): _____ Phone:_____

11. ADDITIONAL INFORMATION

	Check yes or no:
Have you had any surgeries?	❑ Yes ❑ No
If yes, please list:_____	
Have you had any complications from anesthesia or surgery?	❑ Yes ❑ No
If yes, please list:_____	
Have you had any other hospitalizations?	❑ Yes ❑ No
If yes, please list:_____	
Is your spouse/significant other supportive of your decision to donate a kidney?	❑ Yes ❑ No
Is your employer willing to give you time off for the evaluation and recovery after donating?	❑ Yes ❑ No

12. FAMILY HISTORY

	Current Age	Medical Problems	Cause of death and Age at death (if no longer living)
Father			
Mother			
Brothers			
Sisters			
Sons			
Daughters			

13. HEALTH HABITS Check yes or no:

Do you currently smoke? ❑ Yes ❑ No Amount: _____

Have you ever smoked? ❑ Yes ❑ No Packs per day: _____ Quit date: _____

How long have/did you smoke? _____

Have you ever used illegal drugs? ❑ Yes ❑ No

What type of drugs have you used? _____

How many meals do you eat per day? _____ Coffee cups per day: _____

Tea cups per day: _____ Caffeinated beverages per day: _____

Amount of alcohol daily: _____

Completion of this routine health survey is required in order to be considered as a potential living donor.

I, _____, give my permission to be contacted by Texas Health Harris Methodist Hospital Kidney Transplant Program to receive more information about living donation.

❑ Yes I do ❑ No I do not give my permission to have my blood type and tissue typing lab work drawn as part of the initial screening to be a potential living kidney donor.

❑ Yes I do ❑ No I do not give my permission to allow the transplant program to let the potential recipient know that I have submitted this application. No health information will be shared with your potential recipient.

❑ Yes I do ❑ No I do not give my permission to receive text message reminders for appointments. M mobile phone number for text messages is _____

I understand that by giving my permission to be contacted and/or have screening labs drawn required no furtner commitment to proceed with evaluation of living donation

Potential Donor Name: _____ Date: _____