HARTFORD HOSPITAL
TRANSPLANT PROGRAM
Living Donor History and Health Questionnaire

Please answer the following questions to the best of your knowledge. If you are not sure, please leave those questions blank and complete the rest.

Name: _____Date of birth: _____Today's date: _____
Recipient Name _____Your relationship to recipient _____
Primary Care Physician: _____City _____
Have you had a physical within the last 12 months? □No □Yes (If not, you will be required to have one)
Current Medical Insurance □No □Yes- Name of insurance _____
Do you feel pressured or forced into being a donor □No □Yes-Please explain_____
_____
Are you being offered any compensation for being a donor? □No □Yes-Please explain_____
_____
Is your spouse/significant other aware of your decision to be an organ donor? □No □Yes
Is your employer willing to give you time off for the evaluation and recovery after donating? □No □Yes
Do you have any concerns about the recipient's commitment to taking care of the transplanted organ? □No □Yes

MEDICAL HISTORY: (Yes or No, include year)	**SURGICAL HISTORY:** (Include description and year)
Height:	None:
Weight: Weight at birth:	Heart surgery:
Diabetes: Gestational Diabetes:	Carotid surgery:
Hypertension/High Blood Pressure:	Gall Bladder / Appendectomy
Cancer:	Other abdominal surgery
Heart disease:	Prostate surgery:
Lupus/Genetic or Autoimmune Kidney Disease:	Other urologic surgery:
Stroke:	Amputation:
Chronic infections (TB etc)	C-Section / Hysterectomy:
Gout:	Breast biopsy:
Deep vein thrombosis (DVT)/Blood Clot:	Other biopsy:
Seizures:	Any complications from anesthesia?
Hepatitis / liver disease /jaundice:	Other surgery
HIV / AIDS:	What is your blood type?□ A □ B □ AB □ O □ unknown

PAST AND CURRENT MEDICATIONS: (Please indicate dose and frequency) _____
_____
Please list any **allergies** to medications and what reaction they cause: _____
_____
What is your current employment: _____
How long have you worked at your present job: _____
Are you not working due to disability? □No □Yes-When did you become disabled? _____
Are you married? □No □Yes For how many years? _____ Divorced? □No □Yes
Do you have children? □No □Yes If so, how many? _____ Ages: _____
Do any of your children have significant health problems? □No □Yes-Please explain_____
Who would be available to help you around time of surgery ? _____
Use of alcohol: Never _____ Occasionally _____ Regularly _____ Previously, but quit _____
Use of tobacco: Never _____ Packs per day _____ Previously, but quit _____
Use of illegal drugs: Yes: _____Never _____ Previously, but quit _____
Ever been in a drug or alcohol rehabilitation program? □No □Yes-Please explain_____
Ever been under the care of a mental health professional? □No □Yes-Please explain_____
Any tattoos or body piercing ? _____
Ever been in jail? □No □Yes When? _____ How long? _____

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FAMILY HISTORY ***(List which family members have the following?)***

Liver Disease:	Hypertension:
Kidney Disease:	Heart Disease:
Diabetes:	Cancer: Kidney Cancer:
Bleeding Disorder:	Stroke:

	Age	Health Problems/Cause of Death
Mother □ Alive □ Deceased		
Father □ Alive □ Deceased		
Number of Sisters Number of Brothers		

REVIEW OF SYSTEMS **Circle NO/YES**

GENERAL		MUSCULOSKELETAL	
Fever	□NO□YES	Joint Pain/Swelling	□NO□YES
Fatigue	□NO□YES	Muscle/Joint Weakness	□NO□YES
Insomnia	□NO□YES	Back Pain	□NO□YES
Stress	□NO□YES	Cold Extremities	□NO□YES
Chills /night sweats	□NO□YES	Numbness/Tingling in Arms or Legs	□NO□YES
EYES, EARS, NOSE, MOUTH, THROAT		Varicose Veins	□NO□YES
Eye/Vision Problems	□NO□YES	**BREAST**	
Hearing Loss/Ringing	□NO□YES	Breast Pain or Lump	□NO□YES
Earaches	□NO□YES	Nipple Discharge/Bleeding	□NO□YES
Nosebleeds	□NO□YES	Any lump in armpit	□NO□YES
Frequent Colds	□NO□YES	**NEUROLOGIC/PSYCHOLOGIC**	
Dental Problems	□NO□YES	Frequent Headaches	□NO□YES
Sore Throat/Hoarseness	□NO□YES	Lightheaded/Dizzy	□NO□YES
Swollen Glands	□NO□YES	Paralysis	□NO□YES
HEART AND LUNGS		Depression/ Psychiatric problems	□NO□YES
Chest Pain	□NO□YES	**ENDOCRINE**	
Irregular/Fast Heartbeat	□NO□YES	Osteoporosis/bone disease	□NO□YES
Shortness of Breath	□NO□YES	Excessive Thirst or Urination	□NO□YES
Swelling of Feet/Ankles	□NO□YES	Heat or Cold Intolerance	□NO□YES
Cough	□NO□YES	Thyroid problems	□NO□YES
Asthma/Wheezing	□NO□YES	**SKIN**	
Lung Disease	□NO□YES	Rash/Itching	□NO□YES
Spitting up Blood	□NO□YES	Bleeding/Bruising	□NO□YES
GASTROINTESTINAL		Change in Skin/Hair/Nails	□NO□YES
		Skin Cancer	□NO□YES
Abdominal Pain	□NO□YES	**PAST OR CURRENT INFECTIONS**	
Nausea/Vomiting	□NO□YES	Chicken pox	□NO□YES
Diarrhea	□NO□YES	Hepatitis A / B / C	□NO□YES
Constipation	□NO□YES	HIV	□NO□YES
Change in Bowels	□NO□YES	Herpes	□NO□YES
Hemorrhoids	□NO□YES	Tuberculosis	□NO□YES
Bleeding	□NO□YES	Other infections	□NO□YES
GENITOURINARY	□NO□YES	**MALES (ONLY)**	
Frequent Urination	□NO□YES	Pain or Swelling in Testicle	□NO□YES
Pain or Burning with Urination	□NO□YES	Prostate Problems	□NO□YES
Bladder Control Problems	□NO□YES	Erectile dysfunction	□NO□YES
Blood in Urine	□NO□YES	**FEMALES (ONLY)**	
Kidney Stones	□NO□YES	Severe Cramps or Irregular Menses	□NO□YES
Change in Force or Stream	□NO□YES	Heavy bleeding with menses Date of last Menstrual period _____	□NO□YES
Protein in urine	□NO□YES	History of abnormal Pap Smear Date of last Pap Smear _____	□NO□YES
Kidney Injury	□NO□YES	History of abnormal Mammogram Date of last mammogram _____	□NO□YES
BLEEDING/OTHER DISORDERS	□NO□YES	How many Previous Pregnancies	
Slow to Heal after Cuts	□NO□YES	Diabetes in Pregnancy	□NO□YES
Anemia	□NO□YES	High Blood Pressure in Pregnancy	□NO□YES
Blood Clots or Phlebitis	□NO□YES	How many Full-Term Deliveries	
Any religious/ethical concerns regarding blood transfusions	□NO□YES	How many Miscarriages/Abortions	
Any bleeding disorders	□NO□YES	Family History of Breast Cancer	□NO□YES
Leukemia	□NO□YES	Taking hormone replacement:	□NO□YES
Sexually Transmitted Disease	□NO□YES	Birth control pills	□NO□YES