Northwestern Memorial® Hospital

Solid Organ Transplant Program

HEALTH HISTORY QUESTIONNAIRE FOR THE LIVING DONOR

NAME:_____DATE:_____

RECIPIENTS NAME:_____

YOUR RELATIONSHIP TO THE RECIPIENT:_____

YOUR HOME ADDRESS:_____

HOME PHONE:_____WORK PHONE:_____

CELL PHONE:_____OTHER PHONE:_____

EMPLOYER:_____OCCUPATION:_____

EXPLAIN YOUR JOB DUTIES:_____

DATE OF BIRTH:_____ SEX: MALE/FEMALE SS#:_____

COUNTRY OF BIRTH:_____

HOW LONG HAVE YOU LIVED IN THE U.S:_____

HAVE YOU SERVED IN THE MILITARY:_____

NAME OF SIGNIFICANT OTHER / SPOUSE:_____

SINGLE:_____MARRIED:_____WIDOWED:_____ENGAGED:_____OTHER:_____

SEPARATED:_____DIVORCED:_____SIGNIFICANT OTHER / PARTNER_____

CHILDREN YES / NO NUMBER OF CHILDREN:_____

AGES OF THE CHILDREN:_____ _____

YOUR WEIGHT NOW:_____ HAVE YOU EVER BEEN OVERWEIGHT? YES / NO

IF YES HOW MUCH DID YOU WEIGH:_____ YOUR HEIGHT?_____

WHAT ARE YOUR PERSONAL REASONS FOR DONATING?_____

_____

Northwestern Memorial® Hospital

Solid Organ Transplant Program

LIVING ARRANGEMENTS: (WHO DO YOU LIVE WITH?) _____

_____

LIST FAMILY MEMBERS AND/OR FRIENDS WHO CAN HELP WITH YOUR MEDICAL CARE:

_____

_____

WHAT IS YOUR ETHNIC BACKGROUND *(mark all that apply):*_____

American Indian_____	**Chinese_____**	**Puerto Rican_____**
Alaska Native_____	**Filipino_____**	**Cuban_____**
African American_____	**Japanese_____**	**Hispanic other_____**
African (continental)_____	**Korean_____**	**European _____**
West Indian_____	**Vietnamese_____**	**Arab/middle eastern_____**
Native Hawaiian_____	**Asian Other_____**	**White_____**
Pacific Islander_____	**Mexican_____**	**Other_____**

WHAT IS YOUR MOTHERS ETHNIC BACKGROUND *(mark all that apply)*:_____

American Indian_____	**Chinese_____**	**Puerto Rican_____**
Alaska Native_____	**Filipino_____**	**Cuban_____**
African American_____	**Japanese_____**	**Hispanic other_____**
African (continental)_____	**Korean_____**	**European _____**
West Indian_____	**Vietnamese_____**	**Arab/middle eastern_____**
Native Hawaiian_____	**Asian Other_____**	**White_____**
Pacific Islander_____	**Mexican_____**	**Other_____**

WHAT IS YOUR FATHERS ETHNIC BACKGROUND *(mark all that apply)*:_____

American Indian_____	**Chinese_____**	**Puerto Rican_____**
Alaska Native_____	**Filipino_____**	**Cuban_____**
African American_____	**Japanese_____**	**Hispanic other_____**
African (continental)_____	**Korean_____**	**European _____**
West Indian_____	**Vietnamese_____**	**Arab/middle eastern_____**
Native Hawaiian_____	**Asian Other_____**	**White_____**
Pacific Islander_____	**Mexican_____**	**Other_____**

NAME / ADDRESS / PHONE NUMBER OF YOUR PRIMARY CARE PHYSICIAN:

_____

_____

NAME / ADDRESS / PHONE NUMBER OF OTHER SPECIALTY PHYSICIANS YOU SEE:

_____

_____

_____

_____

_____

_____

DO YOU HAVE ANY ALLERGIES? YES / NO

IF YES, WHAT ARE YOU ALLERGIC TO:_____

_____

IF YES, WHAT WERE THE ALLERGY REACTIONS/SYMPTOMS:_____

_____

HAVE YOU HAD ANY INJURIES? YES / NO

IF YES, WHAT TYPE OF INJURIES HAVE YOU HAD?_____

_____

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HAVE YOU EVER BEEN ADMITTED TO THE HOSPITAL? YES / NO

IF YES, FOR WHAT REASON?_____

_____

HAVE YOU HAD ANY OPERATIONS/SURGERIES? YES / NO

IF YES, WHAT TYPE OF OPERATIONS HAVE YOU HAD?_____

_____

_____

HAVE YOU HAD ANY ABDOMINAL SURGERIES/OPERATIONS? YES / NO

IF YES, WHAT TYPE OF ABDOMINAL SURGERIES HAVE YOU HAD?_____

_____

_____

HAVE YOU EVER HAD ANY COMPLICATIONS FROM THE SURGERIES? YES / NO

IF YES, WHAT TYPE OF COMPLICATIONS?_____

_____

HAVE YOU HAD GENERAL ANESTHESIA? YES / NO

HAVE YOU EVER HAD ANY COMPLICATIONS FROM THE ANESTHESIA? YES / NO

IF YES, WHAT TYPE OF COMPLICATIONS?_____

_____

DO YOU HAVE ANY MEDICAL PROBLEMS? YES / NO

IF YES, WHAT ARE THEY?_____

_____

_____

_____

HAVE YOU HAD ANY SEVERE INFECTIONS? YES / NO

IF YES, WHEN WERE THEY?_____

WERE YOU HOSPITALIZED WITH THEM? YES / NO

WHEN WERE YOU HOSPITALIZED?_____

DID YOU RECEIVE ANTIBIOTICS? YES / NO

DO YOU KNOW THE TYPE OF INFECTIONS YOU HAD? YES / NO

IF YES, WHAT TYPE?_____

_____

_____

HAVE YOU HAD ANY BLOOD TRANSFUSIONS? YES / NO

IF YES, WHEN?_____

IF YES, WHEN DID YOU HAVE THE TRANSFUSIONS:_____

IF YES, DID YOU HAVE ANY REACTIONS TO THE BLOOD TRANSFUSIONS AND IF YES, WHAT WERE THEY:_____

_____

DO YOU TAKE MEDICATIONS? YES / NO

IF YES: PRESCRIBED:_____

_____

_____

_____

OVER THE COUNTER:_____

_____

BIRTH CONTROL:_____

HERBAL SUPPLEMENTS:_____

OTHER:_____

REVIEW OF MEDICAL SYSTEMS:

1. **Do you have any skin disease: YES / NO**

   If yes, what kind?_____

2. **Do you have arthritis? YES / NO** _____

3. **Do you have any back pain? YES / NO**
   _____

4. **Do you have any headaches? YES / NO**
   _____

5. **Do you have any loss of feeling in your arms or legs? YES / NO**

   If yes, where?_____

6. **Do you bruise easily? YES / NO**

7. **Have you ever had problems with bleeding? YES / NO**

8. **Have you ever had a blood clot? YES / NO**

   If yes, where was it?_____

   How was it treated?_____

9. **Do you have anemia? YES / NO**

10. **Do you have high blood pressure? YES / NO**

    If you do, are you being treated for it ? YES / NO

    name of medication(s)?_____

11. **Do you have Thyroid disease? YES / NO**

    If yes, are you being treated for it ? YES / NO

    name of medication?_____

12. Do you have a chronic cough? YES / NO

Any wheezing? YES / NO

Bronchitis? YES / NO

Asthma? YES / NO

Tuberculosis? YES / NO

If yes, when & treatment_____

Pneumonia? YES / NO

13. Do you use an inhaler? YES / NO

If yes, what kind ?_____

How often?_____

14. Do you smoke? YES / NO

If you do, how much do you smoke?_____

Did you ever smoke?_____

When did you quit smoking?_____

15. Have you ever had heart disease or a heart attack? YES / NO

16. Have you ever had heart surgery? YES / NO

If yes when?_____

17. Have you ever had chest pain? YES / NO

Do you take medications for it? YES / NO

If yes what kind?_____

18. Do you have high cholesterol? YES / NO

If yes, do you take medications for it? YES / NO

If yes, what type?_____

19. Do you have shortness of breath? YES / NO

20. **Do you use oxygen? YES / NO**

If yes, how much?_____

21. **How many flights of stairs can you climb easily?**_____

22. **Do your feet, ankles, or legs swell? YES / NO**

If yes, when?_____

23. **Do you have ascites (fluid in the abdomen)? YES / NO**

If yes, when?_____

Have you ever had a paracentesis? YES / NO

If yes, when?_____

How much fluid was removed?_____

24. **Do you get stomach aches / pain? YES / NO**

If yes, when?_____

How frequently?_____

Is it food related?_____

Do you take medication for it? YES / NO

If yes, what type?_____

Does it provide relief? YES / NO

What does provide relief from the pain?_____

_____

25. **Have you ever been diagnosed with an intestinal disease / disorder? YES / NO**

If yes, what type?_____

26. **Do you have chronic diarrhea? YES / NO**

If yes, how often?_____

Do you take medications for it?_____

Does it control or stop the diarrhea?_____

27. **Do you have bouts of constipation? YES / NO**

If yes, how often?_____

What provides relief?_____

28. **Have you ever had blood in the stool? YES / NO If yes, when?**_____

29. **Have you ever thrown up blood? YES / NO**

If yes, when?_____

Where you hospitalized? YES / NO

Did you need to receive blood transfusions? YES / NO

30. **Have you ever had stomach ulcers? YES / NO**

If yes, when?_____

Were you treated for it?_____

31. **Have you ever had gallbladder trouble? YES / NO**

32. **Do you have diabetes? YES / NO**

If yes, do you use insulin, oral medication, or diet control?_____

_____

33. **Have you ever been jaundiced? YES / NO**

34. **Have you ever been told you have hepatitis? YES / NO**

If yes, when and what type?_____

35. **Have you ever been told you had liver disease? YES / NO**

If yes, what type of liver disease?_____

36. **Do you drink beer, wine, or alcohol?** **YES / NO**

If yes, how often?_____

Do you drink socially?_____

When was the last time?_____

What is the amount of alcohol do you drink?_____

37. **Did you ever drink beer, wine, or alcohol?** **YES / NO**

If yes, when did you stop?_____

If yes, how much did you drink in the past?_____

38. **Have you ever been told to stop drinking?** **YES / NO**

If yes, when?_____

39. **Have you ever had bladder problems?** **YES / NO**

40. **Have you ever had any problems with painful urination?** **YES / NO**

41. **Do you urinate frequently?** **YES / NO**

42. **Do you have to urinate during the night?** **YES / NO**

43. **Have you ever had difficulty in urination?** **YES / NO**

44. **Have you ever had kidney stones?** **YES / NO**

If yes, when and did you have treatment?_____

45. **Have you ever had an urinary tract infection?** **YES / NO**

If yes, when?_____

Did you have treatment? **YES / NO**

If yes, what kind?_____

46. **Have you ever had a kidney infection?** **YES / NO**

If yes, when and what was used for treatment?_____

47. Have you ever needed dialysis? YES / NO

If yes, when?_____

If you are on dialysis now, what date did you first start?_____

If you are on dialysis now, what days do you go to dialysis?

_____

48. Have you ever had a tumor? YES / NO

If yes, where was it?_____

Was it cancer?_____

How was it treated?_____

48. Have you ever had any blackout spells?_____

50. Have you ever had seizures? YES / NO

If yes, when?_____

Are you still being treated for seizures?_____

51. Have you ever consulted with a psychiatrist? YES / NO

52. Have you ever felt the need to see a psychiatrist? YES / NO

53. Do you have any problems with anxiety? YES / NO

If yes, when?_____

54. Do you take any medications for anxiety? YES / NO

If yes, when?_____

What type of medications are you taking?_____

How do you cope during and anxiety episode?_____

55. **Do you have any problems with depression?** **YES / NO**

If yes, when?_____

56. **Do you take medications for depression?** **YES / NO**

If yes, what is the medication?_____

How do you cope during a depressive episode?_____

_____

57. **Have you ever traveled out of the country?** **YES / NO**

If yes, what countries did you travel to:_____

_____

_____

58. **When was the last time that you did travel out of the country?**_____

_____

QUESTIONS ONLY FOR MALES:----------

1. **Have you ever had a venereal disease?** **YES / NO**

   If yes, what type, when, and treatment?_____

   _____

2. **Do you have any testicular swelling?** **YES / NO**

3. **Have you ever had testicular cancer?** **YES / NO**

   If yes, when?_____

4. **Do you have regular prostate exams?** **YES / NO**

5. **Do you have prostate problems?** **YES / NO**

6. **Do you have any penile discharge?** **YES / NO**

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QUESTIONS ONLY FOR FEMALES----------PAGE 14

1. When was your last menstrual period?_____
2. Are you pregnant now?_____
3. Do you have regular periods? YES / NO
4. Do you have painful cramps? YES / NO
5. Have you ever been diagnosed with endometriosis? YES / NO
6. How many pregnancies have you had?_____
7. Have you had any complications with the pregnancies? YES / NO

   If yes, what were they?_____
8. Did you have vaginal births or C-Sections?_____
9. Do you have frequent vaginal or yeast infections? YES / NO

   If yes, when was the last one?_____

   If yes, what was the treatment?_____
10. Have you ever had a venereal disease? YES / NO

    If yes, what type, when, and treatment? _____
11. Do you have regular PAP Smears and Pelvic Exams? YES / NO

    If yes, when was your last one?_____

    If yes, what were the results?_____
12. Do you have regular Mammograms? YES / NO

    If yes, when was your last one?_____

    If yes, what were the results?_____

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QUESTIONS ONLY FOR FEMALES----------PAGE 15

13. **Have you ever had abnormal Mammograms?** **YES / NO**

If yes, what was the abnormality?_____

14. **Have you ever had breast cancer?** **YES / NO**

If yes, when and how was it treated?_____

_____

13. **Do you take Hormone replacement therapy?** **YES / NO**

If yes, what type?_____

Have you had any other medical problems that were not mentioned? YES / NO

If yes, please list:_____

_____

_____

What treatment(s) are you getting?_____

_____

_____

How do you rank your health status at this present time?

Excellent_____ **Good**_____

Fair_____ **Poor**_____

FAMILY HISTORY:

What diseases are there in your family? (include parents, grandparents, brothers, sisters, children)

_____

_____

_____

Have you ever had:	**Measles:**	**YES / NO**
	Mumps:	**YES / NO**
	Chickenpox:	**YES / NO**
	Rheumatic fever:	**YES / NO**
	Mononucleosis:	**YES / NO**
	Hepatitis A:	**YES / NO**
	Hepatitis B:	**YES / NO**
	Hepatitis C:	**YES / NO**
	Tuberculosis:	**YES / NO**

Have you ever been immunized for the following?

Hepatitis A YES / NO When?_____

Hepatitis B YES / NO When?_____

HAVE YOU HAD ANY OF THE FOLLOWING TESTS / PROCEDURES

1. CT-SCAN? YES / NO If yes when?_____

What part of the body did they scan?_____

2. MRI? YES / NO If yes when?_____

What part of the body did they scan?_____

3. Ultrasound? YES / NO If yes when?_____

What part of they body did they scan?_____

4. Chest X-Ray? YES / NO If yes when?_____

5. Liver Biopsy? YES / NO If yes when?_____

6. Echocardiogram? YES / NO If yes when?_____

7. Cardiac Stress test? YES / NO If yes when?_____

8. Cardiac Catheterization? YES / NO If yes when?_____

9. Pulmonary Function Testing? YES / NO If yes when?_____

10. Upper endoscopy? YES / NO If yes when?_____

11. Colonoscopy? YES / NO If yes when?_____

12. ERCP? YES / NO If yes when?_____

13. TIPS (Transjugular intrahepatic portal-systemic shunt)? YES / NO

If yes when?_____

14. Other tests and when?_____

_____

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APPROVAL_____DATE:_____
Chief, Director of Transplantation MD

APPROVAL_____DATE:_____