University of Washington Medical Center
Living Donor Program

Name_____ Donating to:_____

Thank you for your interest in the University of Washington Medical Center's Living Donor Program. Please answer the following questions.

Your answers will provide us with important information to help evaluate your potential as living kidney donor also to help and support you throughout the donor evaluation process.

Please answer the following questions in your own words (please use a separate sheet of paper if needed). There are no "right" or "wrong" answers; it is a way for us to get to know you better.

Questionnaire

1. How did you come to the decision that you wanted to donate one of your kidneys?

_____

_____

_____

_____

_____

2. How long have you been contemplating this decision?

_____

_____

_____

_____

_____

3. What do you know at this time about being a living kidney donor? Where did you obtain this information?

_____

_____

_____

_____

_____

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4. Who have you talked to about your desire to be a living kidney donor? What reactions have you received?

5. Is there anyone close to you that you haven't talked to? If so, why?

6. What additional information do you need to know in order to make a final decision about whether or not you want to be a living kidney donor?

7. Is there anything else you want us to know about you?

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Donor:_____

Height: _____**ft**_____**in** **Weight:**_____**BMI:**_____

DO HAVE YOU ANY ALLERGIES? PLEASE LIST THEM: (Please include allergies to medications and foods and describe your reactions)

1._____
2._____
3._____
4._____

LIST ALL MEDICATIONS YOU NOW TAKE (Please include medication name, dose and how many times per day and include over-the-counter medications, nonsteroidal pain relievers, vitamins and herbal supplements)

1._____
2._____
3._____
4._____

PLEASE LIST YOUR MEDICAL PROBLEMS AND TREATMENTS (Please include all medical conditions such as hypertension, diabetes, heart disease, kidney failure, etc.)

1._____
2._____
3._____
4._____

PLEASE LIST ALL SURGERIES INCLUDING DENTAL (Please include both medical and dental surgeries with dates)

1._____
2._____
3._____
4._____

Health Questionnaire:

Work	
What type of work do you do?	
How much exercise is associated with the job?	
Are there any physical hazards at your job- dangerous equipment, firearms, risk for falls from high places, chemicals?	

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Work (continued)	
Are you required to do heavy lifting as part of your job?	

Exercise	
Can you walk up two flights of stairs without getting short of breath?	
What type of daily exercise program do you follow?	
How many times a week:	
Do you regularly do any of these activities?	Bike walk golf jog ski
Do you participate in contact sports? If so, which sport and how often?	
How much exercise is associated with your job?	

Diet:	
How many meals a week do you eat out?	
How many fast food meals do you have weekly?	
How many times of week do you use pre-prepared foods?	
Are you a vegetarian?	
How many times a week do you cook from scratch?	
What was your weight at age: 18, 30, 40, 50, and 60?	

Over-the-counter Medications:	
Do you use herbal preparations or megavitamins	
Do you use aspirin on a regular basis?	
If yes, how much and how often?	
Do you use nonsteroidal medications for pain – Ibuprofen, Advil, Indocin etc	
If yes, how much and how often?	

Social Habits	
What time do you go to bed?	
What time in the morning do you usually get up?	
Have you ever used any tobacco products and if so what kind?	
Do you smoke now?	
If yes, how much?	
If yes, how many years?	
Do you use chewing tobacco?	
Do you use a pipe or smoke cigars?	

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Social Habits (continued)	
Do you drink alcohol?	
How many drinks a week do you have? If yes, what type (beer, wine, and hard liquor)?	
Do you participate in any activity work, social or other that puts you at risk for infections?	

Surgery:	
Have you ever had anesthetic?	
If yes, did have a problem with anesthesia?	
Has any one related to you had a problem with anesthesia?	

Other:	
Have you ever traveled outside of the USA and	
If so, where?	
Have you ever been in the military service?	
Have you every been under the care of a counselor, psychologist, or psychiatrist	
Have you donated blood?	
What are your hobbies?	
Have you been in a motor vehicle accident?	
Do you have any physical disabilities?	
lo you need any special assistance?	
Do you have any body piercing or tattoos?	

Health History: Have you been treated for any of the following	**YES**	**NO**	**WHEN**
Frequent headaches			
Migraine headaches			
Numbness or weakness in arm or leg			
Seizures			
Episodes of unconsciousness or fainting			
Eye problem			
Vision disturbances			
Stroke			
Loose teeth			
Dentures and/or caps			
Bridgework			

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Health History (continued)	YES	NO	WHEN
Braces			
Persistent/ongoing cough			
Abnormal chest x-ray			
Difficulty Breathing			
Asthma			
Shortness of breath at night			
Snoring			
Sleep study			
Thyroid problems			
Heart murmur			
Heart attack			
Angina or chest pain			
Abnormal EKG			
High blood pressure			
Hiatus hernia			
Persistent heartburn			
Urinary tract infection			
Kidney stones			
Kidney disease			
Jaundice			
Hepatitis			
Back injuries			
Back problems			
Back pain			
Arthritis			
Bleeding tendencies			
Cancer			

FEMALES:	Date of last period?	Number of pregnancies?	History of preeclampsia during pregnancies?
History of gestational diabetes during pregnancies?	Number of live births?	Number of abortions?	Number of stillborn?
Could you be pregnant?	Type of contraceptive method?		

Family History	YES	NO	WHO
Diabetes			
Hypertension			
Cancer			
Kidney Disease			
Heart Disease			
Lupus			
Rheumatoid Arthritis			