# Transplant Institute of Research Medical Center
# EVALUATION QUESTIONNAIRE

Last name____________________ First Name____________________ M.I. ___________

Height: _______ Weight:______________
Children: No. Boys _______Ages________ Grandchildren No. __________

No. Girls _______Ages________

Education (Highest grade completed) _________________

If under 18: Parent or Legal Guardian's name: ___________________________________

Relationship: _________________________ Telephone No.________________________

Are you a U.S. Citizen?_________________

## PHYSICIAN INFORMATION

**Family Doctor; Internal Medicine Doctor; or Primary Care Physician:**

Doctor Name: ___________________________________________________________________

Clinic/Facility Name ____________________________________________________________

Address ________________________________ Telephone No.__________________________

City __________________ State ______ Zip ________ Fax No.______________________

**Nephrologist (Kidney Specialist)**
Doctor Name: ___________________________________________________________________

Clinic/Facility Name_____________________________________________________________

Address___________________________________ Telephone No.________________________

City____________________ State ________ Zip______ Fax No.________________________

**Endocrinologist (Diabetes Specialist)**
Doctor Name:____________________________________________________________________

Clinic/Facility Name_____________________________________________________________

Address___________________________________ Telephone No. _______________________

City____________________ State _______ Zip ______ Fax No.__________________________

**Other (Please Explain: Cardiologist, Gastroenterologist, etc)** ________________________
Doctor Name: ___________________________________________________________________

Clinic/Facility Name_____________________________________________________________

Address__________________________________ Telephone No.__________________________

City____________________ State ________ Zip _____ Fax No.__________________________

## If you are on dialysis, please answer the following:

Name of your dialysis unit:______________________________________________
Address:____________________________Telephone No.____________________________
City__________________ State ________ Zip________ Fax No.______________________
Name of Social Worker or Nurse Coordinator:________________________________________
Date that you started dialysis: __________________________________

Type of dialysis?

[ ] Hemo (in your dialysis unit)

Schedule: [ ] Mon/Wed/Fri Time of Day: [ ] Morning
[ ] Tues/Thurs/Sat [ ] Afternoon
[ ] Other_______ [ ] Evening

Type of access and where located: Fistula ____________ Graft____________

[ ] Peritoneal (at home dialysis)

CAPD with _________ number of exchanges daily
Overnight Cycler for _______ hours daily. On at ______p.m. Off at _____ a.m
Catheter/Access located:_____________________

## MEDICAL INFORMATION

**PRIMARY KIDNEY DISEASE/ REASON FOR KIDNEY FAILURE:**

______________________________________________________________________

**DATE DIAGNOSED** ____________________ **BIOPSY: Y / N DATE** ________________________
**BIOPSY BY:** ____________________________

**ALLERGIES TO FOODS AND/OR MEDICATIONS AND REACTIONS**:________________________
______________________________________________________________________
**FOOD INTOLERANCE**:______________________________________________________

**IMMUNIZATIONS:**

Did you receive a flu shot this year? Yes [ ] Date:______________No[ ]
Have you ever had a Pneumonia Vaccine? Yes [ ] Date:______________No [ ]
Have you had Hepatitis B Vaccines? Yes [ ] Date:______________No [ ]
When was your last Tetanus shot? __________________
When was your last T.B. skin test?__________________Where?______________
What other Immunizations have you had? ____________When? ______________
______________________________________________________________________

**GENERAL HEALTH:**

Check if you now have – or have ever been told you have – any of the following:

- ☐ Arthritis TYPE:____________________Bone disease:______________________________
- ☐ Diabetes – if yes, complete the Diabetes section on the following page.
- ☐ Heart Disease – Type _____________________Surgery? ______________________________
- ☐ Heart Attack____________Congestive Heart Failure__________ Chest Pain_______________
- ☐ High Blood Pressure – On Medication? Yes [ ] No [ ]

- Circulation Problem Y [ ] N [ ]– Leg pain while walking? Yes [ ] No[ ]
- High Cholesterol – On Medication? Yes [ ] No [ ]
- Liver disease – Type ______________ Treatment? Yes [ ] No [ ]
- Stomach Ulcers or other stomach ailment – Specify _____________________________________
- Seizures - On Medication? Yes [ ] No [ ]
- Stroke Yes [ ] No [ ]
- Thyroid disease – on medication? Y [ ] N [ ] – Surgery? Type _________________________
- Cancer – Type ________________________________________ Date ________________________
- Malignancy___________________
- Gallbladder disease_____________ Removed?________________
- Pancreatitis_____________________Diverticulitits___________________
- Cerebrovascular disease?__________________________________
- Peripheral vascular disease?_________________________ Blood clots?_____________________
- COPD_________________ Asthma_________________

Other Conditions:___________________________________________ Date ____________________
___________________________________________ Date ____________________
___________________________________________ Date ____________________

Bladder Problems__________________Surgeries__________________________________________

History of kidney stones_______________________ Urinary tract infections__________________

Daily urine volume_______________ Number of times void per day_________________________

Number of times void per night_________________ Pain with urination_____________________

Trouble starting a stream_______________________

Produce NO urine in a day?______________ Since when? ________________________________

Have you ever smoked or chewed tobacco? Yes [ ] No [ ]

How many packs per day? _______________

For how long/ Number of Years?__________________________________________

Have you quit? Yes [ ] No [ ] – If yes, when? ______________________

Do you drink alcoholic beverages? Yes [ ] No[ ] If yes, how often? ______________________

Have you ever used any type of street drugs? Yes [ ] No [ ]

If yes, what type? ___________________________________________________

When was the last time? ______________________________________________

WOMEN ONLY:
How many pregnancies have you had? ___________How many live births?_____________
Have you had a Pap smear in the last year? Yes [ ] Date & Doctor__________________ No [ ]
Have you had a Mammogram in the last year? Yes [ ] Date & Doctor________________ No [ ]

**HOSPITALIZATIONS:**

Have you been hospitalized in the past year? Yes [ ] No [□]

Why were you in this hospital? ____________________________________________

What was the date(s) you were there? ______________________________________

Give the name and location of the hospital(s): _____________________________

______________________________________________________________________

Have you ever had any type of surgery? Yes [ ] No [ ]
Type of surgery ______________________________ Date ____________________

______________________________ Date ____________________

______________________________ Date ____________________

______________________________ Date ____________________

Vascular Access: Fistula(s)______________
Graft(s)________________
Catheter(s)_____________

## HISTORY

Have you ever had any of the following tests or surgeries?

**Check all that apply and give the date and doctor or hospital done with**:

[ ] Electrocardiogram (EKG) ____________ [ ] Angioplasty (Balloon) _____________________

[ ] Dental Exam___________

[ ] Heart Catheterization _________ [ ] Pace maker _________________________________

[ ] Colonoscopy___________

[ ] Stress Test _________________________ [ ] Valve Replacement _______________________

[ ] Stool cards___________________

[ ] Echo cardiogram _____________ [ ] Heart Bypass Surgery or CABG___________________

[ ] Chest x-ray__________________

[ ] Angiogram___________________ [ ] Internal Defibrillator____________________________

[ ] PSA__________________

[ ] Cardiology Appointment____________________ [ ] Nephrology Appointment____________

DO YOU KNOW WHAT YOUR BLOOD TYPE IS? Yes [ ] No [ ]
My blood type is: A [ ] B [ ] AB [ ] O [ ]

HAVE YOU EVER HAD BLOOD TRANSFUSIONS? Yes [ ] No [ ]

How Many? ___________ Date of last _______________

## DIABETES INFORMATION

Do you have type I ___ or type II ___
How old were you when you were first diagnosed with diabetes? ____________________
What kind of diabetic diet do you follow? ______________________________________
Do you take pills? Yes [ ] No [ ]
Name of medicine: ______________________________ Dose: _______________
Do you take insulin? Yes [ ] No [ ]
Type of Insulin: ________________________________ Dose: _______________
When was your last eye exam? _______________________________________________
Does anyone else in your family have diabetes? Who?_____________________________

Check all of the complications of diabetes that apply to you:

Have you ever passed out from your blood sugar being too low? [ ] Yes [ ] No
Have you ever been hospitalized because of diabetic coma? [ ] Yes [ ] No
Do you have diabetic eye disease (retinopathy)? [ ] Yes [ ] No
Have you ever had laser treatments on your eyes? [ ] Yes [ ] No
Do you have nerve problems with your feet (neuropathy)? [ ] Yes [ ] No
Do you have nerve problems with your arms/hands? [ ] Yes [ ] No
Do you have problems with diarrhea? [ ] Yes [ ] No
Do you have problems with constipation? [ ] Yes [ ] No
Do you have problems with nausea? [ ] Yes [ ] No
Do you have problems with vomiting? [ ] Yes [ ] No
Do you have problems with gastroparesis? [ ] Yes [ ] No

**Medication List**:

| Name of medication | Dose | What For? |
| --- | --- | --- |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**PLEASE COMPLETE THE FOLLOWING, IF YOU HAVE HAD A PREVIOUS TRANSPLANT:**

What kind of transplant did you have?

[ ] Kidney [ ] Pancreas/Kidney [ ] Pancreas only
[ ] Other (please explain)________________________________________________

Date of your transplant surgery:____________________________________________
Hospital where transplant performed:________________________________________

Was your donor: [ ] A Living donor? [ ] A Deceased Donor?

Has your transplanted organ failed? [ ] Yes [ ] No
If yes, approximately when and cause of failure? ___________________________

Please provide the following information about the Transplant Center &/or Physician who has been taking care of you since your transplant:

Name of Center/Physician ___________________________________________
Address:___________________________________ City:______________
_____________ State________ Zip________________
Phone Number:_____________________________________________

HAVE YOU DISCUSSED TRANSPLANTATION WITH YOUR FAMILY? [ ] Yes [ ] No
Do you think you will have possible donors? [ ] Yes [ ] No
Please list possible donors and relationship to you. If you need more space, please write on the back of this page:
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________

**<u>PLEASE MAKE COPIES OF ALL INSURANCE CARDS (</u>Both front and back of the cards) or have your nephrologist fax us a copy of these cards. Fax # 816-822-8259.**

**Enclose these with this application and return both to the Transplant Institute. If you have any questions or concerns, call 816-822-8257 for assistance.**