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:

_____
_____
_____
_____

PLEASE MAKE COPIES OF ALL INSURANCE CARDS (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.