Clinical Transplant Services
Kidney/Pancreas Transplant Program
Mail Code: CB569 ● 3181 SW Sam Jackson Park Rd. ● Portland, OR 97239-3098
Tel: 503/494-8500 ● Toll free: 800/452-1369 x 8500 ● Fax: 503/494-4492

OHSU Living Donor Health Questionnaire

Last Name _____ First Name _____ MI____

Address _____

City _____ State____ Zip _____ DOB _____ Age ____

Sex _____ Race _____ Height _____ Weight_____

Your recipient's name: _____

How do you know them?_____

Please circle the preferred way to reach you:

Home Phone _____

Work Phone _____

Cell Phone _____

Marital Status S__ M__ D__ W__

Are you a US citizen? Y N

Please circle the highest grade completed:

High school 9 10 11 12 College 1 2 3 4 5 6 7 8

Occupation _____

Hours worked per week_____

Primary support person_____

Are you a Resident Alien? Y N

Email address:_____

Please circle if you have ever been treated for the following:

Anemia	Anxiety	Arthritis
Asthma	Autoimmune disease	Backache
Bladder infection	Bleeding problems	Blood Clots
Blood in urine	Blood transfusions	Cancer
Chest pain	Convulsions/seizure	Depression
Diabetes	Heart disease	Hepatitis
Hypertension	Genital Herpes	Gestational Diabetes
Kidney Infection	Kidney Stones	Lung disease
Lupus	Thyroid problems	Tuberculosis
Ulcerative Colitis	Urinary tract infection	

If you have circled any of these conditions, please provide details and include how many times you were treated and how long you were ill on the reverse side.

_____

_____

_____

_____

What medications *including over-the-counter medicines, herbs or supplements* do you take?

_____

_____

_____

_____

Do you have health insurance? Y N

Name and phone number of your doctor: _____

Date of your most recent physical exam? _____

Please list any active health issues: _____

_____

Please list any hospitalizations, including date, what hospital, and reason.

_____

_____

_____

_____

Have any blood relatives had any of the following? (If yes, who?)

Kidney disease	Yes / No _____	Heart Problems	Yes / No _____
Diabetes	Yes / No _____	Epilepsy	Yes / No _____
High blood pressure	Yes / No _____	Cancer	Yes / No _____
Stroke	Yes / No _____	Breast Cancer	Yes / No _____
Tuberculosis	Yes / No _____	Prostrate Cancer	Yes / No _____
Mental Illness	Yes / No _____	Colon Cancer	Yes / No _____

PLEASE RETURN THIS COMPLETED FORM, YOUR BLOOD PRESSURE LOG AND YOUR SIGNED, DATED, WITNESSED CONSENTS TO THE TRANSPLANT OFFICE IN THE ENCLOSED ENVELOPE.

THE LIVING DONOR COORDINATOR WILL CALL YOU AFTER RECEIVING YOUR MATERIALS.