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 Code _____

Race & Ethnicity: ***Please check all that apply.*** For regulatory purposes, we are required to accurately report this information for potential living donors.

American Indian or Alaska Native

- □ American Indian
- □ Eskimo
- □ Aleutian
- □ Alaska Indian
- □ American Indian or Alaska Native: Other
- □ American Indian or Alaska Native: Not Specified/Unknown

Black or African American

- □ African American
- □ African (Continental)
- □ West Indian
- □ Haitian
- □ Black or African American: Other
- □ Black or African American: Not Specified/Unknown

Native Hawaiian or Other Pacific Islander

- □ Native Hawaiian
- □ Guamanian or Chamorro
- □ Samoan
- □ Native Hawaiian or Other Pacific Islander: Other
- □ Native Hawaiian or Other Pacific Islander: Not Specified/Unknown

Asian

- □ Asian Indian/Indian Sub-Continent
- □ Chinese
- □ Filipino
- □ Japanese
- □ Korean
- □ Vietnamese
- □ Asian: Other
- □ Asian: Not Specified/Unknown

Hispanic/Latino

- □ Mexican
- □ Puerto Rican (Mainland)
- □ Puerto Rican (Island)
- □ Cuban
- □ Hispanic/Latino: Other
- □ Hispanic/Latino: Not Specified/Unknown

White

- □ European Descent
- □ Arab or Middle Eastern
- □ North African (Non-Black)
- □ White: Other
- □ White: Not Specified/Unknown

Please circle the preferred way to reach you:

Home Phone: _____

Work Phone _____

Cell Phone _____

Email Address _____

Marital Status S M D W

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 _____

Are you a US Citizen? Y N

Are you a Resident Alien? Y N

DOB _____ Age _____ Sex _____ Height _____ Weight _____

Your recipient's name _____

How do you know them? _____

Primary support person for post-op recovery _____

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	**OTHER**

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

_____

_____

_____

_____

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/surgeries, including date, what hospital, and reason for hospitalizations.

_____

_____

_____

_____

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

Diabetes	Yes/No	_____	High Blood Pressure	Yes/No	_____
Breast Cancer	Yes/No	_____	Kidney Disease	Yes/No	_____
Cancer	Yes/No	_____	Mental Illness	Yes/No	_____
Colon Cancer	Yes/No	_____	Prostate Cancer	Yes/No	_____
Epilepsy	Yes/No	_____	Stroke	Yes/No	_____
Heart Problems	Yes/No	_____	Tuberculosis	Yes/No	_____

PLEASE RETURN THIS COMPLETED FORM, YOUR BLOOD PRESSURE LOG AND YOUR SIGNED, DATED, WITNESSED CONSENTS TO THE TRANSPLANT OFFICE IN THE ENCLOSED EVELOPE.
ONE OF THE LIVING DONOR COORDINATORS WILL CALL YOU AFTER YOUR MATERIALS HAVE BEEN RECIEVED