UMC
UNIVERSITY MEDICAL CENTER

TRANSPLANT CANDIDATE QUESTIONNAIRE

IMPORTANT NOTE: Information provided in this questionnaire is strictly confidential and becomes a part of your medical record. Complete every line. If it does not apply put "N/A".

PERSONAL

Patient Name:	Date of Birth:
Maiden / Other Name(s):	Social Security #:
Street Address:	Home Phone #:
City: State: Zip:	Work Phone #:
County: Country:	Cell Phone #:

EMPLOYMENT

Employment Status: ❑ Employed ❑ Unemployed ❑ Student ❑ Retired ❑ Disabled ❑ Homemaker

Occupation:_____ Employer:_____

CITIZENSHIP (check one box)

❑ U.S. Citizen ❑ Resident Alien ❑ Non-Resident Alien → Date you entered the United States:_

LANGUAGE & LEARNING

Please check ANY of the following that apply:

❑ I speak English. ❑ I speak: _____

REFERRAL

Referred by: ❑ Self ❑ Dialysis Unit ❑ Physician: Name: Phone: Fax:

DIALYSIS

Are you on Dialysis? ❑ Yes ❑ No → *If Yes, complete the following information. If No, skip to the next section.*

a. Dialysis Schedule: ❑ Mon ❑ Tue ❑ Wed ❑ Thu ❑ Fri ❑ Sat Time:_____

b. Type: ❑ Hemodialysis ❑ Peritoneal Dialysis ❑ Home Hemodialysis

c. Dialysis Unit:_____Phone:_____ Fax:_____

MEDICAL

What is the cause of your kidney failure?_____

TRANSPLANT: Are you listed with another Transplant Center? ❑ Yes ❑ No;

Where?_____Phone: _____

Have you had a transplant before? ❑ Yes ❑ No Organ: Date:

Where:

Have you had a kidney biopsy? ❑ Yes ❑ No; Where?_____

INFECTION

1. Have you had infections in your **bladder or kidneys**? ❑ Yes ❑ No
2. Do you currently have **dental** issues? ❑ Yes ❑ No Date of most recent exam: _____
3. Do you currently have **another** infection? ❑ Yes ❑ No; What? _____
4. Do you have **active**: **TB**? ❑ Yes ❑ No **Hepatitis B**? ❑ Yes ❑ No **Hepatitis C**? ❑ Yes ❑ No Treated?

RESPIRATORY

1. Do you have **COPD**? ❑ Yes ❑ No; **Emphysema**? ❑ Yes ❑ No;
2. Do you use **oxygen**? ❑ Yes ❑ No; When? _____
3. Have you had a **Pulmonary Function Test**? ❑ Yes ❑ No;
4. Do you have **sleep apnea**? ❑ Yes ❑ No;

5. Do you use **CPAP**? ❑ Yes ❑ No

CANCER HISTORY

Have you ever had Cancer? ❑ Yes ❑ No → *If Yes, complete below. If No, skip to next section.*

a. What kind?_____ Any skin cancer (specify type):_____.

b. Date of first Diagnosis:_____

c. Treatment (check all that apply): ❑ NONE ❑ Surgery ❑ Radiation ❑ Chemotherapy ❑

*Treating Physician:*_____ *Phone:*_____ *Fax:*_____

*Treating Facility:*_____ *Phone:*_____ *Fax:*_____

d. Date of Treatment Completion: ❑ N/A – still being treated ❑ N/A – did not receive treatment

HEART HISTORY

High blood pressure ❑ Yes ❑ No Congestive heart failure ❑ Yes ❑ No

Low blood pressure ❑ Yes ❑ No Problems with circulation ❑ Yes ❑ No

Stent ❑ Yes ❑ No Angina (chest pain) ❑ Yes ❑ No ❑ NONE of these

❑ Other (specify):_____

HEART HISTORY CONTINUED

1. Have you ever had an Electrocardiogram (EKG)? ❑ Yes ❑ No
2. Have you ever had an **Echo**cardiogram? ❑ Yes ❑ No
3. Have you ever had a Stress Test? ❑ Yes ❑ No
4. Have you ever had an Angiogram / Heart Catheter? ❑ Yes ❑ No
5. Do you go to a cardiologist? ❑ Yes ❑ No Name:

_____

6. Have you ever had a Stroke? ❑ Yes ❑ No *Date:*_____ *Hospital:*_____

List any problems you still have:

DIABETES HISTORY

1. Have you ever been diagnosed with Diabetes? ❑ Yes ❑ No → *If Yes, how long ago?*_____
2. Are you legally blind? ❑ Yes ❑ No
3. Do you have neuropathy (numbness / tingling of extremities)? ❑ Yes ❑ No
4. Do you have problems with non-healing foot ulcers? ❑ Yes ❑ No
5. Do you currently have any open wounds or ulcers on your legs, feet or toes? ❑ Yes ❑ No
6. Have you had any amputations? ❑ Toe/s ❑ Foot ❑ Leg

NEUROLOGIC & MENTAL HEALTH

1. Have you ever seen a psychologist or psychiatrist? ❑ Yes ❑ No → *If Yes,*

*Name/s:*_____ *Phone:*_____ *Fax:*_____

2. Do you have a history of depression? ❑ Yes ❑ No

*Describe:*_____

3. Do you take any psychiatric or depression medications? ❑ Yes ❑ No, What?

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4. Have you ever taken any medications for seizures? ❑ Yes ❑ No, What?

PERSONAL HEALTH INFORMATION

BLOOD PRODUCTS Will you accept them if needed? ❑ Yes ❑ No

SMOKING

1. Do you **currently** smoke? ❑ Yes ❑ No; What? _____ Do you use tobacco? ❑ Yes ❑ No; What?_____
2. Have you **ever** used or smoked tobacco? ❑ Yes ❑ No; How long? When did you quit?
3. Do you currently use alcohol?❑ Yes ❑ No; What? _____ Do you use drugs? ❑ Yes ❑ No; What?_____

MOBILITY

1. Do you drive and have access to a **car**? ❑ Yes ❑ No *If No, do you have access to reliable transportation?* ❑ Yes ❑ No
2. Do you regularly **exercise**? ❑ Yes ❑ No; What do you do? _____
3. Can you: **Dress** without help? ❑ Yes ❑ No;
   Bathe without help? ❑ Yes ❑ No;
   Climb Stairs without help? ❑ Yes ❑ No;
   Walk Around The Block? ❑ Yes ❑ No;

   Do you require a **Wheelchair or Walker**? ❑ Yes ❑ No; Describe:

INSURANCE INFORMATION

1. Are you covered by insurance? ❑ Yes ❑ No → *If Yes, complete the following. If No, skip to #2.*

   a. Primary Insurance:_____
   Check all that apply: ❑ Group Plan ❑ Cobra Plan
   Employer:_____
   Subscriber's Name:_____
   Subscriber's SSN:_____
   Policy Number:_____
   Insurance Company Phone #:_____

   b. Secondary Insurance:_____
   Check all that apply: ❑ Group Plan ❑ Cobra Plan
   Employer:_____
   Subscriber's Name:_____
   Subscriber's SSN:_____
   Policy Number:_____
   Insurance Company Phone #:_____
2. Are you covered by Medicaid? ❑ Yes ❑ No → *If Yes, Medicaid #:* _____
3. Are you covered by Medicare? ❑ Yes ❑ No → *If Yes, Medicare #:*___
4. Other Medical Coverage (please list):_____
5. Are you a Veteran? ❑ Yes ❑ No → *If Yes, do you have Veteran's Health Benefits?* ❑ Yes ❑ No
6. Monthly Household Income & Source(s):_____
7. Number of people living at home:__ / Number of dependents:___
8. **Please provide copy of insurance cards.**

DOCTORS & HOSPITALIZATIONS

List all doctors you see: **Doctor** **What kind of doctor?**

1. _____ , _____ .
2. _____ , _____ .
3. _____ , _____ .
4. _____ , _____ .
5. _____ , _____ .
6. _____ , _____ .
7. _____ , _____ .
8. _____ , _____ .

List surgeries, hospitalizations or ER visits: **Hospital** **Year**

1. _____ , _____ .
2. _____ , _____ .
3. _____ , _____ .
4. _____ , _____ .
5. _____ , _____ .
6. _____ , _____ .
7. _____ , _____ .
8. _____ , _____ .
9. _____ , _____ .

Time:_____ Date:_____ Patient / Legal Representative Signature:_____

(*If completed by someone other than the patient, print person's name here):*_____