KIDNEY RECIPIENT
UCSF KIDNEY TRANSPLANT
MEDICAL HISTORY QUESTIONNAIRE

Please complete this form as well as you can. Your doctor will discuss this information with you. All information will be kept confidential.

FOR OFFICE USE ONLY

UNIT NUMBER _____ RECEIVED _____

PT NAME _____

BIRTHDATE _____

DATE REVIEWED _____ REVIEWED BY _____

TEST DATE _____

DATE OF SURGERY _____

LOCATION _____ DATE _____

Date Form Completed _____

Name _____

Birthdate _____ Race _____

Marital Status

Occupation _____

Height ___ ___ Weight _____ M / F

1) Insurance _____
   1) Subscriber# _____
   2) Group _____
2) Insurance _____
   1) Subscriber# _____
   2) Group _____

Social Security Number _____

Number of Children _____

Education (last grade or degree completed) _____

Address/City/State/Zip _____

Home phone number: _____ Work phone number: _____

What is your primary language: _____ Do you need an interpreter: Y N

Notify in case of Emergency:

Name: _____ Relationship: _____

Address: _____ Phone Number _____

Are you on Dialysis If yes, which days per week do you dialyze?

Please list any of the following that apply:

Primary Care Physician _____
Address _____
Phone/FAX Number _____

Nephrologist/Kidney Physician _____
Address _____
Phone/FAX Number _____

Dialysis Center _____ Date Started _____
Address _____
Phone/FAX Number _____

Cardiologist / Heart Physician _____
Address _____
Phone/FAX Number _____

Other Health Care Providers/Medical Centers where you have received care: _____
Address: Phone/FAX Number:

This form completed by (name) _____

Signature _____
Date _____

Past Medical History

1. Have you had a previous transplant? If so, when and name of Transplant Center?

   _____

2. Major injuries, auto accidents, or broken bones?

   _____

   Blood transfusions? _____

   Exposure to dangerous chemicals? _____

3. Have you had any operations or over night hospital stays? If so, please list reason (with date or your age, if possible).

   _____

4. Please list any **CURRENT MEDICATIONS:** if known (include medicines and supplements not needing a prescription):

5. Please list any allergies or reactions to medication:

6. Please indicate if you have had any of the following problems **CURRENTLY OR IN THE PAST?**

Anemia
Arthritis
Asthma or Emphysema
Bladder or Kidney Infections
Chronic Diarrhea
Diabetes
If yes, at what age? _____
Emotional Problems
Epilepsy or Seizures
Gall Bladder Disease
Gout
Heart Disease
High Blood Cholesterol

High Blood Pressure
Kidney Disease/Stones
Liver Disease/Hepatitis
Lung Disease/Pneumonia
Rheumatic Fever
Skin Disease
Stroke
Venereal Disease/Syphilis/
Gonorrhea/Chlamydia
Thyroid Disease/Goiter
Tuberculosis
Tumors/Cancer
Ulcers (stomach or intestinal)

If yes to the above, please explain:

Personal Habits

7. Do you smoke?

If Yes:

How many years have you smoked? _____

How many packs per day do you smoke? _____

How soon after you awaken do you smoke you first cigarette?

If No:

Have you ever smoked? _____

How many years did you smoke? _____

How many packs per day did you smoke?

When did you quit smoking? _____

8. Do you drink alcohol?

If no: Have you in the past?

If yes: Specify frequency and quantity _____

On days when you had a drink, about how many drinks (beer, wine, or liquor did you have?

Have you ever felt you ought to cut down on your drinking?

Have people criticized your drinking?

Have you ever felt bad or guilty about your drinking?

Have you ever had to have a drink first thing in the morning to steady your nerves or get rid of a hangover?

Have you ever had black-outs or memory loss?

9. Have you ever used any drugs such as marijuana, cocaine, stimulants, sedatives, narcotics, diet pills? If so, please specify types, quantity and duration of use:

_____

Have you ever injected any such drugs? _____

10. A. Do you follow any special diet?

B. Do you exercise regularly? If yes, what do you do?

C. Risk factors for infection with HIV the AIDS virus, include: homosexual or bisexual activity, intravenous drug use, hemophilia, received a blood transfusion between 1979-1985, and sexual contact with an HIV-positive individual, or contact with a person with these risk factors.

If you have any of these risk factors, or are interested in being tested for HIV infection, please check this box

Do you and your sexual partner(s) practice safe sex?

Family History

11. Have any of the members of your family (including grandparents, parents, brothers, sisters or children) had any of the following conditions?

		State Family Relationship
Alcoholism		
Dmoestic Violence		
Anemia/Bleeding problems		
Bowel/Colon Cancer		
Breast Cancer		
Diabetes		
Heart Disease/Angina		
Hepatitis		
High Blood Pressure		
High Cholesterol		
Kidney Disease		
Strokes		
Tuberculosis		
Other _____		

Review of Symptoms

12. Please indicate if you have any of the following problems NOW:

		Comments
1. Severe or unusual headache		
2. Hearing problems		
3. Problems with vision (other than nearsightedness or farsightedness)		
4. Sinus problems or hay fever		
5. Hoarseness		
6. Problems with teeth or gums		
7. Severe skin problems		
8. Weight loss or gain		
9. Chest pains or discomfort		
10. Shortness of breath		
11. Cough or phlegm		
12. Stomach problems (pain, nausea, or vomitting)		
13. Diarrhea or constipation		
14. Blood in bowel movements or black bowel movements		
15. Difficulty or pain on urinating or blood in urine		
16. Painful Joints		
17. Sexual difficulties, depression, severe sleep problems, severe stress		

Preventive Care

13. Have you received a vaccine to prevent any of the following disease?

		If Yes, when:
Tetanus		
Polio		
Pneumonia		
Hepatitis B		
Influenza ("flu")		
Tuberculosis		
Rubella (German Measles)		

14. Have you had any of the following tests?

		If Yes, when?	Result, if known?
Cholesterol			
Tuberulosis skin test			
Syphilis test			
Stool test for blood			

15. When was your last:

Eye Examination? _____ Dental Examination? _____

16. Do you live alone?
17. Do you have difficulty shopping or carrying home a 10-lb. Bag?
18. Do you have difficulty dressing yourself?
19. Are you receiving any special help at home?
20. Have you had 3 or more falls during the past year?

Other

21. Who will help you when you go home after a surgery?

_____

22. Do you receive help from any community agency now or do you anticipate needing help after your surgery?

_____

For Women Only

Age at start of menstrual period? _____years

Date most recent menstrual period began _____

Usual length of menstrual period _____days

Have you stopped having menstrual periods? ☐ If yes, when _____

Do you have problems with:		Comments
1. Irregular, painful or heavy Menstrual periods?	☐	_____
2. Bleeding between periods or after menopause?	☐	_____
3. Vaginal discharge, pain or itching?	☐	_____
4. Hot flashes?	☐	_____

Please indicate (if any):		Complications?
1. Number of deliveries	_____	_____
2. Number of miscarriages	_____	_____
3. Number of abortions	_____	_____
4. Total number of pregnancies	_____	_____

		If yes, what?	For how long?
Are you using any form of brith control?	☐	_____	_____
Date of last Pap smear?	_____		
Have you ever had an abnormal Pap smear?	☐	_____	_____
Do you have problems with pain or lumps in your breasts?	☐	_____	_____
Have you ever had a mammogram (breast x-ray)?	☐	_____	_____
How often do you examine your breasts?	_____	_____/_____/_____	