Living Kidney Donor Questionnaire

(PLEASE PRINT CLEARLY)

Please complete the following form (email or fax preferred) and return to:

Email: Karen.Curreri@bmc.org **Phone:** 617-638-8368 (Office/Voice mail) or 617-638-8430 (Main Office)
Fax: 617-638-8427

Living Donor Coordinator
Boston Medical Center, Division of Transplant Surgery
85 East Concord St. Second Floor, Room 2402
Boston, MA 02118-2642

Demographic Information:

Name: _____

Address: _____

City/State/Country/Zip: _____

Telephone_____ **SS#:**_____
Is it okay to leave a message? YES NO

Email Address: _____

Primary Language: _____ **Race:** _____

Birthdate: _____/_____/_____

Do you wish to donate a kidney to a specific person? YES NO

If yes, what is the name of the potential recipient? _____

What is your relationship to this potential recipient? _____

Who is your primary care doctor? _____

Doctor's Address (including City/State/Country/Zip)**:** _____

Doctor's Phone Number: _____

What is your Blood Type? A B AB O I'm not sure

Height: _____ Weight: _____

What is your occupation? _____

Are you currently employed? **YES** **NO**

Full Time or Part Time

Do you currently have active health insurance? **YES** **NO**

Type: _____

Do you live with anyone? If so, who? _____

Who would be available to take care of you after surgery? _____

_____

Medications:

Please list your current daily medications: _____

_____

Please list your allergies: _____

Medical History Questions:

Have you ever been diagnosed with High Blood Pressure or Gestational Hypertension?	YES	NO
Have you ever had any issues with your lungs or breathing issues?	YES	NO
Have you ever had any problems with your heart?	YES	NO
Have you ever had any problems with your stomach or intestines?	YES	NO
Have you ever been diagnosed with any autoimmune diseases?	YES	NO
Have you ever been diagnosed with any neurologic diseases?	YES	NO
Have you ever had any issues with your nerves or your brain?	YES	NO
Have you ever been diagnosed with any problems with your kidneys or bladder?	YES	NO
Have you ever been diagnosed with blood disorders?	YES	NO
Have you ever been diagnosed with bleeding or clotting disorders?	YES	NO
Have you ever been diagnosed with Cancer?	YES	NO
Have you ever been treated for infections that keep coming back (VRE, MRSA)?	YES	NO
Do you have any Psychiatric Illnesses?	YES	NO
Do you suffer from Depression?	YES	NO
Have you ever attempted suicide?	YES	NO
Have you ever had a positive test for TB?	YES	NO
If yes, were you treated? YES NO		
How long did you take medication for treatment? _____		
Have you ever had Skin Cancer?	YES	NO
Do you have any suspicious skin lesions?	YES	NO
Have you ever been diagnosed with COVID?	YES	NO

If yes, when? _____

Have you ever been diagnosed with kidney disease?	YES	NO
Have you ever been told you have protein in your urine (Proteinuria)?	YES	NO
Have you ever been told you have blood in your urine (Hematuria)?	YES	NO
Have you ever had an injury to one of your kidneys?	YES	NO
Have you ever been diagnosed with diabetes, including gestational diabetes?	YES	NO
Have you ever been diagnosed with kidney stones (Nephrolithiasis)?	YES	NO
Have you ever had a urinary tract infection (UTI)?	YES	NO
Have you ever taken medications that may have caused an injury to your kidneys?	YES	NO

Cancer Screening Questions:

FEMALES:

Have you ever had cervical or uterine cancer?	YES	NO

When was your last PAP SMEAR test? _____

FEMALES aged 40 and over:

Have you ever had breast cancer?	YES	NO

When was your last mammogram? _____

MALES aged 50 and over:

Have you ever had prostate cancer?	YES	NO

When was your last PSA test? _____

MALES and FEMALES aged 45 and over:

Have you ever had colon cancer?	YES	NO

When/Where was your last colonoscopy? _____

SMOKERS, current and past:

Have you ever had lung cancer?	YES	NO

Any other medical history (examples: asthma, epilepsy, heart disease, COPD, etc.)?	YES	NO

If yes, please list: _____

_____

Surgical history—list all surgeries and years: _____

_____

_____

_____

_____

Family History Questions:

Has anyone in your family been diagnosed with:

Coronary artery disease?	YES	NO
Cancer?	YES	NO
Kidney Disease?	YES	NO
Diabetes?	YES	NO
Hypertension?	YES	NO
Kidney Cancer?	YES	NO
Genetic diseases of the kidneys?	YES	NO

If yes to any of the above, who was it in your family? _____

Social History Questions:

Do you currently smoke? **YES** **NO**

If yes, what year did you start smoking? _____

How many cigarettes or packs do you smoke in a day? _____

Do you drink alcohol, wine or beer? **YES** **NO**

If yes, how many drinks do you have per day? _____

Do you currently or have you ever used any street drugs? **YES** **NO**

If yes, please explain: _____

_____

Are you: Married Single Divorced Separated

Do you have children? Y N Ages: _____

_____

Covid Vaccine and Boosters:

#1 Date: _____ Type: _____

#2 Date: _____ Type: _____

#3 Date: _____ Type: _____

#4 Date: _____ Type: _____

#5 Date: _____ Type: _____

#6 Date: _____ Type: _____

Any Additional Boosters: Please provide Dates and Types:

_____

Is there any other information you would like to provide?

_____

_____

_____