DukeMedicine

KIDNEY LIVING DONOR QUESTIONNAIRE

Duke Transplant Services

Kidney and Pancreas Transplant Program

Toll-Free: 800-249-5864, option 2
Local: 919-613-7777, option 2
Fax: 919-668-3897
E-mail: Kidney_Transplant@mc.duke.edu

USPS: Box 102347, Durham, NC 27710
FedEx/UPS: 330 Trent Drive, Room 208
Hanes House, Durham, NC 27710

Please fill out this form in its entirety prior to your evaluation for donation. Contact the Transplant Office with any questions or concerns. If you need additional space, please attach separate sheets with your name and date of birth at the top of each page.

Donor Demographics

Duke Medical Record Number: _____ Date: _____
Donor Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Social Security Number: _____ Date of Birth: _____ Age: _____
Home Phone: _____ Height: _____ Weight: _____
Cell Phone: _____ Work Phone: _____
Recipient Name: _____ Relationship to Recipient: _____

Donor Medical Information

Medications and Supplements:

Current Health Care Providers (names and contact information):

Food and Drug Allergies (including shellfish and dye):

Current Insurance Provider(s) (names and contact information):

Health Maintenance (dates and provider):

Physical Exam:

Pap Test (for women over 18):

Mammogram (for all women over 40):

Colonoscopy (men and women older than 50):

Prostate Specific Antigen (PSA) (for men older than 50):

TB Testing (PPD test and/or CXR):

Donor Surgical and Hospitalization History

Please list any surgical procedures you have had.

Procedures:	Reason:	Date:

If you have ever been hospitalized for a reason other than the above surgeries, please list here.

Diagnosis:	Description of Stay:	Date:

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Donor Name: _____ Date of Birth: _____

Medical History

Have you ever had	Yes	No	Have you ever	Yes	No	Amount/Frequency
Hypertension	☐	☐	Used Alcohol	☐	☐	_____
Anemia	☐	☐	Smoked Tobacco	☐	☐	_____
High Cholesterol	☐	☐	Quit Smoking	☐	☐	_____
Diabetes Mellitus	☐	☐	Used IV Drugs	☐	☐	_____
Stroke or TIA	☐	☐	Used Cocaine	☐	☐	_____
Heart Murmur	☐	☐	Smoked Marijuana	☐	☐	_____
Urinary Tract Infection	☐	☐	Received a Tattoo	☐	☐	Date: _____
Cancer	☐	☐	Had a Body Piercing	☐	☐	Date: _____
Protein or Blood in the Urine	☐	☐	Had an Irregular Pap Test	☐	☐	Date: _____
Kidney Stones	☐	☐	Had Elevated PSA	☐	☐	Date: _____
Tuberculosis	☐	☐	Had a Psychiatric Issue	☐	☐	Date: _____

Donor Family History

Has anyone in your family ever had	Yes	No	Relationship:	
Kidney Disease	☐	☐	_____	On Dialysis or Transplanted? _____
High Blood Pressure	☐	☐	_____	
Heart Attack	☐	☐	_____	
Stroke or TIA	☐	☐	_____	
Coronary Artery Disease	☐	☐	_____	
Diabetes Mellitus	☐	☐	_____	Age at Onset? _____
Cancer	☐	☐	_____	Type and Date: _____

Additional Questions

Are you married? Yes No If yes, is your spouse supportive of your donating? Yes No Are you ready to donate? Yes No

Do you have additional concerns? Yes No If yes, list them here:

Where were you born? _____ Where did you grow up? _____

Please list your children and their ages: _____

How would you rate your family support system? Excellent Fair No Support

Please list your employer and your occupation: _____

Have you talked to your employer about giving you time off work to be a donor? Yes No

Who will be able to take care of you after your kidney donation surgery? _____

Have you ever consulted a psychiatrist or felt the need to see one? Yes No If yes, why? _____