Stony Brook Medicine

Stony Brook Medicine Department of Kidney Transplant
Living Donor Medical History and Behavioral Risk Assessment Questionnaire

Name (First Last): _____Today's Date: _____

Mailing Address: _____

City:_____ State_____ Zip_____

Home Phone: _____ Cell Phone: _____Other Phone:_____

Email Address: _____

Date of Birth _____ Social Security #: _____ Sex _____

Marital status: _____ Race/Ethnicity: _____ Religion:_____

Primary Language: _____ Translator needed? □ Yes □ No

Where were you born: _____ Country of Citizenship _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____Relationship to you:_____

Emergency Contact Phone Number:_____

PHYSICIAN INFORMATION

Primary Care Physician:_____Phone #_____

Do you have health insurance? □ Yes □ No

POTENTIAL RECIPIENT INFORMATION

Recipient's Name: _____

Donor's relationship to Recipient: ___ _____

HIGHEST LEVEL OF EDUCATION COMPLETED

□ Grade School (0-8) □High School (9-12) □ College/technical school
□ Associate Degree □Bachelor Degree □Post Graduate Degree

EMPLOYMENT INFORMATION

Are you currently working? □ Yes □No □Retired If yes: □ Full Time □ Part Time

Occupation:_____ Employer:_____

MEDICAL HISTORY PART 1

Height:_____ Weight:_____ BMI:_____ Blood Type (If known):_____

List any Medications you currently take and dosages:_____

Supplements/Vitamins/Herbal etc:_____

Allergies:_____

MEDICAL HISTORY PART 2

Do you have or have you ever had any of the following? Please check YES or NO. If YES, please explain in the additional details section:

	YES	NO
Diabetes		
High Blood Pressure		
High Cholesterol		
Lung Disease		
Heart Disease		
Cancer		
Kidney Stones		
Asthma		
Blood Transfusion		
Urinary Tract Infection (UTI)		
Depression		

	YES	NO
Psychiatric Disorder		
Hepatitis		
Lupus		
Arthritis		
Intestine/Stomach Issues		
Sickle Cell		
Blood Clots		
Anemia		
Seizures		
Kidney or Bladder Infection		
Anxiety/Panic Attack		

FEMALES ONLY		
	YES	NO
Abnormal PAP Smear		
Abnormal Mammogram		

MALES ONLY		
	YES	NO
Elevated PSA		

Other Ilnesses: _____

_____

Additional Details: _____

_____

_____

Please list any surgeries and the dates: _____

_____

Have you ever been hospitalized for any reason other than the above surgery? _____

_____

MEDICAL HISTORY PART 2 CONT'D

Have you experienced skin infections (leprosy, eczema, dermatitis, inflammatory skin disease or abrasions? □Yes □ No
If yes; type and when? _____
Have you ever been exposed to any toxic substances (lead, pesticides, or other)? □Yes □ No
If yes; please explain? _____
Have you ever been tested for HIV? □Yes □ No
Have you ever had a positive test for HIV? □Yes □ No

MEDICAL HISTORY PART 3 – CURRENT SYMPTOMS

Are you CURRENTLY experiencing any of the following symptoms?

	YES	NO
Difficulty Breathing		
Leg Swelling		
Unexplained Weight Loss		
Nausea/Vomiting		
Cough		
Pain in legs		

	YES	NO
Chest Pain		
Headache		
Diarrhea		
Fever		
Stiff Joints		

FEMALE DONORS

Number of pregnancies:_____ Number of live births:_____

Gestational Diabetes: □ Yes □ No High Blood Pressure during pregnancy: □Yes □ No

Other problems during pregnancy: _____

FAMILY HISTORY

	YES	NO	Relative		YES	NO	Relative
High Blood Pressure				Kidney Disease			
Diabetes				Kidney Stones			
Heart Attack/Stroke				Kidney Cancer			
Cancer				Type of cancer			

Mother living: □ Yes □ No If deceased: Age & Cause _____

Father living: □ Yes □ No If deceased: Age & Cause _____

VACCINATIONS

In the past 12 months have you been vaccinated or immunized for any reason? □ Yes □ No
If yes; what type? _____
Have you been vaccinated for Hepatitis B? □ Yes □ No
Have you been vaccinated for small pox in the last 8 weeks? □ Yes □ No
Have you recently had close contact with a recipient of the small pox vaccination? □ Yes □ No
If yes; when? _____

SOCIAL HISTORY

TOBACCO USE			
	Current use	Never used	Past use
Cigarettes			
Chewing tobacco			
Other			
For how long?			

ALCOHOL USE

Do you drink alcohol? □Yes □ No
If yes, how often? □ Occasionally □Daily □Rarely
If yes, for how long? _____
If yes, what type? _____

NON-PRESCRIPTION DRUG USE OR OTHER SUBSTANCES

Have you ever, or do you currently use:
□ Marijuana □ Cocaine □ Steroids □Heroin □ Methamphetamine
□Inhalants □ Other (please list below)
What type and route? _____
Date of last use: _____

TRAVEL HISTORY

Have you traveled outside the U.S. in the past 3 years? □Yes □ No
If yes, where and when? _____

ASSESSMENT OF DONOR RISK CRITERIA

	YES	NO
Have you ever had sex with a person known or suspected to have HIV, HBV or HCV?		
Have you ever had sex in exchange for money or drugs?		
Have you ever had sex with a person who has had sex in exchange for money or drugs?		
Have you ever injected drugs for non-medical reasons?		
Have you ever had sex with a person who has injected drugs for no-medical reasons?		
Have you ever been incarcerated for >/= 72 consecutive hours?		
Are you a man who has ever had sex with another man?		
Where you born (or breastfed) by a mother with HIV, HBV or HCV infection?		

If you answered YES to any of the above questions, please explain; _____
_____
_____
_____

Why do you want to be a living kidney donor? _____

_____

Do you feel pressure in pursuing donation? □ Yes □ No

Do you have a support system to help you after surgery? □ Yes □ No

Do you have any concerns that would make you think you should not proceed with living kidney donation? □ Yes □ No

If yes, please explain: _____

_____

_____

_____

_____

By signing this form, I attest the above information is true and accurate to the best of my knowledge.

_____	_____	_____
Patient Signature	**Print Name**	**Date**
_____	_____	_____
Coordinator/Social worker signature Of person reviewing form	**Print Name**	**Date**

Revised 3/3/2021