Stony Brook University Medical Center
Donor Medical History and Behavioral Risk Assessment Questionnaire

Donor's Name: ____Today's Date: _________________

Social Security #: _________________ Date of Birth ____________ Age _______________________

Sex _________ Height___________ Weight____________ BMI__________________________

Address: __________________________________City:_____________ State_______ Zip_________

Telephone #: (home)__________________(work)___________________(cell)___________________

Race/Ethnicity: ___________Citizenship _____________Country of Origin_______________________

Year of entry to US___________________ Highest education level_______________________________

Primary Language: ___________________Translator needed? __________________________________

Primary Care Physician:________________________________Phone:_____________________________

Insurance: _________________ Group number: ___________ Phone: ______________

Email______________________ Emergency Contact name & #_________________________________

Whom are you a donor for? ____

What is your Relationship to the Recipient?____________________________________

Why do you want to donate? ____

Do you feel pressured in pursuing donation? __________________________________

Marital status:

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow/widower ☐ Domestic Partner

Does your significant other know that you are pursuing donation? _______________

Does he/she support you in this? ____

Whom do you live with? ____

Do you have a support system to help you after surgery?________________________

Do You Know Your Blood Type:____

Family history:

Mother living☐ Yes ☐ No If deceased: Age, Cause _____________________________

Father living ☐ Yes ☐ No If deceased: Age, Cause ________________________________

Children: ________ Number living ________ Health status _____________________
Number deceased________________ Cause of death __________________________

Siblings:__________ Number living _________ Health status_________________
Number deceased_____________ Cause of death ____________________________

Has anyone in your family ever had: If yes, who? How are they related to you?

Heart attack? ☐ Yes ☐ No ____

Stroke? ☐ Yes ☐ No ____

High blood pressure? ☐ Yes ☐ No ____

Diabetes? ☐ Yes ☐ No ____

Cancer? ☐ Yes ☐ No What kind of cancer?___________ Where did it start? ___________

Kidney Disease ☐ Yes ☐ No ____

Kidney Stones? ☐ Yes ☐ No Please describe ______________________________________

GENERAL HEALTH INFORMATION

1. Have you been seen by a physician, or been hospitalized for medical illness, psychiatric illness, any suicide attempts or Alcohol or Drug rehab, in the past? ☐ Yes ☐ No
   If yes, by what physician, hospital, psychiatric, or long term care facility?
   ____
2. Have you has any major illnesses or surgical procedure in the past? ☐ Yes ☐ No
   ____
   ____
   ____
3. Are you allergic to any food or medications? ☐Yes ☐No
   If yes, what meds? ____________________________________

4. What medications, vitamins, or supplements, if any, do you take on a regular basis?

____

____

____

5. Have you ever used tobacco products? □ Yes □ No

   Cigarettes? □ Yes □ No Packs per day? _____For how long? _______

   Other tobacco products? _____________________

6. Do you drink alcohol? □ Yes □ No

   How much? ______________What type? ______________For how long? _____________

7. What is your occupation? __________________________________

   Have you ever been exposed to toxic substances (lead, pesticides, or other)? □ Yes □ No

   If yes, what was it: ____

8. In the past three years have you traveled outside of the United States (including Canada)?

   □ Yes □ No If yes, please list dates and locations:

   ____

   ____

   Taken anti-malarial drugs?□Yes □No

   Had malaria or Chagas' disease? □Yes □No

9. Have you recently exhibited unexplained weakness, fatigue or flu-like symptoms such as night sweats, persistent cough, shortness of breath, colds, swollen glands for greater than one month, nausea, vomiting, persistent diarrhea, or fever > 100.5 °F for greater than 10 days? □ Yes □ No

   Had blue or purple spots on the skin or mucous membranes? □ Yes □ No

10. In the past 12 months have you had or been treated for any sexually transmitted disease such as syphilis, gonorrhea, herpes, chlamydia, trichomonas or venereal warts? □ Yes □ No

11. Have you ever had a Colonoscopy? □ Yes □ No If yes when_________________

12. Have you ever had a Mammogram? □ Yes □ No □ N/A If yes when_________________

13. Have you ever had a Pap Smear? □ Yes □ No □ N/A If yes when_________________

14. Do you have any history of heart disease, high blood pressure, or chest pain? □ Yes □ No

    Had poor circulation, especially in the legs? □ Yes □ No

    Take medications for heart or blood pressure problems? □ Yes □ No

    Is so, what medications: ____

Duration of Hypertension _______________Are you compliant with meds? □ Yes □ No

15. Have you ever suffered from any type of liver disease? □ Yes □ No

    Had any history of (being yellow) jaundice? □ Yes □ No Been told you have any type of hepatitis? □ Yes □ No Had a positive test for hepatitis? □ Yes □ No

    Had close contact with persons diagnosed with viral hepatitis in the past 12 months? □Yes □No

16. Have you ever received blood transfusion or blood products? □ Yes □ No What type? ______________ When? __________ Although rare, would you be willing to accept blood transfusion(s) or blood products in the event you needed a transfusion? □ Yes □ No

17. Were you ever refused as a blood donor or told not to donate? □Yes □No If yes when and why?

    ____

18. Have you ever received an organ or tissue transplant (eg. bone, cornea, skin, heart, kidney, dura mater, etc)? □Yes □No if yes, what kind of transplant, and when?

    ____

19. In the past have you had a tattoo, ear/body piercing or acupuncture? □Yes □No If yes, when, where on body, by whom, and how? _____________________________________

20. Have your ever been bitten by an animal suspected of having rabies? □Yes □No

21. Do you have any kidney related diseases? □Yes □ No

22. Had kidney stones?□Yes □ No

23. Had frequent infections? □Yes □No

24. Ever been treated with kidney dialysis?□Yes □No

25. Do you have any history of digestive or intestinal problems?□Yes □No

26. Ever had bloody stools intestinal surgery, or intestinal cancer? □Yes □No

27. Have you experienced any recent periods of explained or unexplained weight loss? □Yes □No

28. Do you have any history of diabetes? □Yes □No If yes: Treated with oral medication? □ Yes □No

    Insulin injections?□Yes □No Duration of treatment? ______________________

29. Female **donors**: Last Menstrual Period ________________

    Number of pregnancy___ Number of births____________ Were you ever diagnosed with gestational diabetes? □Yes □No

    Hypertension with pregnancy? □Yes □No

30. Do you have any history of asthma, emphysema, or any other lung disease?□Yes □No Ever have a positive skin test (PPD) for tuberculosis?□Yes □ No If yes: Any follow-up □Yes □No chest x-ray results? ________

31. Ever been treated for Tuberculosis? □Yes □No

32. Have you ever had cancer, or received radiation therapy or drugs for cancer? □Yes □No If yes: What type of cancer? ________________When diagnosed? _______________________ Type and duration of treatment? ______________ Date of last follow-up? __________________ Where were you seen? ____

33. Have you ever used non-prescribed drugs or other substances (cocaine, marijuana, steroids, and inhalants)? □Yes □No If yes: What drugs and by what route? ____

34. Have you ever suffered from any history of neurologic or brain disease such as Alzheimer's, seizures, periods of confusion or recent memory loss, or history of brain tumor?□Yes □No Is there a family history of Creutzfeldt-Jakob Disease (CJD)? □Yes □No

35. Do you have history of arthritis, bone or joint disease?□Yes □No If arthritis history, was it osteoarthritis or rheumatoid? ___________________________________

36. History of broken bones? □Yes □No ____

37. Any complaints of stiff or sore joints? □Yes □No ______________________________________

38. In the past 12 months, have you been vaccinated or immunized for any reason? □Yes □No If yes, what type: ____

39. Have you been vaccinated for hepatitis B? □Yes □No
If yes, when and for what reason? ____

40. Have you ever been vaccinated for smallpox in the past 8 weeks? □Yes □NO If yes: When? _________
Did the scab fall off by itself? □Yes□ No
Any complications? □Yes□No If yes: ___________________ Have you had close physical contact with a recent recipient of the smallpox vaccination? □Yes □No If yes, When? __________
Any complications? □Yes □No If yes: ___________________________

41. Were you ever given human derived pituitary growth hormone? □Yes □No
If yes, when? ____

42. Have you ever experienced skin infections such as leprosy, eczema, dermatitis, inflammatory skin disease or abrasions? □Yes □No If yes, which one____________________________________

43. Have you ever been tested for HIV? □Yes □No If yes, why: ___________________________
Have you ever had a positive test for HIV? □Yes □No

44. Have you had sex with another man in the past five years? (male donors) □Yes □No

45. Have you ever received human-derived clotting factor concentrates for hemophilia or related clotting disorders? □Yes □No

46. Have you engaged in sex in exchange for money or drugs in the past 5 years? □Yes □No

47. Were you ever exposed to known or suspected viral hepatitis or HIV-infected blood through accidental needle stick or through contact with an open wound, non-intact skin, or mucous membrane in the past 12 months? ☐Yes ☐No
48. Were you ever an inmate of a correctional system or jail, or released from a correctional system or jail, within the past 12 months? ☐Yes☐No If yes, when and for how long?
49. Have you had sex in the past 12 months with any person known or suspected of having viral hepatitis or HIV infections, or any person described in the above questions #35-38?☐Yes ☐No
50. Having answered questions about medical conditions and behavioral risk factors, do you have any concerns that would make you think organ donation should not proceed? ☐Yes ☐No If yes, please explain your concerns
51. May we contact your Primary Care Physician? ☐Yes ☐No ☐ I don't have a Primary Care Physician

52. Would you be interested in a kidney paired donation with another recipient in the event you are not a donor match? ☐Yes ☐No. Kidney Paired Donation is a program which assists donor/recipient pairs who are blood type incompatible or poorly matched with each other to find another donor/recipient pair(s) with whom they can exchange kidneys to enable a more favorable compatibility and allow a transplant to take place.

    Additional comments:

    ____

I acknowledge that it is illegal to buy and sell organs in the United States. My signature indicates that I understand the above and the information I have given is true to the best of my knowledge and I agree to have my picture taken and placed in the medical chart.

Patient's Name (print)___________________________________ Date: ____________

Patient's Signature: ____________________________________ Date:_____________

Person conducting Interview and completing Form:

Stephen Knapik, RN, CPTC, Transplant Senior Specialist
____
Print Name and Title

Additional comments:

____
Signature and Date

Authored by Stephen Knapik, CPTC revised 9/3/15