UNIVERSITY of MARYLAND MEDICAL CENTER

Transplant Candidate Questionnaire

Date:_____
Name:_____
Date of Birth: _____ MRN: _____
Social Security Number: _____

Instructions: Use a black pen. Answer the following questions by filling in the box (☐) before your answer like this:■ If you are not sure of an answer, leave it blank and we will help you with it during your evaluation.

Race: ☐ American Indian or Alaskan Native ☐Black or African-American ☐Hispanic/Latino ☐Asian ☐Native Hawaiian or Other Pacific Islander ☐White/Caucasian

Country of Origin if other then United States _____

Sex: ☐Male ☐Female **Age:**_____ **Height**: _____ **Weight**: _____

Your HOME address: (Street) _____
(City)_____ (State)_____ (Zip)_____
(Phone #) (_____) _____ (FAX #) (_____) _____

Your WORK address: (Work name)_____
(Street) _____
(City)_____ (State)_____ (Zip)_____
(Phone #) (_____) _____ (FAX #) (_____) _____

REFERRING doctor: (Name)_____
(Street) _____
(City)_____ (State)_____ (Zip)_____
(Phone #) (_____) _____ (FAX #) (_____) _____
(Specialty)_____

OTHER doctor: (Name)_____
(Street) _____
(City)_____ (State)_____ (Zip)_____
(Phone #) (_____) _____ (FAX #) (_____) _____
(Specialty)_____

Email address: _____

How did you hear about us?

☐ Family Doctor ☐ Newspaper or Magazine Article

☐ Nephrologist ☐ Internet Search

☐ Gastroenterologist/Hepatologist ☐ Family Member

☐ University of Maryland Web Site ☐ Friend

Do you have any potential Living Donors? ☐ Yes ☐ No

KIDNEY DISEASE

Do you have kidney disease? ☐ Yes ☐ No **(IF NO, GO TO NEXT SECTION.)**

When did you first become aware that you have kidney disease? Month_____ Year _____

What caused your kidney disease? ☐High blood pressure ☐Diabetes ☐Other_____

Are you currently on dialysis? ☐Not on dialysis now ☐Hemodialysis ☐Peritoneal dialysis

If on dialysis, when did you start dialysis? Month _____ Day _____ Year _____

What is the name of your kidney doctor (Nephrologist)? _____

What is your dialysis unit? (Name)_____

(Street)_____

(City)_____ (State)_____

(Phone #) (_____) _____ (FAX #) (_____) _____

If on dialysis, what days do you dialyze? _____☐AM ☐PM How long? _____

Have you had a dialysis access placed? ☐ Yes ☐ No

If yes, what kind and where was it done? _____

If not on dialysis, what was your latest creatinine level? _____

How much urine do you make in a day? ☐Less than 1 cup ☐Between 1 cup and 1 quart ☐Over 1 quart

LIVER DISEASE

Do you have liver disease? ☐ Yes ☐ No (**IF NO, GO TO NEXT SECTION.)**

When did you first become aware that you have liver disease? Month_____ Year _____

Do you have confirmed cirrhosis? ☐ Yes ☐ No

What is the cause of your liver disease? _____

Have you ever had the following:

☐ Yes ☐ No Fluid in your abdomen (ascites)?

☐ Yes ☐ No Require the fluid to be tapped (paracentesis)?

If yes, how often _____ Last tap? _____

☐ Yes ☐ No Have you ever vomited blood?

If yes, how many times _____ When was the last time? _____

☐ Yes ☐ No Have you ever had blood in your stools?

☐ Yes ☐ No Have you ever had black or tarry stools?

☐ Yes ☐ No Have you ever suffered from periods of confusion?

If yes, are you on any treatment, such as lactulose? ☐ Yes ☐ No

DIABETES

Have you ever been treated for diabetes? ☐ Yes ☐ No (**IF NO, GO TO NEXT SECTION.)**

If yes, what was your weight at time of diagnosis? _____

How old were you when you were diagnosed with diabetes? _____

Was your diabetes ever treated with pills alone? ☐ Yes ☐ No

What treatments do you now use to treat your diabetes? ☐Diet ☐Pills ☐Insulin

If you are now taking insulin, what dose are you taking per day? _____

Have you ever used an insulin pump? ☐Never ☐Used one in the past ☐Use one now

How often do you feel your blood sugar is too low?

☐Less often than once a month ☐About once a week ☐About once a day ☐More than once a day

Can you usually tell when your blood sugar is too low without actually checking it?

☐Usually know when too low ☐Sometimes ☐ Usually do not know

How many times per day do you check your blood sugar? _____

What is the *lowest* blood sugar you might have in the course of a week? _____

What is the *highest* blood sugar you might have in the course of a week? _____

How many times in your life have you *blacked out* from low blood sugar? _____

How many times in your life have you had a *seizure* from low sugar? _____

How many times have you been hospitalized to treat *high* blood sugar? _____

Have you ever been told the diabetes has harmed your kidneys? ☐ Yes ☐ No

Have you ever been told the diabetes has harmed your eyes? ☐ Yes ☐ No

How is your vision? ☐Good ☐Somewhat impaired ☐Legally blind in one eye ☐Legally blind in both eyes

Do you have numbness or pain in your feet from diabetes? ☐No ☐Mild ☐Medium ☐Severe

Do you ever have problems with vomiting from diabetes? ☐No ☐Occasionally ☐Often

Do you know your last hemoglobin A1C level? ☐ Yes ☐ No If yes, what was the result? _____

HEART AND VASCULAR DISEASE

Have you ever had chest pain? ☐ Yes ☐ No

Have you ever had a heart attack? ☐ Yes ☐ No

Have you ever had cardiac stent procedure of surgery? ☐ Yes ☐ No

Have you ever been treated for high blood pressure? ☐ Yes ☐ No

If yes, when were you diagnosed? _____

If yes, how is your blood pressure now? ☐Good control ☐Fair control ☐Poor control

OTHER MEDICAL HISTORY **Have you ever been treated for any of the following conditions?**

CARDIOVASCULAR

- ☐ **Congenital heart disease**
- ☐ **Irregular heart beat**
- ☐ **Stroke/CVA**
- ☐ **Poor circulation**
- ☐ **High cholesterol**
- ☐ **Other** _____

_____

INFECTIONS

- ☐ **HIV/AIDS**
- ☐ **Hepatitis C**
- ☐ **Hepatitis B**
- ☐ **Tuberculosis**
- ☐ **Other** _____

_____

GI/GASTROINTESTINAL

- ☐ **Diabetes**
- ☐ **Gastric reflux/stomach ulcers**
- ☐ **Gallbladder disease**
- ☐ **Diverticulitis**
- ☐ **Pancreatitis**
- ☐ **Colon Cancer**
- ☐ **Other** _____

_____

RESPIRATORY

- ☐ **Asthma**
- ☐ **Pneumonia (Requiring hospital stay)**
- ☐ **COPD/ Emphysema**
- ☐ **Other** _____

_____

URINARY

- ☐ **Kidney Disease**
- ☐ **Kidney stones**
- ☐ **Urinary Tract infections**
- ☐ **Prostate enlargement**
- ☐ **Prostate cancer**
- ☐ **Bladder tumors**
- ☐ **Other** _____

_____

NEURO/PSYCHIATRIC

- ☐ **Paralysis**
- ☐ **Neuropathy**
- ☐ **Anxiety/Depression**
- ☐ **Other** _____

_____

GYNECOLOGY

- ☐ **Breast Disease**
- ☐ **Breast Cancer**
- ☐ **Cervical Cancer**
- ☐ **Fibroid Uterus**
- ☐ **Endometriosis**
- ☐ **Polycystic ovaries**
- ☐ **Other** _____

_____

OTHER

- ☐ **Anemia**

☐ **Blood transfusions**

If yes, how many in your lifetime?

☐**0** ☐**1 - 5** ☐**6 or more**

☐ **Pregnancies If yes, how many** _____

Miscarriages? _____ **Abortions?** _____

☐ **Hospital stays** _____

_____

HAVE YOU EVER HAD SURGERY?

List the surgical operations you have had in the past, including dialysis access procedures. List the **Operations and the Date it occurred:**

_____

_____

_____

_____

_____

_____

_____

_____

CURRENT MEDICATION LIST

List the medications you are taking, how much and how often.

Name **Dose** **How often**

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

MEDICATION OR FOOD ALLERGIES

List the medications or foods you are allergic to, and the reaction you had when you took them

Medication or food	Reaction
_____	☐Rash ☐Itching ☐Difficulty breathing ☐Other _____
_____	☐Rash ☐Itching ☐Difficulty breathing ☐Other _____
_____	☐Rash ☐Itching ☐Difficulty breathing ☐Other _____

FAMILY HISTORY

Are you adopted? ☐ Yes ☐ No

Which of these diseases are found among <u>any</u> of your parents, brothers, sisters, or children?

☐ High blood pressure

☐ Coronary Artery Disease/Heart Attacks

☐ Bowel/colon cancer

☐ Diabetes

☐ Alcoholism

☐ Hepatitis B

☐ High cholesterol

☐ Other liver disease

☐ Tuberculosis

☐ Polycystic kidney disease /other kidney disease

☐ Cervical cancer

☐ Breast Cancer

☐ CVA/Stroke/TIA

☐ Depression

☐ Other psychiatric condition

☐ Other _____

YOUR SOCIAL INFORMATION

Relationship Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered

Do you have any children? ☐ Yes ☐ No

If yes, how many children and their ages: _____

Cigarette smoking? Currently ☐ Yes ☐ No In the past? ☐ Yes ☐ No

If yes, how much did you smoke? _____ Packs per day, ____ How many years? _____

If you quit smoking, when did you quit? _____

Your highest educational degree: _____

Your present employment status: ☐Work full time ☐Work part time ☐Unemployed ☐ Disabled ☐Retired

What is your present (or past) occupation? _____

Alcohol use: Currently ☐ Yes ☐ No In the past? ☐ Yes ☐ No - If yes, when did you stop drinking? _____

If yes, how often? ☐ Daily ☐ Weekly ☐ Monthly ☐ A few times a year

Illicit drug use: ☐Never ☐ Still using ☐ In the past - Date you stopped using? _____

What drugs did you use? _____

Intravenous drug use: ☐Never ☐ Still using ☐ In the past - Date you stopped using? _____

What drugs did you use? _____

Have you ever been involved in a Detox or Rehabilitation program? ☐ Yes ☐ No If yes when? _____

Have you attended a 12 step program or meetings for support? ☐ Yes ☐ No If yes when? _____

Would you accept transfusion of blood products? ☐ Yes ☐ No

SYSTEMS REVIEW

Please check (√) these problems that have *significantly* bothered you RECENTLY?

General/ Constitutional	Sleep disturbances		**Urinary/ Genital**	Bloody Urine	
	Weight loss			Difficulty urinating	
	Weight gain			Need to urinate at night	
	Fatigue			Increase frequency of urine	
	Chills			Urgency to urinate	
	Night Sweats			Unable to control urine	
Eyes	Change in visual field			Change in urine stream	
	Blindness			Erectile dysfunction	
	Photophobia			Unusual discharge	
	Seeing Double		**GYN/ Breast**	Menstrual irregularities	
	Discharge			Not Menstruating	
	Yellow/ Icteric eyes			Breast Tenderness	
Ears, Nose Throat	Sore throat			Breast Discharge	
	Teeth Pain		**Skin**	Rash	
	Difficulty Swallowing			Itching	
	Gum Overgrowth			Open Wound	
	Nose Bleeds			Bruises	
	Recent Cold			Jaundice/yellow skin	
	Sinus Infection		**Hormonal**	Change in hair texture	
Lungs	Sneezing			Change in skin texture	
	Cough			Excessive hair growth	
	Blood in sputum			Excessive thirst	
	Wheezing			Excessive hunger	
	Shortness of breath			Intolerance to heat	
	Difficulty breathing			Intolerance to cold	
	SOB walking up stairs		**Brain/ Nerves**	Tremors	
Heart/ Blood Vessels	Chest Pain			Seizures	
	Need to sleep on pillows			Memory problems	
	Pain in legs when walking			Confusion	
	Fluttering in chest			Dizziness	
Digestive Tract	Loss of appetite			Fainting spells	
	Vomiting			Headache	

	Gastric reflux/heartburn		**Muscle and Bones**	Muscle weakness	
	Nausea			Painful joints	
	Diarrhea			Joint swelling	
	Constipation			Muscle wasting	
	Hemorrhoids		**Allergic**	Seasonal allergies	
	Fluid around stomach			Allergic rhinitis	
	Increase in stomach size		**Blood Disorders**	Easy bruising	
	Abdominal pain			Increased bleeding tendency	
	Bleeding from rectum		**Psychiatric**	Depression	
	Dark or Tar colored stools			Anxiety	
				Mental illness	
				Hallucinations	