Transplant Institute
THE GEORGE WASHINGTON UNIVERSITY HOSPITAL

Living Donor Kidney Medical and Behavioral Questionnaire

Date: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Social Security Number: _____ Sex: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

What city were you born in? _____ Are you a US Citizen? YES ☐ NO ☐

Race: _____ Ethnicity: Hispanic ☐ Non- Hispanic ☐ Unknown ☐

Preferred Language: _____

Religious Preference: _____ Marital Status: _____

Employment Status: Full Time ☐ Part Time ☐ Not Working ☐

Highest Level of Education: Grade School (0-8) ☐ High School (9-12) ☐

Some College/Technical School ☐ Associate/Bachelor Degree ☐ Post Graduate Degree ☐

Emergency Contact Name: _____ Relationship to you: _____

Emergency Contact Phone Number: _____

Potential Recipient: _____ Relationship to you: _____

Has someone in your family been diagnosed with the following?

Kidney Disease? YES ☐ NO ☐ If yes, relationship to you: _____

Hypertension? YES ☐ NO ☐ If yes, relationship to you: _____

Diabetes? YES ☐ NO ☐ If yes, relationship to you: _____

Medical History

Height: _____ Weight: _____ BMI: _____

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

	Yes	No
High Blood Pressure	☐	☐
Diabetes	☐	☐
Heart Disease	☐	☐
Heart Attack	☐	☐
Hepatitis	☐	☐
HIV	☐	☐
Peripheral Vascular Disease	☐	☐
High Cholesterol	☐	☐
Lung Disease	☐	☐
Cancer	☐	☐
Kidney Stones	☐	☐
Asthma	☐	☐
Blood Transfusion	☐	☐
Psychiatric Disorder	☐	☐

	Yes	No
Ever been treated by a mental health professional	☐	☐
Ever thought about self-harm or hurting oneself	☐	☐
History of drug and/or alcohol abuse	☐	☐
Arthritis	☐	☐
Intestine Issues	☐	☐
Stomach Issues	☐	☐
Sickle Cell	☐	☐
Blood Clots	☐	☐
Anemia	☐	☐
Seizures	☐	☐
Kidney/Bladder Infection	☐	☐
Anxiety/Panic Attacks	☐	☐
Gestational Diabetes	☐	☐

ADDITIONAL DETAILS: _____

_____

_____

_____

Please list all of the medications you are taking: _____

Do you smoke tobacco products? YES ☐ NO ☐ If yes, how often: _____

Have you had any surgeries in the past? YES ☐ NO ☐

If yes, please list surgeries and their corresponding years: _____

_____

Have you had any of the following tests within the past year?

Cardiac Testing (EKG, Echo, Stress Test): YES ☐ NO ☐ Where: _____

Chest X-Ray: YES ☐ NO ☐ Where: _____

Renal Ultrasound: YES ☐ NO ☐ Where: _____