University of Washington Transplant Services

DEMOGRAPHIC INFORMATION
KIDNEY/PANCREAS FORM

Last Name: _____ Date: _____

First Name: _____ Middle Name: _____

Name you prefer to be called: _____

Maiden Name (If applicable): _____

Circle One: Mr. Mrs. Miss. Ms. Dr.

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Other Phone: _____

Social Security Number: _____ Date of Birth: _____

Gender: [ ] Male [ ] Female

Citizenship:
[ ] United States Citizen
[ ] Resident Alien
[ ] Non-resident Alien
[ ] Other
[ ] Unknown

Race:
[ ] Caucasian
[ ] African American
[ ] American Indian
[ ] Indian Sub-continent
[ ] Asian
[ ] Pacific Islander
[ ] Middle-East/Arabian
[ ] Alaskan Native
[ ] Hispanic
[ ] Unknown

LEGAL NEXT OF KIN

Name: _____ Relationship to you: _____
Address: _____
City, State, Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

PERSON TO NOTIFY IN CASE OF AN EMERGENCY

Name: _____ Relationship to you: _____
Address: _____
City, State, Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

EMPLOYER

Name: _____
Address: _____
City, State, Zip: _____
Work Phone: _____ Work Extension: _____

INSURANCE INFORMATION

Guarantor (person who will pay for your care if you are not covered by insurance)
Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

Primary Insurance Name: _____
Phone Number: _____ Policy ID Number: _____
Subscriber Name: _____ Subscriber Employer: _____
Subscriber Social Security Number: _____
Group Name: _____ Group Number: _____

Secondary Insurance Name: _____
Phone Number: _____ Policy ID Number: _____
Subscriber Name: _____ Subscriber Employer: _____
Subscriber Social Security Number: _____
Group Name: _____ Group Number: _____

PHYSICIAN WHO REFERRED YOU TO THE UW MEDICAL CENTER

Name: _____
Address: _____
City, State, Zip: _____
Office Phone: _____ Office Fax: _____
Physician Specialty: [ ] Nephrology (Kidney) [ ] Endocrinology (Diabetes)
[ ] Other [ ] Gastroenterology (Stomach) [ ] Hepatology (Liver)

PRIMARY CARE PHYSICIAN

Name: _____
Address: _____
City, State, Zip: _____
Office Phone: _____ Office Fax: _____
Physician Specialty: [ ] Nephrology (Kidney) [ ] Endocrinology (Diabetes)
[ ] Other [ ] Gastroenterology (Stomach) [ ] Hepatology (Liver)

OTHER MEDICAL SPECIALIST INVOLVED IN YOUR CARE

Name: _____
Address: _____
City, State, Zip: _____
Office Phone: _____ Office Fax: _____
Physician Specialty: [ ] Nephrology (Kidney) [ ] Endocrinology (Diabetes)
[ ] Other [ ] Gastroenterology (Stomach) [ ] Hepatology (Liver)

KIDNEY DIALYSIS CENTER YOU ATTEND

Name of Kidney Center: _____
Name of Contact Person (Nurse, Director, etc.): _____
Address: _____
City, State, Zip: _____
Office Phone: _____ Office Fax: _____

PATIENT HEALTH ASSESSMENT

Height: _____ Weight: _____

HIGHEST EDUCATIONAL LEVEL

[ ] None [ ] Grade School (0-8) [ ] High School (9-12) [ ] Associate/Bachelors Degree
[ ] Unknown [ ]Attended College/Technical School [ ] Post-College Graduate School

PLEASE LIST ALL ALERGIES?
Include medication and food allergies. Please list all and describe your reactions:

1. _____
2. _____
3. _____
4. _____

PLEASE LIST ALL CURRENT MEDICATIONS (Name, dose, and how many times per day):

1. _____ 7. _____
2. _____ 8. _____
3. _____ 9. _____
4. _____ 10. _____
5. _____ 11. _____
6. _____ 12. _____

PLEASE LIST YOUR MEDICAL PROBLEMS (Hypertension, kidney failure, etc., and what treatment)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

PLEASE LIST ALL SURGERIES (Type, date, and reason):

_____
_____
_____
_____

	The following section provides information regarding your kidney disease.			
	Questions	No	Yes	Comments
KIDNEY DISEASE	What is your kidney disease?			How long have you suffered from this Disease?
	Have you ever had a kidney biopsy?			Date: Location:
	Do you make urine?			How many cups per day?
	Are you on dialysis? Hemo Dialysis_____ Peritoneal Dialysis_____			Date started: Dialysis Center: Days of the week:
	Do you have a graft?			Access site: Forearm [ ] Arm [ ] Groin [ ] Any problems?
	Do you have a fistula?			
	Do you have any urinary tract problems?			Burning [ ] Up to void at night [ ] Frequency [ ] Difficulty voiding [ ] Urgency [ ] Urinary retention [ ] Leakage [ ] Seen a urologist? Yes [ ] No [ ] If yes, who?
	Have you ever had blood in your urine?			If yes, when?
	Have you ever had kidney stones?			If yes, when?

	The following section provides information regarding your diabetes.			
	Questions	No	Yes	Comments
DIABETES	Do you have diabetes?			If no, please go to the next section.
	Do you have insulin dependent diabetes?			Date of diagnosis:
	Do you manage your diabetes with insulin?			What Insulin: Average Dose per day:
	Is your blood sugar control good?			Average blood sugar during the day: HbA^1c
	Have you ever been hospitalized for blood sugar control (acidosis)?			When? Where?
	Have you ever had eye surgery for retinopathy?			When, where, type of surgery?
	Do you have burning, tingling, or numbness of the feet?			Describe what level:
	Have you ever had ulcers in the legs or toes?			
	Have you had any amputation?			Describe your symptoms, surgeries, and interventions:
	Do you suffer from nausea, vomiting, or lazy stomach?			
	Do you suffer from diarrhea?			
	Do you suffer from constipation?			
	Do you get dizzy when standing up from a lying position?			

TRANSPLANT

The following section provides information regarding your transplant history.			
Questions	No	Yes	Comments
What is your blood group?			
Have you had a previous transplant? Date: Location:			Kidney [ ] Pancreas [ ] Other [ ] Specify: Living Related [ ] Living Unrelated [ ] Deceased donor [ ]
Is it still functioning?			
If graft has failed, has it been removed?			When? Where?
Cause of failure?			
Do you still have your own kidneys?			

INFECTION AND CANCER

The following section provides information regarding your infection and cancer risks.			
Questions	No	Yes	Comments
Have you had any of these childhood illnesses?			Rheumatic Fever [ ] Measles [ ] Mumps [ ] Chicken Pox [ ]
Have you had any of these infections?			TB [ ] Hepatitis [ ]
Are you up to date on your vaccinations?			Influenza [ ] Pneumovax [ ] Tetanus [ ] Polio [ ] MMR [ ] Diphtheria [ ]
Sexual history: Number of partners: _____ Male [ ] Female [ ]			History of sexually transmitted diseases (list):
Do you have pets at home?			How many and what types:
What is the source of your water supply?			City [ ] Well [ ] Bottled [ ]
Have you ever had cancer?			Type and procedure:
Is there a history of cancer in your family?			Who and when?
Have you been screened for cancer with any of these tests?			Stool Guaiac [ ] Mammogram [ ] Pap Smear [ ] PSA Test for prostate [ ]

HEART AND LUNGS

The following section provides information regarding your heart and lungs

Questions	No	Yes	Comments
Do you have any of these cardiac problems? Describe the symptoms:			Hypertension [ ] Chest pain [ ] Shortness of breath [ ] Heart murmurs [ ] Swelling of legs [ ] Heart attack [ ]
Have you ever had heart surgery?			What type? When? Where?
Have you had any of these tests?			Electrocardiogram [ ] Date: Echocardiogram [ ] Date: Cardiac Stress Test [ ] Date: Angiogram [ ] Date:
Do you have difficulty breathing when sleeping or exercising?			Describe symptoms:
Can you walk continuously for more than one block without symptoms?			Describe symptoms (chest pain, leg cramps, etc.):
Have you ever had any of these respiratory problems? Describe symptoms:			Pneumonia [ ] Asthma [ ] Sinusitis [ ] Hay fever [ ] Frequent colds [ ]

GASTROENTEROLOGY

The following section provides information regarding your gastrointestinal history.

Questions	No	Yes	Comments
Have you had any gastrointestinal problems?			Nausea [ ] Vomiting [ ] Diarrhea [ ] Constipation [ ] Flatulence [ ] Loss of appetite [ ] Weight loss or gain [ ] Rectal pain [ ] Rectal bleeding [ ]
Have you had any gall stones?			When, where, and treatment:
Have you had any diverticular disease?			When, where, and treatment:

BLOOD

The following section provides information regarding your blood history.

Questions	No	Yes	Comments
Have you had any of these hematologic problems?			Anemia [ ] Bruising [ ] Bleeding [ ]
Are you taking a prescription blood thinner?			Coumadin [ ] Aspirin [ ] Other [ ] Specify:
Have you ever had a blood transfusion?			Date, location, and reason:

	The following section provides information regarding your neurological history.			
NEUROLOGICAL	Questions	No	Yes	Comments
	Have you ever had any of these neurological problems?			Headaches [ ] Shakiness [ ] Migraines [ ] Visual disturbance [ ] Describe the problem: Describe the treatment: Describe the outcome:
	Have you ever had trauma or head injury?			Describe the event:
	Have you ever had any eye problems?			What were your symptoms?
	Have you ever had any ear problems?			What were your symptoms?
	Have you ever had any mouth/throat problems?			What were your symptoms?

	The following section provides information regarding your skin, joint, and muscular history.			
SKIN JOINT MUSCLES	Questions	No	Yes	Comments
	Have you ever had muscle or joint problems?			Joint pain [ ] Gout [ ] Joint swelling [ ] Tremor [ ] Rheumatoid Arthritis [ ]
	Have you ever had any skin problems?			Skin change [ ] Itching [ ] Hair loss [ ] Eczema [ ]
	Do you currently have unfinished dental work?			What type?
	Dentist's name:			Dentist's phone number:
	Do you have any loose teeth?			
	Do you wear dentures?			

	The following section provides information regarding your gynecological history.			
GYNECOLOGIC	Questions	No	Yes	Comments
	Have you had any gynecological or obstetric problems?			Describe:
	Are your menstrual cycles regular?			Length of menstrual period:
	Could you be pregnant now?			Number of pregnancies: Number of live births:
	Contraceptive method (if used):			
	Age at menopause:			

PERSONAL AND FAMILY

The following section provides information regarding your personal and family history.

Questions	No	Yes	Comments
Are you married?			Spouse's name:
Do you have children?			How many?
Do you have siblings?			How many?
Are any of the above interested in being a living donor for you?			List names and number of those interested:
Do you know of anyone else interested in being a living donor for you?			List names, numbers, and relationship to you:
If your donor is incompatible with you due to blood group, are you interested in the donor exchange program?			List name of donor(s) who is interested:
Do family members live at home with you?			
Is there a family history of any of the following illnesses?			Cancer [ ] Heart disease [ ] Kidney disease [ ]
Are you employed?			Full time [ ] Part time [ ] Self employed [ ] Disabled [ ]
Do you have a history of mental problems?			Describe:
Do you have significant stresses at home?			Describe:
Do you have any trouble following a physician's advice?			Describe:
Do you have any unusual dietary restrictions?			Describe:
Have you ever smoked cigarettes?			If yes, how many packs per day? Have you quit smoking cigarettes? When?
Do you drink alcohol?			How often?
Do you use IV drugs or marijuana?			What/How often?
Have you lost weight lately?			How much/over what period of time?
Have you gained weight lately?			How much/over what period of time?