Stony Brook Medicine

Transplantation Services
Renaissance School of Medicine at
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Stony Brook, NY 11794-8192

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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 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 with 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		YES	NO
Diabetes			Psychiatric Disorder		
High Blood Pressure			Hepatitis		
High Cholesterol			Lupus		
Lung Disease			Arthritis		
Heart Disease			Intestine/Stomach Issues		
Cancer			Sickle Cell		
Kidney Stones			Blood Clots		
Asthma			Anemia		
Blood Transfusion			Seizures		
Urinary Tract Infection (UTI)			Kidney or Bladder Infection		
Depression			Anxiety/Panic Attack		

FEMALES ONLY			MALES ONLY		
	YES	NO		YES	NO
Abnormal PAP Smear			Elevated PSA		
Abnormal Mammo					

FEMALE DONORS

Number of pregnancies:______________________ Number of live births:________________________

Gestational Diabetes: ____ Yes ____ No High Blood Pressure during pregnancy: ____Yes ___ No

Other problems during pregnancy:
____

SURGICAL HISTORY

Please list any PAST and UPCOMING SCHEDULED Surgeries and the dates: ____________________________

____

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

ADDITIONAL MEDICAL INFORMATION

List ANY Additional Details regarding your Medical History: _______________________________________

____

MEDICAL HISTORY PART 3-CURRENT SYMPTOMS

Are you CURRENTLY experiencing any of these symptoms?					
	YES	NO		YES	NO
Difficulty Breathing			Chest Pain		
Leg Swelling			Headache		
Unexplained Weight Loss			Diarrhea		
Nausea/Vomiting			Fever		
Cough			Stiff Joints		
Pain in Legs					

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: ________________________________

TOBACCO USE

	Current Use	Never Use	Past Use	Quit: How long ago
Cigarettes				
Chewing Tobacco				
Other				
For how long?:				

ALCOHOL USE

	Current Use	Never Use	Past Use	Quit- How long ago
Do you drink Alcohol?				
If YES, how often?	Daily	Occasionally		Rarely
If YES, for how long?				
If YES, why type of Alcohol?				

NON-PRESCRIPTION DRUG USE OR OTHER SUBSTANCES

Have you ever, or do you currently use the following:

___ Marijuana ____ Cocaine ____ Steroids ___ Heroin ____ Methamphetamine ___ Inhalants

? Other (please list) :____

What type and route? ________________________

Date of last use: ____________________________

VACCINATION HISTORY

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 Covid-19 ? Yes ? No
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? ____

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:

PREVENTATIVE CARE TESTING

TEST	YES	NO	N/A	DATE	**Where was test performed- Please enter Dr. name or Practice Name**
Colonoscopy					
Cologuard					
Cardiology Evaluation					
Echocardiogram					
Cardiac Stress Test					
PSA (male)					
Mammography					
Pap Smear (female)					

KIDNEY DONATION

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**