

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

TEL: 631 444 2209
FAX: 631 444 3831

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) school	_____ High School (9-12)	_____ College/technical
_____ Associate Degree Degree	_____ Bachelor Degree	_____ Post Graduate

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						
Diabetes						
Heart Attack/Stroke						
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