Beaumont

Beaumont Health Multi-Organ Transplant Program
Confidential Living Donor Medical History Questionnaire

Please complete this form giving specific information whenever possible. Return this questionnaire and the *Donor Consent for Initial Blood Work* in the enclosed self-addressed stamped envelope. Thank you.

Today's Date: _____

Recipient's Name: _____

Your relationship to recipient: _____

Are you blood related to recipient? YES NO

Your Name: _____Date of Birth_____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Other Phone: _____ Email address: _____

Best day and time to be reached: _____

Are you working? _____ Full Time_____ Part Time_____ Retired_____

If yes, what type of work do you do? _____

Height _____ Weight _____ Race _____

Marital Status: Single Married Divorced Separated Widowed

Number of children and their ages: _____

Do you know your blood type? _____ If yes, circle: A B AB O

On a scale of 1-10 (with 10 being very willing to donate and 1 not willing to donate at all) how do you feel about being an organ donor?

1 2 3 4 5 6 7 8 9 10

Do you have allergies? YES NO

If yes, what are you allergic to? _____

Have you ever had a reaction to iodine (CT Dye) YES NO

If you have asthma, a special medication protocol will be required for CT studies.

Have you ever had or been treated for any of the following problems?

High Blood Pressure (HBP) YES NO

Diabetes YES NO

Pregnancy Complications:
- High Blood Pressure YES NO
- Diabetes YES NO

Kidney Infection YES NO

Kidney Stones YES NO

Bladder Infection YES NO

Cancer YES NO

Heart Disease/Heart Attack YES NO

Stroke YES NO

Blood Clot YES NO

Lung Disease/Asthma/COPD YES NO

Liver Disease YES NO

Hepatitis YES NO

Arthritis YES NO

Lupus YES NO

Tuberculosis (TB) YES NO

Bleeding Problems YES NO

Anemia YES NO

Received blood transfusions YES NO

- If yes, when? _____
- How many? _____

Tobacco Use YES NO

Smokeless Cigarettes Cigars eCigarettes

- How much? _____
- How often? _____

Alcohol Use YES NO

Beer Wine Liquor

- How much? _____
- How often? _____

Recreational Drug Use YES NO

- What kind? _____
- How much? _____
- How often? _____

Tattoos /Body Piercing YES NO

- If yes, professionally done? YES NO
- If yes, when? _____

Have you ever been seen by a psychiatrist or been treated for mental illness? YES NO

If you answered yes to any of the questions on the previous page, please describe your illness/condition. Include number of times you were treated and/or how long you were ill.

_____
_____
_____
_____

Have you ever had surgery? YES NO

If yes, please describe and give date(s):

_____
_____
_____
_____

Do you take any prescription medications? YES NO

Do you take any over-the-counter medications? YES NO

Do you take any herbal supplements? YES NO

If yes to the above, please list all medications, over-the-counter medications, and herbal supplements you are taking. Include dosage and frequency of use.

_____
_____
_____
_____
_____
_____
_____
_____

Submitted by _____ Date: _____

This information will be reviewed by the Transplant Team. The Transplant Nurse Coordinator will call you with more information about the next step. Please feel free to call us at 248-551-1033 or 1-800-253-5592, if you have any questions.

The enclosed booklet will provide you with general information about being a potential living organ donor. Please read the information carefully. If you have any questions, please call the transplant center.

Thank you,
Beaumont Transplant Team