MASSACHUSETTS GENERAL HOSPITAL
TRANSPLANT CENTER

Living Kidney Donor Candidate

Personal Data Sheet

Instructions:

(1) Save this form to your computer, then close your browser. (This will prevent you from losing data!).

(2) Reopen the form and enter the data requested.

(3) Return form by fax, mail or email to: mghlivingdonors@partners.org; MGH Transplant Program, Attn: Donor Team. 165 Cambridge Street, Suite 301. Boston, MA 02114. Fax 617-726-9335. Note: security and confidentiality of email transmission is uncertain. The risk of data disclosure due to email transmission must be assumed by the sender.

Today's Date: _____/_____/_____

Your First Name: _____ MI_____ Last Name: _____

Date of Birth: _____/_____/_____ Age: _____ Marital Status: _____

Your MGH Medical Record number (*if available*; ***if not available, skip***). : _____

Phone: _____ ◯ Home / ◯ Cell

Email: _____

Home Address: _____

Potential Kidney Recipient's name: _____ Your relationship to Recipient: _____

Do you work for income? ◯ Yes/ ◯ No ◯ Part time/ ◯ full time

Your Occupation and Title (*if applicable*): _____

Primary Care Physician name / address / telephone:_____

Your Blood (ABO) Group: ◯ A ◯ B ◯ O ◯ AB ◯ unknown

Your Height: _____ Weight: _____ Your Body Mass Index (BMI) (*if known*): _____

Who do you live with? _____

Number of children: _____

Does your family/significant other support the idea of you donating a kidney? _____

If you donate a kidney, who will take care of you after surgery? _____

Do you get regular exercise? ◯ Yes/ ◯ No If yes, what type?_____

Do you smoke cigarettes, cigars or a pipe? ◯ Yes/ ◯ No If Yes, how much/how long?_____

Do you drink beer, wine or cocktails? ◯ Yes/ ◯ No If Yes, how much/how long?_____

Do you smoke marijuana? ◯ Yes/ ◯ No If Yes, how much/how long? _____

Do you use drugs such as cocaine or others? ◯ Yes/ ◯ No If Yes, how much/how long? _____

Have you ever had addiction problems, or attended alcohol or narcotics anonymous or other substance abuse programs or counseling? ◯ Yes/ ◯ No

Personal Medical History

Have you ever had any of the following?	Yes	No	Please provide details
• Hypertension or high blood pressure?	○	○	
• Diabetes or 'sugar diabetes'	○	○	
• *Females only*: Diabetes or hypertension during pregnancy (gestational diabetes) N/A ○	○	○	
• *Males only:* Prostate enlargement or prostate problems, or prostate cancer N/A ○	○	○	
• Heart Disease	○	○	
• Lung Disease	○	○	
• Gastrointestinal Disease (such as inflammatory bowel disease, diverticulitis)	○	○	
• Neurological Disease (such as strokes, seizures, or migraine headaches)	○	○	
• Cancer (including skin cancer)	○	○	
• Bleeding or clotting disorders	○	○	
• Hematological (blood) disease	○	○	
• Autoimmune disease (such as lupus or rheumatoid arthritis)	○	○	
• Chronic infections such as tuberculosis or lyme disease	○	○	
• Genitourinary Disease such as bladder problems or bladder catheterization	○	○	
• Kidney disease	○	○	
• Kidney stones	○	○	
• Protein in the urine	○	○	
• Blood in the urine	○	○	
• Kidney injury	○	○	
• Recurrent urinary tract infections	○	○	
• Depression	○	○	
• Suicide attempt	○	○	
• Anxiety	○	○	
• Post Traumatic Stress Disorder	○	○	
• Hospitalization for psychiatric reason	○	○	
• Other illness requiring care by a psychiatrist, psychologist or other therapist?	○	○	

Have you ever been in a hospital overnight? ○ Yes/ ○ No If yes, please enter details:

Reason for / type of hospitalization **Location** **Date of Hospitalization**

Have you ever had surgery? ○ Yes/ ○ No If yes, enter details below:

Surgery Type	Location	Date of Surgery

Have you had any other serious illnesses and injuries or accidents including broken bones (fractures)?

○ Yes/ ○ No If yes, enter details below:

Illness or Injury	Date

What medicines do you take on a regular basis, and why do you take them?

Name of Medication	Dosage	How many times per day?	Why?

Do you take motrin, advil, aleve, nuprin, ibuprofen or other pain pills on a regular basis? ○ Yes/ ○ No

If Yes, what drug, dose, and how often? _____

Do you have any allergies to medicines, latex, IV contrast or food? ○ Yes/ ○ No If yes, enter details below:

Name of Medicine or other agent that causes allergy	Reaction

Family Medical History

To your knowledge, has any relative had:	Yes	No	Relation to You
Kidney Disease	○	○	
Diabetes	○	○	
High Blood Pressure	○	○	
Coronary artery/heart disease	○	○	
Cancer including kidney cancer	○	○	
Depression, suicide attempts or other mental illness	○	○	

Are there any other diseases not listed that run in your family? ○ Yes/ ○ No If yes, enter details below:

_____

_____

_____

_____

_____

Date of last physical exam with primary care provider: _____

Date of last: Pap (females only): _____ Mammogram (females > 40): _____

PSA (prostate test) (males age > 50)_____ Colonoscopy (age > 50): _____

Were you born in US? ○ Yes/ ○ No If No, where were you born? _____ Year came to US _____

Have you lived outside US for an extended period of time? ○ Yes/ ○ No If YES, where/when? _____

Do you follow a special diet? ○ Yes/ ○ No If Yes, what type of diet? _____

Certification (*to be completed during MGH visit*)

I, _____ certify that the information on this form is accurate to the best of my knowledge.
(*enter donor candidate name)*

Donor Candidate Signature: _____ Date: _____