Please mail or fax to:
Methodist Dallas Medical Center
Transplant Program
1411 N. Beckley
Pavilion III, Suite 261
Dallas, TX 75203
Fax: (214) 947-1828

Donor Application & Health History

Donor Name: ____SS#: ____________________

Potential Donor For:______________________________________ Relationship:____________

Date of birth: __________________________ Age: ______ Sex: M: ____ F: ____ Race: ______

Address: ____

City/State/Zip Code: ____

Home phone number: ______________________ Cell phone number:_______________________

Work phone number: ______________________ May we contact you are work? ☐ Yes ☐ No

Email: ____

Emergency contact name and phone number: ___________________________________

Married: ____ Single: ____ Divorced: ____ Widow(er): ____ Separated: ____

Do you speak English? ☐ Yes ☐ No If NO, what language do you speak? _____________

If unable to donate due to blood type / cross match issues, would you be interested in Paired Exchange Program? ☐ Yes ☐ No

Would you like more information about the Paired Exchange Program? ☐ Yes ☐ No

MEDICATIONS

List all medications (including dose and how often you take it):

____________________________________ ____________________________________

____________________________________ ____________________________________

Please list all over the counter medications (examples: Tylenol, Advil) herbal supplements and vitamins you currently take:

____________________________________ ____________________________________

____________________________________ ____________________________________

Allergies:____

Occupational / Social History

Your Occupation: ____
Are you currently working? Yes: ____ No: _____ Disabled: _____ Retired: _____
Are you working full time? Yes: ____ No: _____ Part time? Yes: ____ No: _____
Indoors: ____ Outdoors: ____ Is heavy lifting involved? Yes: ____ No: _____
Do you have health insurance? Yes: ____ No: _____
What are the best days/times for appointments to be scheduled? ____________________

Do you currently smoke? Yes: ____ No: _____ If yes - _______packs per day
How long have you smoked? ________ When did you last smoke? __________

Have you ever smoked? Yes: ____ No: _____ If yes - _______packs per day
How long did you smoke? ______________ When did you quit? ____________

Have you ever used illegal drugs? Yes: ____ No: _____
What type of drugs have you used? _____________________________________
When did you last use drugs? _____________________

Amount of coffee? __________ cups per day. Amount of tea? _________ cups per day

Other caffeinated beverages (colas, energy drinks)? ___________ per day

Do you currently consume alcoholic drinks? Yes: ____ No: _____
How many alcoholic drinks do you consume per day? _______ Per week? ________

If you are approved for transplant:

Who will be with you at the hospital when you donate?______________________________
Where will you stay after you are discharged from the hospital? _______________________
Who will assist you after you go home? ____

FAMILY HISTORY

	Age	Medical Problems	Cause of Death/Age at death (If no longer living)
Father	____	_______________	____________________________
Mother	____	_______________	____________________________
Brothers	____	_______________	____________________________
	____	_______________	____________________________
Sisters	____	_______________	____________________________
	____	_______________	____________________________
Sons	____	_______________	____________________________
	____	_______________	____________________________
Daughters	____	_______________	____________________________
	____	_______________	____________________________

Check if any of your blood relatives had any of the following:

	Disease	**Relationship to you**
☐	Diabetes	____________________
☐	Heart Disease	____________________
☐	Stroke	____________________
☐	High Blood Pressure	____________________
☐	Kidney Disease	____________________
☐	Kidney Cancer	____________________
☐	Other Cancer	____________________
☐	Tuberculosis	____________________
☐	Chemical Dependency	____________________
☐	Bleeding Disorders	____________________
☐	Other	____________________

ADDITIONAL INFORMATION

Name, address and telephone # of your personal physician:
Dr. ____

Did you have any serious illnesses as a child? ☐ Yes ☐ No
If yes, please explain ____

Have you had the following?:

Mumps	Yes: ____	No: _____	Measles	Yes: ____	No: _____
Chickenpox	Yes: ____	No: _____	Rheumatic Fever	Yes: ____	No: _____
Mononucleosis	Yes: ____	No: _____			

Do you travel outside the United States? ☐ Yes ☐ No
If yes, where and when ____

Any other Medical Problems:
____
____

Have you had any surgeries? Yes: ____ No: _____
If yes, please list____
____
____
____
____

Have you had any complications from anesthesia or surgery? Yes: ____ No: _____
If yes, please list____

Have you had any other hospitalizations? Yes: ____ No: _____
If yes, please list____

Are you willing to receive blood products if needed at time of surgery if needed?
Yes: ____ No: _____

GENERAL:

Your height is: ___________ Your current weight is: ______________

Is this your usual weight? Yes: ____ No: ____

Have you had any weight loss surgery (gastric bypass, lap banding)? Yes: ___ No: ____

If yes, when was the surgery? _________ How much weight did you lose? ____________

Please indicate any of the following that apply to your health condition in the past 6 months:

Weight Gain: Yes: ____ No: ____

Weight Loss: Yes: ____ No: ____

Fever: Yes: ____ No: ____

Chills: Yes: ____ No: ____

Night Sweats: Yes: ____ No: ____

EYE, EAR, NOSE, AND THROAT *Check any that apply to you…*

Blindness Yes: ____ No: ____

Deafness/Hearing Loss Yes: ____ No: ____

Sinus infections Yes: ____ No: ____

ENT Doctor: _______________________________ phone #: _______________________

PULMONARY (Lungs) *Check any that apply to you…*

TB/Tuberculosis Yes: ____ No: ____

Bronchitis Yes: ____ No: ____

Asthma Yes: ____ No: ____

Wheezing Yes: ____ No: ____

Sleep Apnea Yes: ____ No: ____

Do you use CPAP? Yes: ____ No: ____

Shortness of breath Yes: ____ No: ____

Coughing up blood Yes: ____ No: ____

History of lung masses/nodules/lung cancer Yes: ____ No: ____

Pulmonologist (Lung Doctor):____________________ phone #: ______________________

CARDIAC (Heart) *Check any that apply to you…*

High Blood Pressure Yes: ____ No: ____

Heart disease Yes: ____ No: ____

Heart Attack Yes: ____ No: ____

Pacemaker Yes: ____ No: ____

Heart surgery Yes: ____ No: ____

Heart palpitations Yes: ____ No: ____

Cardiologist (Heart Doctor):_______________________ phone # :___________________

GASTROENTEROLOGY (Abdomen/intestines/liver/stomach) *Check any that apply…*

History of Hepatitis? Yes: ____ No: ____
Ulcer in stomach / intestines Yes: ____ No: ____
History of blood in stools Yes: ____ No: ____
History of gallstones / gallbladder problems Yes: ____ No: ____
Diverticulosis Yes: ____ No: ____
Have you ever had a colonoscopy (lower endoscopy) or EGD (upper endoscopy)?
Yes: ____ No: ____
When? ____________________ Why? ___________________________
Any additional GI problems/surgeries/recent testing: ___________________________________
Gastroenterologist (Doctor for abdomen, stomach, liver and/or intestines): _________________

Telephone #: _________________

UROLOGY/ RENAL (Kidney/bladder/ureter/urethra) *Check any that apply to you …*

Frequent bladder infections Yes: ____ No: ____
Painful urination Yes: ____ No: ____
Difficult to urinate Yes: ____ No: ____
Blood in your urine Yes: ____ No: ____
Protein in your urine Yes: ____ No: ____
Urinate frequently Yes: ____ No: ____
Loss control of bladder Yes: ____ No: ____
History of kidney infections Yes: ____ No: ____
History of kidney stones Yes: ____ No: ____
If yes – When? ____
History of enlarged prostate Yes: ____ No: ____
Urologist (Doctor for bladder/ureter/urethra): _______________phone #: _________________

GYNECOLOGY (Breasts/Female Organs)

Date of last pap smear: _______________ Date of last mammogram: _____________
Number of times you have been pregnant? ____________________________________
Number of living children you have? ____
How many miscarriages have you had? ___________________________________
Was your blood pressure elevated while you were pregnant? Yes: ____ No: ____
Was your blood sugar elevated while you were pregnant? Yes: ____ No: ____
Have you had a hysterectomy (uterus surgically removed) Yes: ____ No: ____
If yes, why? ____
Have you ever had an abnormal pap smear? Yes: ____ No: ____
If yes, what was wrong? ____
Have you ever had an abnormal mammogram? Yes: ____ No: ____
If yes, what was wrong? ____________________________________
Treatment for abnormal mammogram was _________________________
History of breast biopsy? Yes: ____ No: ____
Gynecologist (Female Doctor):_________________________ phone #:___________________
Breast Doctor: _______________________________________phone #:___________________

MUSCULOSKELETAL *Check any that apply to you…*

Arthritis Yes: ____ No: ____
Joint Pain / Swelling Yes: ____ No: ____
Osteoporosis Yes: ____ No: ____

NEUROLOGY (Brain and Spinal Cord) *Check any that apply to you…*

Headaches Yes: ____ No: ____
Head Injury Yes: ____ No: ____
Seizures Yes: ____ No: ____
Back pain Yes: ____ No: ____

Neurologist (Brain Doctor):______________________________ phone #:_____________________

ENDOCRINOLOGY (Diabetes or Thyroid) *Check any that apply to you…*

Do you have diabetes? Yes: ____ No: ____
Age when diagnosed ____________________
Thyroid problems? Yes: ____ No: ____
Endocrinologist (Diabetes/Thyroid Doctor):_________________ phone #:____________________

HEMATOLOGY/ONCOLOGY/RHEUMATOLOGY (Blood/Cancer) *Check any that apply…*

History of Bleeding Problems Yes: ____ No: ____
History of Difficulty Clotting Yes: ____ No: ____
Frequent bruising Yes: ____ No: ____
Blood clots in legs or lungs Yes: ____ No: ____
Frequent nosebleeds Yes: ____ No: ____
Do you have Systemic Lupus Erythematosus? Yes: ____ No: ____
Do you have a history of cancer? Yes: ____ No: ____
If yes, what type?____
When was the cancer
diagnosed?____
What treatment was done?__________________Date of last treatment was: _________________
Have you ever had a blood transfusion? Yes: ____ No: ____
Total number of blood transfusions__________When was the last blood transfusion? __________

Hematologist/Oncologist/Rheumatologist: _______________________phone #: _____________

PSYCHOSOCIAL (Mental/Social) *Check any that apply to you…*

History of Mental Illness Yes:_____ No;___
Anxiety Yes:____ No: __
Depression Yes:____ No: __
Have you ever attempted to kill yourself? Yes:____ No: __
History of Alcohol/Substance Abuse Yes:____ No:___
Have you ever been incarcerated? Yes:____ No:___

Psychiatrist/Psychologist: _______________________________phone #: ____________________

Patient signature: ____ Date: ________________