

Recipient Health History

Recipient Name: _____ SS#: _____

Date of birth: _____ Age: _____ Sex: M: ____ F: ____ Race: _____

Address: _____

City/State/Zip Code: _____

Email Address: _____

Home phone number: _____ Cell phone number: _____

Additional phone numbers: _____

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

Do you speak English? Yes No If **NO**, what language do you speak? _____

Nephrologist (Dialysis/Kidney Doctor): _____

First Date of Dialysis: _____ Dialysis Center: _____

Dialysis Days/Shift: _____

Are you on the waiting list at another center? Yes No

If yes, where are you listed? _____ When were you listed? _____

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: ____

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

Have you ever used illegal drugs? Yes: ____ No: ____

What type of drugs have you used? _____

When did you last use drugs? _____

Do you currently consume alcoholic drinks? Yes: ____ No: ____

How many alcoholic drinks do you consume per day? _____ Per week? _____

When did you last consume alcohol? _____

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

<u>Disease</u>	<u>Relationship to you</u>
<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Heart Disease	_____
<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> High Blood Pressure	_____
<input type="checkbox"/> Kidney Disease	_____
<input type="checkbox"/> Kidney Cancer	_____
<input type="checkbox"/> Malignancy/Cancer	_____
<input type="checkbox"/> Tuberculosis	_____
<input type="checkbox"/> Bleeding Disorders	_____
<input type="checkbox"/> Other	_____

ADDITIONAL INFORMATION

Have you had the following?:

Mumps Yes: _____ No: _____ Measles Yes: _____ No: _____
Chickenpox Yes: _____ No: _____

Any other Medical Problems:

Have you had any surgeries? Yes: _____ No: _____

If yes, please list _____

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/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 if any apply...

- History of Hepatitis? A B C 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: ___
- History of diarrhea? Yes: ___ No: ___ History of constipation? Yes: ___ No: ___
- Have you ever had a colonoscopy (lower endoscopy) or EGD (upper endoscopy)?
Yes: ___ No: ___
- When? _____ Why? _____

Gastroenterologist (Doctor for abdomen, stomach, liver and/or intestines): _____

Telephone #: _____

UROLOGY/ RENAL (Kidney/bladder/ureter/urethra)

Check all that apply...

- Frequent bladder infections Yes: ___ No: ___
- Blood in your urine Yes: ___ No: ___
- Protein in your urine Yes: ___ No: ___
- Lose 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? _____

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 _____ First date of Insulin: _____
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: ___
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 #: _____

Completed by: _____ Date: _____