The Transplant Institute
METHODIST DALLAS

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

Paired or Non Directed Donor Application & Health History

Donor Name: _____SS#: _____

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

Address: _____

City/State/Zip Code: _____

Email Address:_____

Home phone number: _____ Cell phone number:_____

Work phone number: _____ May we contact you at work? ☐ Yes ☐ No

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? _____

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: _____
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? _____
Are you a former smoker? _____ 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? _____

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 are transplanted? _____
Where will you stay after you are discharged from the hospital? _____
Who will assist you after you go home? _____

FAMILY HISTORY

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	_____
☐	Malignancy/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 if any 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: ____
History of vomiting blood? Yes: ____ No: ____
Problems with esophagus? 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? _____
Any additional GI problems/surgeries/recent testing: _____
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: ____
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: ____
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? _____
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 arthritis? 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: _____