Donor Health History

Name: _____ **DOB:** ___ / _____/ _____
Day Month Year

Marital Status: Married/Single/Divorced/Widowed/Other

Sex: Male /Female

Weight:_____lbs or _____kg Height:____in._____cm

BMI (WE WILL COMPLETE FOR YOU) _____

Address: _____

_____**(City)**_____**(Province)**_____ _____**(Postal Code)**

Telephone: (___)_____-_____ E-Mail Address:_____

Occupation: _____

Work Telephone: (___)_____-_____ Can we contact you at work? Yes θ No θ

Health Card Number: _____

Family Doctor: _____ **Tel. (____)** _____- _____

Address: _____

Please indicate the name of the recipient to whom you wish to direct your donation:_____
Please indicate your relationship to recipient:
_____

Medical History:

These questions are used to gather important information about your health and lifestyle that might impact on your potential to become a living donor. This will be used by the health care professionals on our team to determine your overall well being. All information on this questionnaire is kept strictly confidential.

GENERAL HEALTH	*YES*	*NO*
Have you ever had abdominal surgery? (Such as gallbladder, bowel or hysterectomy)?	θ	θ
Have you ever had any other surgery? If yes, what?_____	θ	θ
Did you have any problems after surgery/anaesthetic If yes, what were the problems?_____	θ	θ

	YES	NO
Have you had any hospitalization for other reasons?	θ	θ
If yes, why?_____		
Name of Hospital _____		
Do you routinely take any medications (including over the counter)	θ	θ
If yes, list:_____		
Do you have any allergies?	**O**	**O**
If yes, to what?_____		
Reaction?_____		
Do you smoke cigarettes?	θ	θ
How many per day? ____ **For how long?** _____ **years**		
Do you drink alcohol?	θ	θ
How much per day? ____ **For how long?** ____ **years**		

LIVER HEALTH

Have you ever had jaundice (yellow skin)?	o	o
Have you ever had a liver problem?	o	o
Have you ever had a an inflamed liver - hepatitis	o	o
Is there a family history of liver problems?	o	o

If yes, what?_____

_____

CANCER HISTORY

Have you had cancer?	θ	θ

Type:_____

Treatment: Radiation:_____ **Chemo:**_____ **Surgery:**_____ **Other:**_____

INFECTION RISKS (including exposures or risk factors for "AIDS" or sexually transmitted diseases)

Do you have a chronic infection of any type?	o	o
If yes, type?_____ **When:**_____		
Have you ever received a blood transfusion or other blood product?	o	o
If yes, type?_____ **When:**_____		
Have you ever had a tattoo, body piercing or acupuncture?	o	o

If yes what?_____

	YES	NO
When? _____		
Do you or have you ever used recreational drugs (such as marijuana or intravenous drugs)?	o	o
If yes, what? _____		
Have you had any recent unexplained weight loss?	o	o
Have you been treated for <u>any</u> infection in the past 12 months?	o	o
Have you ever tested positive for HIV?	o	o
Have you had unprotected casual sex (which is a risk factor for "AIDS" or sexually transmitted diseases)?	o	o
Where were you born? _____		
Where were you immunized? _____		
Have you had any recent vaccinations? If yes, what? _____	o	o
Have you been vaccinated for Hepatitis B? If yes, when or at what age? _____	o	o
Have you traveled outside North America in the past 3 years? If yes, where? _____	o	o

NEURO/PSYCHO/SOCIAL

Do you have a seizure disorder/epilepsy?	o	o
Have you ever had a stroke/transient ischemic attack?	o	o
Have you ever had treatment for depression? Treatment: _____	o	o
Have you ever had treatment for a psychiatric problem? Treatment: _____	o	o

CARDIOVASCULAR

Do you have a history of heart disease or chest pain? If yes, elaborate: _____	o	o
Have you ever had high blood pressure? If yes, when? _____ Type of treatment: _____	o	o
Have you had a heart attack? If yes, when? _____	o	o
Have you ever had rheumatic fever, or been told you had		

	YES	NO
a heart murmur?	o	o
If yes, when?_____		

Do you and/or a family member have hemophilia or a clotting problem?
o o
If yes, what?_____

Have you and/or a family member ever had a blood clot in your lungs or legs?
o o

RESPIRATORY

Have you ever had any lung disease such as asthma or emphysema?	o	o
If yes, what?_____ When:_____		
Have you ever been exposed to someone with tuberculosis or had a positive TB skin test?	o	o
Do you routinely use any inhalers or take medications to help your breathing?	o	o

GASTROINTESTINAL

Do you have any stomach or intestinal problems?	o	o
If yes, what?_____		
Have you ever had gallbladder problems or gallstones?	o	o
Have you ever had a colonoscopy?	o	o

GENITOURINARY

Have you ever had problems with your kidneys (such as infections or stones)?	o	o
If yes, what?_____ When:_____		
Have you ever had any problems with your bladder (such as infections, incontinence or difficulty voiding)?	o	o
Do you have any problems related to an enlarged prostate?	o	o
If yes, what?_____		
Have you ever had a gynecologic problem?	o	o
Date of last PAP smear, breast exam or mammogram:_____		
Did you experience any problems with pregnancies or deliveries (such as high blood pressure, toxemia or blood sugar)?	o	o

	YES	NO
ENDOCRINE		
Do you have diabetes?	o	o
Do you have a family history of diabetes?	o	o
Have you ever had increased blood sugars, i.e., with pregnancy?	o	o
Have you ever been diagnosed with thyroid disease?	θ	θ
OTHER		
1. Is there any other health information that we should know?	o	o

_____

_____

_____

I have answered these questions to the best of my ability and have received the letter of information for the living donor liver program.

Signature: _____

Date: _____