University Transplant Center
Experts On Life.

A University Health System & UT Health Science Center Partnership | San Antonio

PLEASE COMPLETE THIS FORM AND MAIL TO:

UNIVERSITY HEALTH SYSTEM
UNIVERSITY TRANSPLANT CENTER
ATTN: Claudia Grimmer, BSN, RN
4502 MEDICAL DRIVE- MS 18
SAN ANTONIO, TEXAS 78229-9976

FORM MAY ALSO BE FAXED DIRECTLY TO 210-358-1111

POTENTIAL DONOR SCREENING FORM

Name:_____**Date of Birth**:_____ **Age**:_____
Social Security #:_____

Marital Statusl: ☐**Single** ☐**Married** ☐**Separated** ☐ **Divorced**

Spouse's Name:_____

Home Phone:_____**Cell**_____**Work**:_____

Address:_____**City/State**:_____ **Zip:** _____

Height:_____**Weight**:_____**Race**:_____**Gender:** ☐**Male** ☐**Female**

Do you have insurance: ☐**Yes**☐**No** **Name of insurance provider:** _____

Name of primary care physician and phone #: _____

Do you get regular medical care: ☐**Yes** ☐**No**

Name of person receiving your organ:_____**Relationship**:_____

PAST MEDICAL HISTORY **Please check if you have had any of these conditions**:

☐ Heart Disease	☐ Asthma	☐ HIV/Aids
☐ High Blood Pressure	☐ Lung Disease	☐ Migraine Headaches
☐ High Cholesterol	☐ Cancer	☐ Seizures/Eplilepsy
☐ Bleeding Problems	☐ Kidney Disease	☐ Prostate Problems
☐ Ulcers	☐ Diabetes	☐ Intestinal Problems
☐ Esophageal Reflux	☐ Depression	☐ Eye Problem
☐ Stroke	☐ Mental Illness	☐ Tuberculosis or Positive TB skin test
☐ Blood Clots	☐ Arthritis	☐ Problems urinating, blood in urine, kidney pain
☐ Liver Disease	☐ Vascular Disease	☐ High risk behaviors (multiple sexual partners, homosexuality)
☐ Hepatitis	☐ Thyroid Disease	☐ Other:

Number of pregnancies: _____ **Miscarriages**_____**Abortions**_____**Cesarean Births**_____**Vaginal Birth**____

Do you have any problems with your menstrual periods ☐**Yes** ☐**No** **Last menstrual cycle**_____

Last mammogram_____ **Results**_____
Last Pap Smear _____ **Results**_____

Did you have diabetes or high blood pressure when you were pregnant? ☐Yes ☐No

Were there any other complications of pregnancy? ☐Yes ☐No

What type of birth control do you use:_____

Have you ever received any blood transfusions? ☐Yes ☐No

PAST SURGICAL HISTORY **List any surgical procedures/operations:**

Date

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

MEDICATION **List all prescribed and over the counter medications you are currently taking, include all suppliments, herbal, teas:**

Medication	Dose	How often	Reason

Are you allergic to anything?_____What kind of reaction?_____

REVIEW OF SYSTEMS: Circle any problems or symptoms you have had or currently have.

GENERAL: Recent illness, fever, chills, night sweats, weight gain/loss

SKIN: Bruising, rashes, itching, skin cancer, other diseases of the skin

CARDIOVASCULAR: Shortness of breath, palpitations, chest pain, swelling in arms or legs, murmur, angina

RESPIRATORY: Chronic cough, wheezing, pain with breathing, productive cough, phlegm

GASTROINTESTINAL: Nausea, vomiting, diarrhea, constipation, heartburn, ulcers, blood in stool, jaundice

GENITOURINARY: Blood in urine, difficulty controlling bowel, or bladder, urinary frequency/urgency

NEUROLOGIAL: Headaches, seizures, tremors, paralysis, loss of consciousness, dizziness

MUSCULOSKELETAL: Joint pain, tingling or burning, backache, neckache, fatigue

PSYCHOLOGICAL: Anxiety, suicidal thoughts, mood swings, constant crying, loss of sleep

ENT: Problems with hearing, speech, throat

DENTAL: Use of dentures, partials, swollen gums? Last dental visit?_____

FAMILY HISTORY: Give the following information about your immediate family

Alive or Deceased; Age (or age at death); Health status (or cause of death)

Mother: ☐Alive ☐Deceased Age: _____ Health: _____
Father: ☐Alive ☐Deceased Age: _____ Health: _____

CIRCLE ONE:
Brother/Sister ☐Alive ☐Deceased Age: _____ Health: _____
Brother/Sister ☐Alive ☐Deceased Age: _____ Health: _____
Brother/Sister ☐Alive ☐Deceased Age: _____ Health: _____
Brother/Sister ☐Alive ☐Deceased Age: _____ Health: _____
Brother/Sister ☐Alive ☐Deceased Age: _____ Health: _____
Brother/Sister ☐Alive ☐Deceased Age: _____ Health: _____

Son/Daughter: ☐Alive ☐Deceased Age: _____ Health: _____
Son/Daughter: ☐Alive ☐Deceased Age: _____ Health: _____
Son/Daughter: ☐Alive ☐Deceased Age: _____ Health: _____
Son/Daughter: ☐Alive ☐Deceased Age: _____ Health: _____
Son/Daughter: ☐Alive ☐Deceased Age: _____ Health: _____
Son/Daughter: ☐Alive ☐Deceased Age: _____ Health: _____

SOCIAL HISTORY

Do you have a history of being arrested, on probation, or in legal trouble: _____

Do you smoke ☐Yes ☐No Packs per day/month _____How many years? _____

Do you drink alcohol? ☐Yes ☐No. What type?_____How often?_____How many years?_____

Are you willing to quit smoking AND drinking for the purpose of donation? ☐Yes ☐No

Drug history ☐Yes ☐No. Type of drug used:_____ Shared Needles: ☐Yes ☐No
How long have you been drug free?_____

Have you been in a program for drug or alcohol abuse? ☐Yes ☐No

Do you have tattoos? ☐Yes ☐No. How many? _____ Professional or homemade?_____

PERSONAL HISTORY

Are you a US citizen? ☐Yes ☐No. If no, what is your status?_____

Occupation: _____Level of Education: _____

Are you a Federal or State employee? ☐Yes ☐No

Are you active Military or Reservist? ☐Yes ☐No

Are you willing to lose weight if needed? ☐Yes ☐No

Are you willing to have all testing needed? ☐Yes ☐No

Are you willing to continue a healthy lifestyle (healthy diet, weight control, exercise, and medical care) for the rest of your life after donation: ☐Yes ☐No

Do you have someone who can help you if needed (family or friend) while you recover from surgery? ☐Yes ☐No

Donor testing, surgery and clinic visits are covered by recipient's insurance. Do you understand that travel, time off from work and lodging for family is NOT covered by recipient's insurance? ☐Yes ☐No

Do you give permission for members of the transplant team to discuss the results of compatibility testing with your family members, the recipient, and the recipient's referring physician? ☐Yes ☐No

Why do you want to donate?_____

_____

_____

What questions do you have regarding donation?_____

_____

_____

_____ _____

Signature **Date**