Patient Name:
Date of Birth:

VCU Health
Hume-Lee
Transplant Center

Kidney Transplant Program
1200 East Marshall Street
Gateway Building, 7th floor
P.O. Box 980274
Richmond, VA 23298-0274
O 804.828.4104
F 804.628.0708
www.vcuhealth.org/transplant

Medical History

1) Please provide the name of your primary care doctor (PCP) and their phone number.

_____

2) Have you ever had any heart problems? **If yes, please describe.** Yes No

_____

3) Who is your cardiologist?

_____

4) Do you have diabetes?
Type 1 Type 2 No

5) Have you ever had any liver problems?
Yes No

6) Do you have hepatitis? Yes No

If yes to liver problems/hepatitis, who is your hepatologist or GI doctor?

_____

7) Do you have HIV? **If yes, who is your infectious disease doctor?** Yes No

_____

8) Have you ever had any kind of cancer? **If yes, please specify what kind of cancer, what kind of treatment you had, where you had your treatment, and what year.**

9) Do you have any lung problems? If yes, please describe.
Yes No

_____

10) Do you use oxygen? Yes No

11) Do you have sleep apnea? Yes No

12) Have you ever had a stroke? **If yes, when, and what hospital were you seen at?** Yes No

_____

13) Have you ever had a seizure? Yes No

14) Do you currently have any open wounds, ulcers, or infections? Yes No

15) Do you have any circulation problems? Yes No

16) Have you ever had any amputations? Yes No

Social History

1) Do you use tobacco products? **If yes, what do you use, and how much/how often?** Yes No

_____

2) Do you use alcohol? **If yes, how much/how often?**
Yes No

_____

3) Do you use any recreational drugs? **If yes, what kind, and how often?** Yes No

_____

4) Please list 1 or 2 friends or family members who would help with your care after transplant and who could provide reliable transportation to your appointments when you are unable to drive yourself:

_____

_____

_____

5) Do you have anyone who is interested in donating a kidney to you? (Donors do not have to be related.)
Yes No

Please have the patient complete this questionnaire to be included in the referral. If resources allow, please also have the patient view the Hume-Lee Kidney Transplant Education video.

https://youtu.be/ZQSaBpZFjWY

Education video viewed? Yes No

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Surgical History

Please list any surgeries you have had on your abdomen, where you had surgery, and when.

_____
_____
_____

Procedure History

Please tell us if you have ever had any of the following tests. If you have, please write the year you had the test and where the test was done (which hospital, clinic, or doctor).

Procedure	Year	Location
Echocardiogram		
Stress Test		
Cardiac Catheterization		
Colonoscopy *		
CT Scan of Abdomen & Pelvis		
Pap Smear *		
Mammogram *		

*** Pre-Transplant Cancer Screenings:** These cancer screenings should be a part of your routine health care and will be required as part of your kidney transplant evaluation.

Colonoscopy: All patients, male and female, over 50 years old, within 10 years of kidney transplant evaluation, or more frequently as recommended by your physician.

Pap smear: All females from 21 to 65 years old, within 3 years of kidney transplant evaluation (unless patient has had a hysterectomy with removal of the cervix), or more frequently as recommended by your physician.

Mammogram: All females over 40 years old, within 2 years of kidney transplant evaluation, or more frequently as recommended by your physician.