NEW TRANSPLANT CANDIDATE INFORMATION SHEET
UPMC Pinnacle Transplantation Services
Harrisburg Hospital

Please fill out each page.

Name: _____ Maiden Name:_____

Date of birth: ____________ Sex: _____ Race: _____

Home phone: (___)_____

Cell phone: (___)_____

Email: _____

Address: _____ State: _____ Zip Code: _____

What language do you speak? _____

Do you have a difficulty reading English? _____

Height: _____ft. _____in. Weight: _____lbs.

HISTORY OF PRESENT ILLNESS

How did you find out that your kidneys were failing? _____

_____

What is the cause of your kidney failure? _____

Do you know the year that your kidney problems began? _____

Have you ever had a kidney biopsy? YES / NO

If you answered YES, when and where? _____

DIALYSIS INFORMATION

Are you currently on dialysis? YES / NO

If so, when did you start? ____________

What type of dialysis are you on at this time? (Please circle) Hemodialysis / Peritoneal Dialysis

Name of dialysis unit: _____ Phone: (___)_____

What days do you have dialysis? _____

Any problems with dialysis (if so please explain)?_____

_____

***Have you had any of the following vaccines?** If yes, please include the month/year:

Pneumonia _____ Flu _____ Shingles_____

Hepatitis _____ Any others? _____

Name:_____ Date of Birth:_____

Present kidney doctor: _____

Address: _____

Phone: (___)_____ Fax: (___)_____

Family doctor: _____

Address: _____

Phone: (___)_____ Fax: (___)_____

Please list any additional physicians involved in your care: cardiologist, pulmonologist, gynecologist, dentist, endocrinologist, etc.

Physician: _____

Type of physician _____

Address: _____

Phone: (___)_____ Fax: (___)_____

Physician: _____

Type of physician _____

Address: _____

Phone: (___)_____ Fax: (___)_____

Physician: _____

Type of physician _____

Address: _____

Phone: (___)_____ Fax: (___)_____

Physician: _____

Type of physician _____

Address: _____

Phone: (___)_____ Fax: (___)_____

Physician: _____

Type of physician _____

Address: _____

Phone: (___)_____ Fax: (___)_____

Name:_____ Date of Birth:_____

MEDICAL HISTORY

List **all hospitalization(s)/surgeries** in your lifetime with approximate dates. Please use additional paper as needed. You may need to ask your doctor or dialysis unit for assistance.

Date	Hospital	Reason you were hospitalized?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		

Have you had any of the following tests or procedures?

Test/Procedure	Where was it completed?	Date
Echocardiogram		
Stress Test		
Cardiac Cath		
Colonoscopy		
Prostate Exam (Men >50)		
Mammogram (Women >40)		
GYN/PAP (Women)		

Name:_____ **Date of Birth:**_____

SYSTEM REVIEW AND PAST MEDICAL HISTORY

From the following list, please check any symptoms or conditions that apply to you.

SKIN
- ☐ Rashes, psoriasis or dermatitis
- ☐ History of skin cancer
- ☐ New skin growth or mole

EYES
- ☐ Laser eye surgery
- ☐ Permanent blindness in either eye
- ☐ Cataracts
- ☐ Glaucoma

EARS/NOSE/THROAT
- ☐ Loss of hearing
- ☐ Ringing in the ears
- ☐ Attacks of vertigo
- ☐ Frequent sinus infections
- ☐ Seasonal Allergies
- ☐ Problems with teeth (infections?)

RESPIRATORY
- ☐ Asthma or wheezing
- ☐ Recent bronchitis/pneumonia
- ☐ Cough for over the past 2 months
- ☐ Loud Snoring
- ☐ Sleep apnea
  - Wear C-PAP? ☐ Yes ☐ No
- ☐ Shortness of breath
- ☐ Wear oxygen

HEART & CIRCULATION
- ☐ Heart attack
- ☐ Hypertension (high blood pressure)
- ☐ Heart murmur
- ☐ Chest discomfort (angina) with physical activity
- ☐ Heart failure or fluid on the lungs (CHF)
- ☐ Palpitations, racing or pounding heart beat
- ☐ Blood clot
- ☐ Syncope
- ☐ Aneurysm of any blood vessel
- ☐ Frequent ankle swelling at bedtime
- ☐ Hypotension

NEURO
- ☐ Frequent headaches
- ☐ Migraine headaches
- ☐ Stroke
- ☐ "Mini-strokes" or TIA's
- ☐ Epilepsy or seizures
  - Date of last seizure: _____
- ☐ Neuropathy

STOMACH/INTESTINES
- ☐ Stomach ulcer
- ☐ GERD
- ☐ Hiatal hernia
- ☐ Gallbladder attacks or gallstones
- ☐ Frequent diarrhea
- ☐ Chronic constipation
- ☐ Bright red blood from rectum
- ☐ Dark, tarry stools
- ☐ Crohn's/Colitis/IBS
- ☐ Liver disease or jaundice

ENDOCRINE/METABOLISM
- ☐ Thyroid disorder
- ☐ Thyroid nodule or goiter
- ☐ Recent weight gain or loss (more than 10 lbs.)
- ☐ Diabetes
  - ☐ Type 1 ☐ Type 2

KIDNEYS/URINARY TRACT
- ☐ Kidney stones
- ☐ Kidney infections
- ☐ Pain or burning with urination
- ☐ Trouble starting urinary stream
- ☐ Dribbling or incontinence
- ☐ Multiple trips to the bathroom to urinate at night
- ☐ Bladder infections during past year
- ☐ Blood in urine during past year
- ☐ Prostate disease

MUSCLES/BONES/JOINTS
- ☐ Arthritis or other joint disease
- ☐ Chronic back trouble
- ☐ Bone or joint surgery in past year

PSYCHOLOGICAL
- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar disorder

MISC.
- ☐ Bleeding or bruising tendency
- ☐ Previous blood transfusion
- ☐ History of hepatitis
- ☐ Cancer
  - Please specify: _____

Name:_____ Date of Birth:_____

List current medications (or attach list). Please include all vitamins and dietary supplements.

NAME OF MEDICATION	DOSE	FREQUENCY

List all allergies:

Allergy	Reaction

Name:_____ Date of Birth:_____

SOCIAL HISTORY

Marital status: Single Married Divorced Separated Widowed

Your present employer_____ Title_____

Employer Address _____

Length of employment_____

Who lives with you in your home? _____

How active are you in your daily life? _____

How do you see your present state of health? _____

Have you or do you currently use any of the following?

Cigarettes? YES / NO

Vaping? YES / NO

Smokeless Tobacco? YES / NO

If you answered "yes" to any of the above please answer the following:

For how long _____ Amount? _____ How often? _____

Date you quit (if applicable): _____

Have you ever used alcohol? _____ (usage does not exclude you from the program)

What kind? _____ Amount? _____ How often? _____

Date you quit (if applicable): _____

Have you ever used illegal drugs? _____ (usage does not exclude you from the program)

What kind? _____ Amount _____ How often? _____

Date you quit (if applicable): _____

Have you ever had mental health or addictions counseling? YES / NO

Have you ever attended drug or alcohol rehab? YES / NO

Has anyone assisted you in filling out this form? YES / NO If yes, who? _____

Why? _____

Name:_____ Date of Birth:_____

POTENTIAL DONORS

Have you approached anyone for possible living kidney donation? _____

If so, who? _____

If not, please give reason_____

FAMILY HISTORY

Relationship	Male or Female	Alive or Deceased	Current Age or Age Deceased	Health issues or cause of death (ex. Diabetes, stroke, high blood pressure, cancer, kidney disease)
Mother's Name:				
Father's Name:				
Brothers/Sisters' Names:				
Children's Name:				
Spouse's Name:				