



**Lutheran
Health Network**
Lutheran Hospital

Kidney Transplant Living Donor Demographic Information/Health History

Date of first contact: _____ Referral type: Phone / Recipient / Self

Name: _____ Age/DOB _____ Blood type _____

SS# _____ Phone (work / cell) _____

Address: _____

E-mail address: _____

Recipient: _____ Relationship: _____

Height: _____ Weight: _____ BMI: _____ Race: _____

SCREENING HISTORY	NOTES/DATES
Diabetes Family history of diabetes Gestational diabetes	
Hypertension Family history of hypertension	
Kidney stones	
Kidney/bladder problems	
Family history of kidney disease	
Bleeding/clotting disorders	
Hospitalizations/surgeries	

History of MRSA infection	
Pregnancies	
Cancer Family history of cancer	
Smoking Packs per day	
Alcohol use/drug use & frequency	
Colonoscopy Performing physician/hospital & date completed	
Gynecology: Pap/pelvic - Mammogram – Performing physician/hospital & date completed	
Risk factors/concerns:	

Allergies: _____

Medications: _____

Family physician/location: _____