Abbott Northwestern Hospital Kidney Transplant Program
Initial Interview Packet

Date: ______________________

Personal Information:

Recipient Name: ______________________

Preferred Name: ______________________

Name of Person Completing Form: ______________________

Relationship to Patient: ______________________

Address: ______________________

____

Phone: (H) ______________________ (Cell) ______________________

(W) ______________________ (Other) ______________________

Social Security Number: ______________________

Date of Birth/Age: ______________________

Marital Status: ______________________

Height: ______________________ Weight: ______________________

Are you a U.S. Citizen: ______________________

If not, what is your immigration status: ______________________

Physician/Dialysis Information:

Kidney Doctor: ______________________

Cause of kidney disease: ______________________

Type of Dialysis: Hemo ☐ Peritoneal ☐

Home Hemo ☐ Not on dialysis ☐

Dialysis Unit: ______________________

Dialysis Days/Time: ______________________

Past Medical History:

Please indicate if you have had any of the following by checking "yes" or "no". If you answer "yes" please provide details of when and where so we may get additional records if needed.

	YES	*NO*
Stroke	☐	☐
Seizure	☐	☐
Mental Illness	☐	☐
Counseling	☐	☐

Additional information: ______________________________

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Cancer	☐	☐

Additional Information: ______________________________

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Heart attack	☐	☐
Chest pain	☐	☐
Calf pain	☐	☐
Heart or blood vessel surgery	☐	☐
Heart stress test	☐	☐
Angiogram	☐	☐
Lung disease	☐	☐

Additional Information: ______________________________

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	YES	***NO***
Liver disease	☐	☐
Ulcer	☐	☐
Gastrointestinal disorder	☐	☐
Blood in stool	☐	☐
Urinary tract infections	☐	☐

Additional information: ______________________________

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Diabetes	☐	☐
Type (circle one)	**I**	**II**

Year of diagnosis: ______________________________

Blood transfusions	☐	☐
Would you accept blood transfusion if needed?	☐	☐
Pregnancies	☐	☐

If yes, how many? ____________________

Allergies to medications	☐	☐

If yes, please list medication(s) and reaction(s) __________

____

____

____

____

Routine Screens

Please indicate if you are up-to-date with the following routine health screens.

	YES	NO
Colonoscopy (>50)	☐	☐
PSA (men >50)	☐	☐
Mammogram (women >40)	☐	☐
Pap/pelvic (women)	☐	☐

Additional information: ____

____

Vaccinations

	WHEN	WHERE
Pneumonia	________	____________________
Hepatitis B series	________	____________________
Influenza	________	____________________
Tdap	________	____________________
Skin test for tuberculosis	________	____________________

Current Medications

You may include a current medication list instead of writing all medications.

Name	Dose	Times Per Day

Social History

	YES	*NO*
Do you smoke	☐	☐
Have you ever smoked	☐	☐
Smokeless tobacco use	☐	☐
Alcohol	☐	☐

Amount per week: ______________________________

	YES	*NO*
Illegal drug use	☐	☐
Chemical dependency treatment	☐	☐

When/where: ______________________________

How do you prefer to learn new information:

Listening	☐	Disucssion	☐
Reading	☐	Demonstration	☐
Visual	☐	Other	☐

What language do you speak at home? ____________________

If not English, do you speak English? ____________________

Hospitalizations

Date	*Hospital*	*Reason*

Doctors

Specialty	*Name*	*Phone Number*
Family Doctor	______________________	______________________
Cardiologist	______________________	______________________
OB / GYN	______________________	______________________
Psychiatric	______________________	______________________
Endocrinologist	______________________	______________________
Gastrointestinal	______________________	______________________
Urologist	______________________	______________________
Other	______________________	______________________
Other	______________________	______________________
Other	______________________	______________________

Thank you for taking the time to complete this form. Please mail back along with the signed "Release of Information" form that was included in your packet. If you have any questions about this form, please call the Transplant Office at 612-863-5638 and a coordinator will assist you.

Abbott Northwestern Hospital
Kidney Transplant Candidate
Infection History Questionaire

Name: ______________________________
Date: ______________________________

To keep your body from rejecting a transplanted kidney, you must take medicines to suppress your body's immune response. These "immunosuppressant" medications also decrease our ability to fight infection. You can develop new infections or you can have recurrences of infetions you have had in the past.

The following questions will help determine your past history of infection and your potential exposures to infections (if you have had contact with known infections, or if you have traveled to specifice areas of the world). If you have a high risk for a specific infection, additional blood tests may be needed during your transplant evaluation.

History of Infection:
Please indicate if you have had any of the following. If "yes" please provide date of infection or age at which you had the infection.

YES	NO		
________	________	Tuberculosis	______________________
________	________	Hepatitis	______________________
________	________	HIV / AIDS	______________________
________	________	Chicken pox	______________________
________	________	"Red" measles	______________________
________	________	German measles	______________________
________	________	Cold sores	______________________
________	________	Genital herpes	______________________
________	________	Chronic infections (skin, cellulits, open wounds, ulcers, urinary tract infections etc)	

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Name: ______________________________

Date: ______________________________

Potential Exposures to Infection:

Please indicate if you have had close contact with any of the following. If yes, plese list date of the exposure or possible exposure or your age at the time. Please provide details about the exposure or potential exposure.

YES	NO	
________	________	Person(s) with tuberculosis ______________________
________	________	Sexual or intimate or blood contact with individual(s) at risk for exxposure to HIV/AIDS, hepatitis (intravenous drug users/abusers, multiple sexual partners) ______________________ ______________________

Exposure to geographic areas associated with specific infections (place of birth, place of residence, or military service). If "yes" please circle area where exposure or potential exposure occurred.

YES	NO	
________	________	Arizona, New Mexico, Southern California, Southwest Texas, Northern Mexico (infection: Valley Fever) ______________________
________	________	Tropical areas (infection: Strongyloides) ______________________
________	________	Appalachia, Southeastern United States, Europe, Australia, Japan (infection: strongyloides) ______________________
________	________	Brazil, Argentina, Venezuela, Bolivia, Chile, Nicaragua, Mexico, El Salvador (infection: T. Cruzi) ______________________