TRANSPLANT CENTER | THE QUEEN'S MEDICAL CENTER

Patient Health Questionnaire for Kidney/Pancreas Transplant Evaluation

Legal Name (Last): _____ (First):_____ (Middle Initial): _____

Date of Birth: _____ Race/Ethnicity: _____

Primary Language: _____ Language preference: _____

Mailing Address: _____ City/State/Zip: _____

Physical Address (if applicable):_____ City/State/Zip: _____

E-mail: _____ Do you have access to the internet? ☐ Yes ☐ No

Cell phone: _____ Best time to reach you at this number: _____

Home Phone: _____ Best time to reach you at this number: _____

Work phone: _____ Best time to reach you at this number: _____

Please check box for the best way to contact you: ☐ Phone ☐ Mail ☐ E-mail

Emergency Contact Person: _____ Phone: _____Relationship: _____

Citizenship: ☐ US ☐ Non-US Resident, If so what is your country of citizenship?_____

Currently working: ☐ Full Time ☐ Part-time ☐ Retired or Not Working Employer: _____

Please check box if you have any of these special needs:

☐ Wheelchair ☐Cane/Walker ☐ Oxygen use ☐ Visual impairment ☐ Hearing impairment ☐Other: _____

Do you have anyone willing to donate a kidney to you? ☐ Yes ☐ No

Blood Type: ☐ Unknown ☐ A ☐ B ☐ O ☐ AB.

HEALTH CARE PROVIDER INFORMATION

Please give full names of your doctors, their phone number, and last month and year that you saw them.

Specialty	Provider Name	Phone Number	Month/Year Last Seen
Primary Care Physician (PCP)			
Nephrologist (kidney doctor)			
Dentist			
Endocrinologist (Diabetes specialist)			
Cardiologist (Heart doctor)			
OB/GYN (Women's Specialist)			
Other:			
Other:			
Other:			

Have you ever been hospitalized? ☐ Yes ☐ No

If YES, please list medical facility where you were hospitalized, date hospitalized, and reason for hospitalization.

Medical Facility/Hospital	Date hospitalized	Reason for hospitalization

If you have had any surgeries, please state the date of surgery, and where the surgery was done.

Type of Surgery	Date of Surgery	Medical Facility where surgery was done
Transplant ☐ Yes ☐ No		Type of transplant:
Heart Surgery ☐ Yes ☐ No		
Cardiac stent placement ☐ Yes ☐ No		
Other surgery:		
Other surgery:		
Other surgery :		

MEDICAL HISTORY

Please check "Yes" or "No" if you had any of the problems listed below. If yes, state year diagnosed & treatment received.

Problem List	Yes or No	Year Diagnosed	Treatment Received
Breathing Problems	☐ Yes ☐ No		
Obstructive Sleep apnea	☐ Yes ☐ No		
COPD (Ex: Emphysema)	☐ Yes ☐ No		
Chest Pain	☐ Yes ☐ No		
Heart Disease	☐ Yes ☐ No		
Heart attack	☐ Yes ☐ No		
Stomach or bowel problems	☐ Yes ☐ No		
Cancer	☐ Yes ☐ No		Type of Cancer:
Hepatitis or liver problems	☐ Yes ☐ No		
High Blood Pressure	☐ Yes ☐ No		
Diabetes Type 1	☐ Yes ☐ No		
Diabetes Type 2	☐ Yes ☐ No		
Stroke	☐ Yes ☐ No		
Bleeding disorder	☐ Yes ☐ No		
Neuro or brain problems	☐ Yes ☐ No		
Thyroid problems	☐ Yes ☐ No		
Psychiatric (Ex: anxiety, depression)	☐ Yes ☐ No		
Tuberculosis (TB)	☐ Yes ☐ No		If Yes, where was treatment received:
Positive TB Test	☐ Yes ☐ No		

Date of last TB Test: _____

Check the box if currently using any of the following: ☐ Tobacco/Nicotine ☐ Marijuana ☐ Illegal Drugs

For females only: Date of Last Pap Smear: _____ Date of Last Mammogram: _____

Ever had a colonoscopy? ☐ Yes ☐ No. If YES, date completed: _____ Where completed: _____

If on dialysis, have you missed dialysis treatment(s)? ☐ Yes ☐ No. If YES, explain:_____

_____ _____

Name of Patient Patient's Legal Representative

_____ _____

Signature of Patient / Legal Representative Date & Time

_____

Authority of Legal Representative