Legacy Transplant Services
1130 NW 22nd Ave. Suite 400, Portland, OR 97210
Phone: 503-413-6555 Fax: 503-413-6557

Last Name	Legal First Name	Middle Name

Address	City	State	Zip

Mailing address (if different from above)	City	State	Zip

Home Phone	Cell Phone	Work Phone
( )	( )	( )

Social Security Number	Email Address
- -	

Sex	
☐ Male ☐ Other____________ ☐ Female	Date of Birth: ______/_______/_____ Country of birth:_____________ Month Day Year

Marital Status: ☐Single ☐Married ☐Divorced ☐Widow ☐ Separated ☐Living with significant other

Who will be your care partner in the transplant process? (please see "What is a Care Partner" enclosed)

Name:____ Phone: ( )

Do you have a medical case manager? Name:_________________________ Phone: ( )

Do you have a religion you would like listed in your record, if yes, specify____________________________

Race/Ethnicity (***Check all that apply)***

☐White ☐Asian American ☐African American ☐Alaska Native ☐American Indian ☐Pacific Islander

☐Other ☐Hispanic ☐Non-Hispanic

Do you need an interpreter? ☐Yes ☐No If yes, specify language?__________________________

Who is completing this form: ☐Patient ☐ Patient, with assistance ☐ Other person:________________

Occupation: **Employer:**	**Work**: ☐Full Time ☐ Part Time ☐ Retired ☐ Self Employed ☐ Homemaker ☐ Student ☐ Disabled ☐ Unemployed

Insurance Information

PRIMARY Insurance Name		**SECONDARY** Insurance Name	
Group Number	I.D. Number	Group Number	I.D. Number
☐ Medicare ☐ Medicare Advantage Plan ☐ Medicare Supplement ☐ Employer insurance ☐ Cobra ☐ Individual Plan ☐Not sure		☐ Medicare ☐ Medicare Advantage Plan ☐ Medicare Supplement ☐ Employer insurance ☐ Cobra ☐ Individual Plan ☐Not sure	

Prescription Drug Coverage: ☐ Not sure ☐ Employer insurance ☐ Medicare ☐ Individual Plan

Name: ____ Date of Birth:______________

Why did your kidneys fail?		
Were you seen anywhere else for a transplant?	Where?	When?
Are you listed for a transplant anywhere else? ☐Yes ☐No	Where?	When?
Have you had a kidney transplant before? ☐Yes ☐No ☐Left side ☐right side	Where?	When?
Are you on dialysis? ☐Yes ☐No ☐ Hemodialysis ☐Peritoneal dialysis ☐ Home hemodialysis	When did you start?	Hemodialysis unit
Why do you want a transplant?	Do you have a potential living donor? ☐Yes ☐No ☐ Don't know	

Substance Use:

Cigarette smoking or Tobacco use (please circle)

History of use: ☐ Yes ☐ No Quit date? ___________

Current use: ☐ Yes ☐ No ☐ Currently using e-cigarette

If Yes, how many years total have you smoked?___ How many cigarettes per day?_____

If still using, are you ready to quit? ☐ Yes ☐ No

Drug use (marijuana, cocaine, amphetamines, any medications that weren't prescribed to you, etc.)?

Current use: ☐ Yes ☐ No

History of use: ☐ Yes ☐ No Quit date? ___________

Drugs used: ____

Do you use medical marijuana ☐ Yes ☐ No

Do you drink alcohol ☐ Yes ☐ No	Wine: ______glasses/week
Beer: _____________cans/week	Liquor: _____shots/week

Weight: _______ lbs	Height: _______ ft _____ in
In the past 6 months, have you used a: ☐ cane ☐ wheelchair ☐ scooter	
Can you walk up a flight of stairs ☐Yes ☐No	Can you walk half a mile ☐Yes ☐No

Name: ____ Date of Birth:______________

Have you had, or been told you had, any of the following medical conditions?

		If yes, please give dates/details
Anemia	☐ Yes	
Arthritis	☐ Yes	
Blood Transfusions	☐ Yes	
Heart condition a. Heart attack or MI (myocardial infarction) b. Angina or chest pains c. Congestive heart failure d. Heart murmur	 ☐ Yes ☐ Yes ☐ Yes ☐ Yes	
Blood clot in legs	☐ Yes	
Blood clot in lungs	☐ Yes	
High Blood Pressure	☐ Yes	
Have you ever had a heart stent?	☐ Yes	
Sleep Apnea	☐ Yes	
Do you use CPAP	☐ Yes	
Lung problems a. Asthma b. Recent Pneumonia c. COPD d. Emphysema	 ☐ Yes ☐ Yes ☐ Yes ☐ Yes	
Heartburn or reflux (GERD)	☐ Yes	
Gout	☐ Yes	
Headaches	☐ Yes	
Hearing Loss	☐ Yes	
Meningitis	☐ Yes	
Hernia (write in type)	☐ Yes	
Urinary problems a. Kidney stones b. Infections c. Leakage of urine	 ☐ Yes ☐ Yes ☐ Yes	
Prostate Problems	☐ Yes	
Diabetes Do you use insulin?	☐ Yes ☐ Yes	
Stroke	☐ Yes	
TIA (Transient Ischemic Attack)	☐ Yes	
Hepatitis (write in type of hepatitis)	☐ Yes	
Cancer (write in type of Cancer)	☐ Yes	
Sexually transmitted disease	☐ Yes	
Seizures	☐ Yes	
Shingles	☐ Yes	
Thyroid Disease (write in type of disease)	☐ Yes	
Tuberculosis	☐ Yes	
Ulcers a. Skin b. Stomach	 ☐ Yes ☐ Yes	
Osteoporosis	☐ Yes	

Name: ____ Date of Birth:______________

Surgeries: Please list all surgeries you have had.

	Year (ok to estimate)
1.	
2.	
3.	
4.	
5.	
6.	
7.	

Have you ever had problems with anesthesia ☐Yes ☐No

If yes: explain

Medications: Please list all prescription, over the counter medications, vitamins and supplements you are taking.

Name of drug	Dosage/strength/mg	When do you take it (for example: am, pm, am and pm, meals)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

Allergies: Please list any medication allergies you have.

Name of medicine	Type of reaction (for example: rash, stomach upset, swelling)
1.	
2.	
3.	

Please list any additional allergies (e.g. food, animals, etc)

____

____

Name: ____ Date of Birth:______________

Immunization History

Vaccination	Date received	Facility where received
Flu		
Prevnar 13		
Tetanus TDAP		
Hepatitis A		
Hepatitis B		
HPV		
MMR		
Zostavax		

The vaccines listed above are required for transplant. You can receive the vaccines at dialysis, your local pharmacy or doctor's office.

Health Maintenance History

Test	N/A	When (ok to estimate)	Where
Last Colonoscopy			
Last Pap-smear			
Last Mammogram			

Pregnancy history

How many times have you been pregnant? _____________ How many live births? ____________

Doctors: Please provide full name of any doctor you have seen in the last 5 years

Primary Care:	City:	Office Phone ( )
Nephrologist (kidney doctor):	City:	Office Phone ( )
Cardiology (Heart doctor):	City:	Office Phone ( )
Others:	City:	Office Phone ( )
Others:	City:	Office Phone ( )
Others:	City:	Office Phone ( )
Others:	City:	Office Phone ( )

Remember to attach a copy of your insurance card (front & back) to this form*