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

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| http://mylegacy.lhs.org/Administrative/Marketing/Resources/Documents/lh_logo_small_rgb.jpg | | |  | | |
| 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 | | |

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| 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 | | | | |

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| 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 | |

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| **Family history** |  |  |
| Did anyone in your family have  Diabetes Yes No Heart disease Yes No  Cancer Yes No Kidney disease? Yes No | | |

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| **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 |

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| --- | --- | --- | --- | --- | --- | --- | --- |
| 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 | | | | | |
| **Have you had, or been told you had, any of the following medical conditions?**   |  |  |  | | --- | --- | --- | |  |  | If yes, please give dates/details | | Anemia |  Yes |  | | Arthritis |  Yes |  | | Bleeding problems |  Yes |  | | Blood Transfusions |  Yes |  | | Heart condition   1. Heart attack or MI (myocardial infarction) 2. Angina or chest pains 3. Congestive heart failure 4. 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/BiPAP |  Yes |  | | Lung problems such as Asthma, recent Pneumonia, COPD or emphysema |  Yes |  | | Heartburn or reflux (GERD) |  Yes |  | | Gout |  Yes |  | | Headaches |  Yes |  | | Hearing Loss |  Yes |  | | Meningitis |  Yes |  | | Colon or Intestinal problems |  Yes |  | | Hernia (write in type) |  Yes |  | | Urinary problems such as kidney stones, infections, leakage of urine |  Yes |  | | Prostate Problems |  Yes |  | | Diabetes  Do you use insulin? |  Yes   Yes |  | | Stroke or TIA (Transient Ischemic Attack) |  Yes |  | | Hepatitis/Liver problems |  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 (skin or stomach) |  Yes |  | | Osteoporosis |  Yes |  | | | | | | | | | | | |
| 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.

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| 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)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Immunization History

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| --- | --- | --- |
| 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

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

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| **Pregnancy history** |  |  |
| How many times have you been pregnant? \_\_\_\_\_\_\_\_\_\_\_\_ How many live births? \_\_\_\_\_\_\_\_\_\_\_ | | |

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| 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\*\*\***