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