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| Legacy Transplant Services1130 NW 22nd Ave. Suite 400, Portland, OR 97210Phone: 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 |

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

|  |  |  |
| --- | --- | --- |
| **Family history** |  |  |
| Did anyone in your family have Diabetes [ ] Yes [ ] No Heart disease [ ] Yes [ ] NoCancer [ ] 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  **[ ]** NoDrug 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 |
| **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 condition1. 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 [ ] NoIf 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)

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

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? \_\_\_\_\_\_\_\_\_\_\_ |

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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\*\*\***