

Please complete the information below to the best of your ability.

Name: _____

Age: _____

Primary Physician: _____

Other physicians involved in your care: _____

Past Medical History:

Major Illness: Check the diseases that you have had or currently have, and the approximate date you were diagnosed:

- _____ Kidney disease _____
- _____ Liver disease _____
- _____ Lung disease _____
- _____ High blood pressure _____
- _____ Heart disease _____
- _____ Diabetes _____
- _____ Thyroid disease _____
- _____ Autoimmune disease (arthritis, multiple sclerosis) _____
- _____ Cancer (if yes, what type) _____ / _____

Surgeries:

<u>Type of Surgery</u>	<u>Date</u>
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Current Medications (prescribed and over-the-counter including herbal supplements):

<u>Name</u>	<u>Dose</u>	<u>How long have you been taking this medication?</u>
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Allergies (food and/or medications): _____

Vaccinations: (information required for all transplant patients and donors)

(check the vaccinations that you have received since childhood and approximate date of last vaccination)

- _____ Small pox _____
- _____ Polio _____
- _____ Mumps _____
- _____ Measles _____
- _____ Rubella _____
- _____ Varicella Zoster _____
- _____ Hepatitis series _____
- _____ Tetanus _____

Last date of TB test _____ Result: Positive or Negative (circle one)

Last date of diptheria test _____ Result: Positive or Negative (circle one)

Blood Transfusion History:

Have you ever received a blood transfusion? Yes No (circle one)

If yes, please give approximate date of transfusion(s) and number of units of blood you received:



1000 East 21st Street, Suite 1200
Sioux Falls, SD 57105-1080
(605) 322-3035
Fax (605) 322-3036

Dental History:

Do you see a dentist regularly? Yes No (circle one)

When was your last dental exam? _____

Name and Phone # of your dentist: _____

Marital Status:

- _____ Married
- _____ Divorced
- _____ Single
- _____ Widowed

For Females:

Number of pregnancies: _____

Number of children: _____

Employment:

Current occupation: _____

If retired, previous occupation: _____

Do you have exposure in your current or previous occupations to:

- _____ Radiation
- _____ Asbestos
- _____ Agent Orange
- _____ Chemotherapy

Alcohol Use:

_____ None

Number of drinks per week: _____

Smoking:

_____ None

_____ Recently quit: date quit: _____

How many cigarettes per day: _____

For how many years: _____

Travel History:

Have you traveled outside the country? Yes No (circle one)

If yes, where and when



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Family History:

Mother's health:

_____ Alive with no health problems

_____ Alive with health problems. Please indicate the health problems:

_____ Deceased at age _____ from _____

Father's health:

_____ Alive with no health problems

_____ Alive with health problems. Please indicate the health problems:

_____ Deceased at age _____ from _____

Brother's health:

_____ Number of alive brothers with no health problems: _____.

_____ Number of alive brothers with health problems: _____. Please indicate the health problems:

_____ Number of deceased brothers _____ at age(s) _____
from _____

Sister's health:

_____ Number of alive sisters with no health problems: _____.

_____ Number of alive sisters with health problems: _____. Please indicate the health problems:

_____ Number of deceased sisters _____ at age(s) _____
from _____

Children's health:

_____ Number of alive children with no health problems: _____.

_____ Number of alive children with health problems: _____. Please indicate the health problems:

_____ Number of deceased children _____ at age(s) _____
from _____

Only check the boxes of which you are having symptoms.

CONSTITUTIONAL

- fever
- chills
- facial flushing
- weight loss
- night sweats
- fatigue
- sweating

EYES

- pain
- double vision
- color blindness
- vision difficulty
- glaucoma
- macular degeneration
- redness
- cataracts

EARS

- hearing problems
- excessive wax
- ringing in the ears
- pain
- recurrent infection
- drainage

NOSE

- runny nose
- difficulty with breathing through nose
- bloody nose
- nasal congestion

MOUTH

- loss of taste
- recurrent ulcers
- excessive salivation
- soreness
- dental problems
- lesions
- dryness

THROAT

- difficulty with speech
- painful swallowing
- soreness

CARDIOVASCULAR

- chest pain
- swollen ankles
- palpitations
- varicose veins
- passing-out spells
- shortness of breath while lying on back or awakening middle of night gasping for breath
- temporary numbness or weakness in arm or leg
- pain in legs with walking a certain distance

RESPIRATORY

- cough
- coughing up blood
- asthma
- wheezing
- history of bronchitis
- history of tuberculosis
- pain in chest on deep breathing
- history of pneumonia
- shortness of breath

GASTROINTESTINAL

- decreased appetite
- nausea
- history of ulcers
- vomiting blood
- abdominal pain
- rectal bleeding
- hemorrhoids
- very light-colored stool
- difficulty swallowing
- vomiting
- stomach burning
- diarrhea
- constipation
- dark stools
- history of jaundice (yellow skin)

GENITOURINARY

- painful urination
- blood in urine
- inability to urinate
- history of kidney stones
- inability to control urination
- urination at night
- pain with urination
- change in color of urine

FEMALE

- vaginal bleeding
- breast tenderness
- swelling
- pregnancy
- discharge
- lumps

MALE

- impotence

MUSCULOSKELETAL

- arm pains
- joint pains
- swelling
- stiffness
- dislocations
- leg pains
- painful walking
- muscle soreness
- muscle weakening
- history of fractures

SKIN

- rashes
- ulcers
- itchiness
- lesions
- hair loss
- dryness
- acne
- abnormal nails such as ridging or discoloration

NEUROLOGIC

- history of seizures
- double vision
- difficulty with: vision taste touch memory smell
- tingling sensation in hands or feet
- headaches
- weakness on one side of the body or the other

PSYCHIATRIC

- history of anxiety
- inability to sleep
- hyperirritability
- increased motor activity
- depression
- over talkativeness
- schizophrenia (severe emotional disorders)

ENDOCRINE

- deepening voice
- weight gain or loss
- palpitations
- urinating frequently
- hoarseness
- thyroid disease
- hot flashes
- cold intolerance

HEMATOLOGIC

- history of blood transfusions
- bleeding
- bruising easily
- fatigue

IMMUNOLOGIC

- history of allergies to drugs
- allergies to latex
- hives
- hay fever
- allergies to iodine
- history of allergy to shots

Signature Patient/Representative

Date