The Johns Hopkins Hospital
Liver Transplant Office
600 N. Wolfe Street /Blalock 242
Baltimore, Maryland 21287
410-614-2989 T
410-614-8741 F
www.hopkinsmedicine.org/transplant

JOHNS HOPKINS
MEDICINE
THE JOHNS HOPKINS HOSPITAL

Living Donor Liver Transplantation Candidate Profile

Welcome to the Living Donor Liver Transplant Program at The Johns Hopkins Comprehensive Transplant Center. We understand that the decision to become a live liver donor is a major one. Your safety and well being throughout the donation process are paramount in our program. As such, it is essential that your evaluation is thorough and that we have all pertinent past medical and current medical history on all our potential donors. Below is an initial candidate profile and medical questionnaire. The information obtained will be confidential and part of your medical record here at Johns Hopkins.

Demographic Information

Name: ____ Date ____/____/20____

Date of Birth: ________________ Social Security Number: ________-_______-______

Address: ____

____

City: ______________________ State: __________________ Zip Code: __________________

Phone Number: (Home) ______________________________

(Cell) ______________________________

(Work) ____________________________

What is the best way to contact you? ______________

E-mail address: ____

Emergency Contact (Name, Number, Relationship) __________________________________

Who are you interested in donating to?

____

What is your relationship to this person?

____

Employment & Family Information

Employment status: Employed ____ Retired ____ Unemployed ______ Other ______
Current Occupation: _________________________
Previous Occupation: __________________

Are you able to take 6 to 8 weeks off of work? Yes ______ No_____

Level of education: Elementary ____ High school ____ College____ Graduate school_____

Marital Status: Single _____ Married_____ Divorced____ Widowed_____
Domestic Partnership____

Do you have any children? Yes _____ No _____ Age (s)___________________________

Are you a caregiver for any other dependent person? Yes _____ No _____

Are you the only wage earner in your family? Yes_____ No _____

Who lives with you? _________________ If sick, who would help you? __________________

Have you discussed your decision with your family? Yes_____ No _____
Have they agreed with your decision? Yes _____ No_____
Are you under any pressure to donate? Yes_____ No_____

Why do you wish to donate?

____

____

____

____

____

Medical Questionnaire

Primary Care/Family Physician:

Name: ____

Address:____
____

Phone:____

Other physicians you would like to receive copies of your evaluation:

Name: ___________________________

Address: ___________________________
____

Specialty **:** _________________________

Name: ___________________________

Address: ___________________________
____

Specialty **:** _________________________

Past Medical History:

Have you had any of the following? Please check if YES:

- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Disorders
- ☐ Back Trouble
- ☐ Bladder Infections
- ☐ Bleeding Disorders
- ☐ Blood Transfusion
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy or Seizures
- ☐ Glaucoma
- ☐ Heart Disease/ Chest Pain/ Angina
- ☐ Hemorrhoids
- ☐ Hepatitis A, B or C
- ☐ Hernia
- ☐ High Cholesterol
- ☐ High or Low Blood Pressure
- ☐ HIV or AIDS
- ☐ Hives or Eczema
- ☐ Infectious Mono
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Mitral Valve Prolapse
- ☐ Mumps
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers or Reflux
- ☐ Whooping Cough
- ☐ Blood Clots

Do you have any other medical problems not listed above?

____
____
____
____

Have you had any surgeries? If so please list with an approximate date.

1. ____________________________________
2. ____________________________________
3. ____________________________________
4. ____________________________________
5. ____________________________________
6. ____________________________________

CURRENT MEDICATIONS: (including herbs, vitamins and 'over the counter')

Medication	Strength (mg)	Dose (#/day)

ALLERGIES: Are you allergic to anything? Please check if yes:

What are you allergic to?	**What reaction do you have?**
Shellfish / Iodine / Dye	
Penicillin	
Other:	
Other:	

Health Maintenance:

Weight: Current: _______ pound Lowest weight: _______ pounds Highest weight: _______ pounds

Height: _____ft _____ inches Blood Type (If Known):___________

Have you ever had any of the following tests? If so, please check if YES:

- ☐ CT scan When? _____________
- ☐ Ultrasound When? _____________
- ☐ MRI When? _____________

- ☐ Colonoscopy When? _____________
- ☐ Cholesterol When? _____________
- ☐ PSA When? _____________
- ☐ Pap When? _____________
- ☐ Mammogram When? _____________
- ☐ Chest X-ray When? _____________
- ☐ Echocardiogram When? _____________
- ☐ Cardiac Stress test When? _____________

Check if you have been vaccinated for:

- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Pneumovax (pneumonia)
- ☐ Flu shot (for this season)

Do you exercise regularly? Yes_______ No__________
Type:________________________________

Women Only:

How many times have you been pregnant? ______ # of children ______
Date of last menstrual period? _____/_____/_____ Irregular periods? ___Yes ___No
Are you using birth control pills? ______

Family History:

Family Member	Age (if living)	Health / Illnesses	Age (at death) & Cause
Father			
Mother			
Sister / Brother			
Sister / Brother			
Sister / Brother			
Sister / Brother			
Sister / Brother			
Son / Daughter			
Son / Daughter			
Son / Daughter			
Son / Daughter			
Mother's Mother			
Mother's Father			
Father's Mother			
Father's Father			

Has any blood relative had any of the following? If so, please provide relationship:

- ☐ Cancer:
  - Breast
  - Colon
  - Ovary / Uterus
  - Other: _______________
- ☐ Epilepsy
- ☐ Migraine
- ☐ Mental illness
- ☐ Alcohol or drug abuse
- ☐ Stroke/ TIA
- ☐ High blood pressure
- ☐ High cholesterol/triglycerides
- ☐ Heart disease
- ☐ Heart attack
- ☐ Diabetes
- ☐ Ulcer (duodenal or gastric)
- ☐ Arthritis
- ☐ Crohn's disease
- ☐ Ulcerative Colitis
- ☐ Irritable bowel syndrome
- ☐ Liver disease
- ☐ Kidney disease
- ☐ Lung disease
- ☐ Genetic disorder
- ☐ Goiter
- ☐ Blood clots

Alcohol and Drug History

Substance	Ever Used?	Current Use?	Amount per day / week	# Years Used	If Stopped, When?
Tobacco	Y N	Y N			
Street drugs	Y N	Y N			
Injected drugs	Y N	Y N			
Alcohol	Y N	Y N			

Other Pertinent Social History:

Have you ever been seen by a mental health counselor or psychiatrist? Yes _____ No_____

Over the past 12 months have you:

Had contact with persons with hepatitis? ____Yes ____ No
Had unprotected sex? ____Yes ____No
Unexplained flu-like symptoms, cough, cold, swollen lymph nodes, night sweats, fever or significant weight loss? ___Yes ____No

Have you had any of the following:

Tattoos	Yes	No
Body Piercings	Yes	No
Acupuncture	Yes	No
Needle Stick Injury	Yes	No
Traveled outside the US	Yes	No

REVIEW OF SYSTEMS:

Do you CURRENTLY have any of the following? Please check if YES:

Constitutional Symptoms:
- ☐ General good health
- ☐ Recent weight changes
- ☐ Fever
- ☐ Fatigue
- ☐ Headaches

Eyes
- ☐ Eye disease or injury
- ☐ Wear glasses or contacts
- ☐ Blurred or double vision

Ears/Nose/Mouth/Throat
- ☐ Hearing loss
- ☐ Ringing in ears
- ☐ Earaches
- ☐ Chronic sinus problems
- ☐ Rhinitis
- ☐ Nose bleeds
- ☐ Bleeding gums
- ☐ Bad breath or bad taste
- ☐ Sore throat or voice change
- ☐ Swollen glands in neck

Cardiovascular
- ☐ Heart Trouble
- ☐ Chest Pain or angina
- ☐ Palpitations
- ☐ Shortness of breath
- ☐ Swelling of feet, ankles, hands

Respiratory
- ☐ Chronic or frequent cough
- ☐ Spitting up blood
- ☐ Wheezing

Gastrointestinal
- ☐ Loss of appetite
- ☐ Change in bowel movements
- ☐ Nausea or vomiting
- ☐ Frequent diarrhea
- ☐ Abdominal pain

Genitourinary
- ☐ Frequent urination
- ☐ Burning or painful urination
- ☐ Blood in urine

Musculoskeletal
- ☐ Joint pain
- ☐ Joint stiffness
- ☐ Weakness of muscles
- ☐ Muscle pain or cramps
- ☐ Back pain
- ☐ Cold extremities
- ☐ Difficulty walking

Integumentary
- ☐ Rash or itching
- ☐ Change in skin color
- ☐ Change in hair or nails
- ☐ Varicose veins
- ☐ Breast pain
- ☐ Breast lumps

Neurological
- ☐ Frequent or recurrent headaches
- ☐ Dizziness
- ☐ Numbness or tingling
- ☐ Tremors
- ☐ Head injury

Endocrine	Hematologic/Lymphatic	Psychiatric
	☐ Incontinence ☐ Sexual difficulty	
Endocrine ☐ Glandular or hormone problem ☐ Excessive thirst ☐ Excessive urination ☐ Heat or cold intolerance ☐ Skin becoming drier ☐ Change in hat or glove size	**Hematologic/Lymphatic** ☐ Slow to heal after cuts ☐ Bleeding or bruising tendency ☐ Anemia	**Psychiatric** ☐ Memory loss or confusion ☐ Nervousness ☐ Depression ☐ Insomnia ☐

Explain any positive responses:

____

____

____

____

Anything else we should know about you?

____

____

____

____