UCLA Health

UCLA Kidney and Pancreas Transplant Program
NEW PATIENT QUESTIONNAIRE

Date: _____

Please complete all pages of the questionnaire:

Last Name:_____ First Name: _____ M: _____

Date of Birth: _____ Social Security Number: _____

Are you on dialysis? ☐ Yes ☐ No Type: (Circle one) Hemo Home-Hemo PD

Dialysis Unit: _____ Days: (Circle one) MWF TTS Shift:

What is your blood type? ☐ O ☐ A ☐ B ☐ AB ☐ Don't know

Have you ever been evaluated for kidney transplant? ☐ Yes ☐ No

If yes, where:_____

Are you currently listed at another transplant center? ☐ Yes ☐ No

What is the cause of your kidney disease? _____

Do you have a living donor? ☐ Yes ☐ No

Do you exercise? ☐ Yes ☐ No

If yes, how often? _____

How far can you walk? _____

Do you travel outside of U.S.? ☐ Yes ☐ No

If yes, where? (mark all that apply)

☐ Africa ☐ Appalachia ☐ Asia ☐ Central America ☐ Eastern Europe

☐ Latin America (including the Caribbean) ☐ Mexico ☐ Middle East

☐ South America ☐ Southeastern United States ☐ Other

Medical Tests	**Yes**	**No**	**Which hospital/facility?**
Last stress test, echo or cardiac cath	☐	☐	
Last kidney / abdominal Ultrasound	☐	☐	
Last hospitalization	☐	☐	

~ GO TO PAGE 2 ~

Do you have or have you had:	Yes	No	Comments
Blood Transfusion (**if yes**, when)	☐	☐	
Prior organ Transplant (**if yes**, what organ)	☐	☐	
One or both of your kidneys removed	☐	☐	
Kidney biopsy (**if yes** where and date of biopsy)	☐	☐	
Cardiac stent placement	☐	☐	
Cardiac bypass surgery	☐	☐	
Asthma / COPD / Lung disease	☐	☐	
Blood clots	☐	☐	
Cancer	☐	☐	
Diabetes	☐	☐	
If yes, do you give yourself insulin	☐	☐	
If no, who administers your insulin			
Difficulty walking or pain during walking	☐	☐	
Frequent urinary tract infection	☐	☐	
Gallstones or gallbladder problems	☐	☐	
Heart disease	☐	☐	
High blood pressure	☐	☐	
Liver disease, Hepatitis, other liver disease	☐	☐	
Lost control of urine or stool	☐	☐	
Pregnancy (females only - **if yes**, how many)	☐	☐	
Seizure	☐	☐	
Stroke	☐	☐	
Thyroid disease	☐	☐	
Treated for TB or Valley Fever	☐	☐	
Ulcer (circle) Foot Skin Stomach	☐	☐	

Do you drive yourself to appointments/dialysis? ☐ Yes ☐ No

If no, why?:_____

Do you have reliable transportation? ☐ Yes ☐ No

Do you care for yourself or does someone else? _____

Do you live alone? ☐ Yes ☐ No

Do you have difficulty affording your insurance co-pays? ☐ Yes ☐ No