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Pre-evaluation for living donation

Recipient information:

Name, surname:	Height:	Weight:
Date of birth:	Blood group:	

Donor information:

Name, surname:	Height:	Weight:
Date of birth:	Blood group:	

How are you related to the recipient?

Previous operations:

Previous thrombosis:

Pre-existing medical conditions:

Medications:

Allergies: ☐ no ☐ yes, I am allergic to:

Nicotin: ☐ no ☐ yes, I smoke _____ cigarettes per week

Alcohol consumption: ☐ no ☐ yes, I drink _____ glasses beer/wine/spirits per week

Patient name:

Questionnaire before donor evaluation

Question	Yes	No
Have you ever had a thrombosis or pulmonary embolism?	☐	☐
Do you often have headaches?	☐	☐
Do you have a known seizure disorder?	☐	☐
Do you have a known thyroid dysfunction?	☐	☐
Do you have a high blood pressure?	☐	☐
Do you suffer from irregular heartbeats?	☐	☐
Do you suffer from hay fever?	☐	☐
Do you have a known asthma?	☐	☐
Are you diabetic or have you ever had an abnormal high blood sugar?	☐	☐
Do you have a cough more often?	☐	☐
Have you ever been diagnosed with gastric or duodenal ulcer?	☐	☐
Do you have gallstone(s)?	☐	☐
Have you ever had a pancreatitis?	☐	☐
Do you have diarrhea more often?	☐	☐
Have you ever had a hepatitis or jaundice?	☐	☐
Have you ever noticed blood in your stool?	☐	☐
Do you have kidney stone(s)?	☐	☐
Do you have any family members, who had a thrombosis or pulmonary embolism before? If you do, then which family members:	☐	☐
For women: Are you pregnant?	☐	☐
For women: Do you breastfeed a child?	☐	☐