



LOYOLA
UNIVERSITY
HEALTH SYSTEM
Loyola University Chicago

Kidney Transplant History & Physical Exam [Kidney Donor]

Name: _____

MR# _____

Date: _____

REFERRING PHYSICIAN: _____

CHIEF COMPLAINT: Kidney Donor

HISTORY OF PRESENT ILLNESS: _____

PAST HISTORY

Surgical: None _____

Medical: None _____

Medications: None _____
 ASA Ibuprofen

Allergies: None _____

Habits:

Tobacco: None _____

EtOh: None _____

Drugs: None _____

SOCIAL HISTORY:

Marital status: Single Married Divorced

Occupation: _____

Lives w/: _____

FAMILY HISTORY:

HPTN _____

DM: _____

CADz: _____

ESRD: _____

Cancer: _____

Other _____

Physician: _____ Date: _____

Review of Systems Loyola Kidney Transplant Service

Do you now or have you had any problems related to the following systems?

Check **Yes** or **No** below

Please explain any 'Yes' answers in the space provided

Name: _____

MR# _____

Constitutional Symptoms

Fever Yes No _____
Weight changes Yes No _____
Headaches Yes No _____
Change in appetite Yes No _____

Other: _____

Eyes

Blurred Vision Yes No _____
Double Vision Yes No _____
Pain Yes No _____
Glasses/contacts Yes No _____

Other: _____

Allergic/Immunologic

Hay Fever Yes No _____
Drug allergies Yes No _____

Other: _____

Neurological

Seizures Yes No _____
Weakness Yes No _____
Numbness/tingling Yes No _____

Other: _____

Endocrine

Excessive thirst Yes No _____
Too Hot/Cold Yes No _____
Tired/Sluggish Yes No _____
Thyroid problems Yes No _____

Other: _____

Gastrointestinal

Abdominal Pain Yes No _____
Nausea/Vomiting Yes No _____
Constipation Yes No _____
Ulcer Yes No _____
Hemorrhoids Yes No _____
Jaundice/hepatitis Yes No _____
Blood from rectum Yes No _____

Other: _____

Cardiovascular

Chest Pain Yes No _____
Heart Murmur Yes No _____
High Blood Pressure Yes No _____

Other: _____

Integumentary

Skin Rash Yes No _____
Boils Yes No _____
Persistent Itch Yes No _____

Other: _____

Musculoskeletal

Joint Pain Yes No _____
Neck Pain Yes No _____
Back Pain Yes No _____

Other: _____

Ear/Nose/Throat/Mouth

Ear infection Yes No _____
Sore Throat Yes No _____
Sinus Problems Yes No _____

Other: _____

Genitourinary

Urine Infection Yes No _____
Wetting Accidents Yes No _____
Urinary Frequency Yes No _____
Painful urination Yes No _____
Kidney stones Yes No _____
Blood in urine Yes No _____

Other: _____

Respiratory

Wheezing Yes No _____
Frequent Cough Yes No _____
Pneumonia Yes No _____

Other: _____

Hematologic/Lymphatic

Swollen Glands Yes No _____
Blood Clotting Problem Yes No _____
Phlebitis Yes No _____

Other: _____

Psychologic

Are you generally satisfied with your life? Yes No _____

Do you feel severely depressed? Yes No _____

Have you considered suicide? Yes No _____

Other: _____

Physician: _____

Date: _____



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Kidney Transplant Physical Exam [Kidney Donor]

Name: _____

MR# _____

Date: _____

Nursing Staff: Please fill in all blanks within this box.

Temp: _____ Pulse: _____, B/P _____, R = _____, Wt. = _____ Kg, Ht. = _____ cm

General appearance: Normal _____

Skin: Normal _____

Eyes: Normal, PERRLA, Full EOMs _____

Head & Neck: Normal _____

Chest: Normal _____

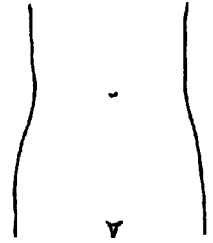
Breasts: Normal _____

Lymphatic: Normal _____

Heart:

Heart sounds - Normal; Murmur _____

Pulses: Normal _____



Abdomen: Normal _____

G/U:

Male: Normal _____

Female: Normal _____

Rectum: Normal _____

Extremities: Normal _____

Neurologic: Normal _____

Psychiatric:

Orientation: Normal _____

Judgement/Insight: Normal _____

Physician: _____ Date: _____



LOYOLA
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Kidney Transplant Lab/Imaging [Kidney Donor]

Name: _____

MR# _____

Recipient: _____

Date: _____

Laboratory

	Date	Date	Date
WBC (4.0 – 10)			
Hgb F (12 – 16) M (14 – 18)			
Hct: F (34-51) M (40-54)			
Plt (150-400)			
PT (11.0–13.0)			
PTT (2–33)			
INR			
Glu (70–110)			
Cholesterol (125–200)			
Alk Phos (30 – 110)			
SGPT (10-45)			
SGOT (10-40)			
PSA (<4.0)			
BUN (9–22)			
Cr (0.7–1.5)			
Cr Clearance			
24 h Urine Pro			
24 h Microalb.			
Urinalysis			
Urine Cx			
HLA Typing	A:	B:	DR:
HCG	<input type="checkbox"/> Neg <input type="checkbox"/> Pos		
RPR	<input type="checkbox"/> Neg <input type="checkbox"/> Pos		
Sickle Cell Prep	<input type="checkbox"/> Neg <input type="checkbox"/> Pos		

Virology

CMV Ab	<input type="checkbox"/> Neg 1:
EBV Ab	<input type="checkbox"/> Neg 1:
HIV	<input type="checkbox"/> Neg 1:
Hep A Ab	<input type="checkbox"/> Neg 1:
HB Core Ab	<input type="checkbox"/> Neg 1:
HB Surface Ag	<input type="checkbox"/> Neg 1:
Hep C	<input type="checkbox"/> Neg 1:
Herpes Ab	<input type="checkbox"/> Neg 1:
Varicella Ab	<input type="checkbox"/> Neg 1:

CXR: / / NI _____

Mammogram: / / NI _____

EKG: / / NI _____

Stress Test: / / NI _____

Dob. Echo: / / NI _____

Gyn/Pap: / / NI _____

3D-CT: / /

	Left	Right
Arteries		
Veins		
Size		

Comments: _____

Soc. Work Evaluation: Yes No

Physician: _____ Date: _____

Problem List: _____

Plan:

- L Laparoscopic Nephrectomy
- R Laparoscopic Nephrectomy
- L Open Nephrectomy
- R Open Nephrectomy

Physician: _____ Date: _____