

ANATOMY GIFTS REGISTRY

7522 Connelley Drive Hanover, Maryland 21076

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Medical / Social History

DONOR NAME: _____

FORM COMPLETED BY: _____ RELATION TO DONOR: _____ PHONE # _____

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Donor **HEIGHT:** _____ Donor **WEIGHT:** _____

*** IF YOU ANSWER **YES** TO ANY OF THE FOLLOWING QUESTIONS, PLEASE EXPLAIN IN AS MUCH DETAIL AS YOU CAN.

*** **PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR KNOWLEDGE:**

1. Does the donor have a history of any **heart disease**, high blood pressure or chest pain? Poor circulation, especially in the legs? Any history of the following: Stroke, **Bypass** surgery, carotid artery surgery, **saphenous** or femoral vein removal? **Y N UNK**

2. Does the donor have any history of digestive or **liver disease**? Any history of Yellow Jaundice? Is the Donor Jaundice at this time? Has there been any history of **hepatitis** or contact with persons known or suspected of having hepatitis? Has the donor ever had Gall Stones or Gall bladder removal? **Y N UNK**

3. Does the donor suffer from any type of neurologic or brain disease such as Alzheimer's, Parkinson's, seizures, periods of confusion, memory loss, brain tumor, **dementia**? Does the donor have any history of any of the following diseases: encephalitis, **meningitis**, multiple sclerosis, muscular dystrophy? **Y N UNK**

4. Does the donor suffer from any kidney related disease? Kidney Stones, Frequent kidney infections, **kidney dialysis**? **Y N UNK**

5. Does the donor have any past **surgical** procedures? Please explain in detail. **Y N UNK**

6. What **medications** does/did the donor take on a regular basis? Please be **Y N UNK**

specific. _____

7. Does the donor have any history of **diabetes**? For how long? How is it treated? (Oral, injections, Diet) _____ **Y N UNK**

8. Does the donor have any history of arthritis or **joint disease**? How is it treated? How severe? Any history of **Osteoporosis**? Carpal Tunnel Syndrome? Any **broken bones**? Any bone or spinal surgeries? _____ **Y N UNK**

9. Does the donor have any history of asthma, emphysema, chronic bronchitis, COPD, or any other **lung disease**? Has the donor ever had a positive skin test or treatment for **Tuberculosis (TB)**? _____ **Y N UNK**

10. Does the donor have any history of **Cancer**? What type of Cancer? Did the cancer spread, and to what other organs or tissue? What type of **diagnosis** was made? What type of **therapy or treatment** has the donor had? How long ago? Is/was the cancer in remission? _____ **Y N UNK**

11. Does the donor have any history of **skin disease**, such as Skin Cancer, Psoriasis or Eczema? Please Explain. _____ **Y N UNK**

12. Has the donor ever received a **blood transfusion**? Any other blood products? What type? Amount? When? _____ **Y N UNK**

13. Has the donor ever been **refused as a blood donor** or told not to donate? Please explain: _____ **Y N UNK**

14. Has the donor ever received an organ or tissue transplant? Y N UNK

15. Does the donor have any history of glaucoma, cataracts, cornea disease, retinoblastoma, or *any other eye disease*, infection, injury or surgery? Laser correction surgery? Please explain. Y N UNK

16. Does the donor have any history of urinary tract or bladder problems? Any history of incontinence or frequent urination? Any prostate problems, or tests including: prostate specific antigen test-PSA or transrectal ultrasound? What were the results? Y N UNK

17. Has the donor ever used **tobacco products**? What kind? How long? How many per day? Y N UNK

18. Does the donor drink **alcohol**? How much? Frequency? What type? For how many years? Y N UNK

19. In the past 12 months has the donor been immunized or vaccinated for any reason? What type? When? Y N UNK

20. Does the donor have a primary physician? Please include name, address, phone number and for what reason the donor has been seeing the doctor and for how long. Also include any hospice or long term facility information Y N UNK

21. Is/was the donor physically active? Please explain. Y N UNK

22. Has the donor recently exhibited **flu like symptoms**? Example: Cough, Colds, shortness of breath, swollen lymph nodes, nausea, vomiting, diarrhea, night sweats or fever? Currently taking antibiotics? Any periods of unexplained weight loss? Y N UNK

23. Has the donor ever been **incarcerated** or institutionalized? Where and for how long? _____ **Y N UNK**

24. Has the donor ever used any illegal substances or drugs such as cocaine or marijuana? Has the donor ever been involved with **IV drug use**? Please explain. _____ **Y N UNK**

25. Has the donor ever been a participant in any **high risk** sexual activity? Has the donor ever been tested for **HIV** virus? Test results? Please Explain. _____ **Y N UNK**

26. Has the donor ever been diagnosed or **tested positive** for any sexually transmitted or communicable disease? Please Explain. _____ **Y N UNK**

ADDITIONAL SPACE IS PROVIDED BELOW (PLEASE REFERENCE QUESTION NUMBER, IF APPLICABLE):

Future Donor Signature: _____ Date: _____

*****FOR AGR OFFICE USE ONLY*****

Employee Signature: _____ Date/ Time: _____

AGR Assigned Donor Number: _____