PARKER™ UNIVERSITY

Anatomical Gift Program

Medical History and Research Assessment Questionnaire SAB ID:_____

_____

Donor Name: _____

Person completing form:_____ Relationship to donor: _____

Note: The person completing this form should answer ALL questions YES or NO, to the best of your knowledge; comment and elaborate on all questions marked YES.

1. Do you feel you know (Donor Name) well enough to answer questions regarding his/her medical and social history? ❑ Yes ❑ No

2. Weight and Height of Donor
   _____Weight
   _____Height

3. Has s/he:
   A. Been treated by a physician in the past two years? ❑ Yes ❑ No
   B. Been hospitalized in the past two years? ❑ Yes ❑ No
      Reason: _____
      _____
      _____

4. Did s/he:
   A. Have any serious illnesses or infections in the past? ❑ Yes ❑ No
      What type and when? _____
      _____
      _____
   B. Have any surgical procedures in the past? ❑ Yes ❑ No
      What type and when? _____
      _____
      _____

5. Has s/he ever been diagnosed with the following contagious illnesses?
   A. HIV or AIDS ❑ Yes ❑ No
   B. Hepatitis B ❑ Yes ❑ No
   C. Hepatitis C ❑ Yes ❑ No
   D. Tuberculosis ❑ Yes ❑ No

6. Did s/he ever use non-prescribed drugs, "street" drugs or other substances, e.g. cocaine, marijuana, steroids, inhalants, heroin? ❑ Yes ❑ No
*List type used, how much, when, and by what route (injected, smoked, snorted, etc.):*_____
_____
_____

7. Did s/he ever drink alcoholic beverages? ❑ Yes ❑ No
List type, amounts, and length used: _____
_____
_____

8. Did s/he ever use tobacco products? ❑ Yes ❑ No
Amount and length used: _____
_____
_____

9. Did s/he ever receive blood transfusions or blood products? ❑ Yes ❑ No
When and why? _____
_____
_____

10. Was s/he ever refused as a blood donor or told not to donate? ❑ Yes ❑ No
When and why? _____
_____
_____

11. In the past 12 months did s/he have any of the following?

A. Tattoo ❑ Yes ❑ No
B. Ear/body piercing ❑ Yes ❑ No
C. Acupuncture ❑ Yes ❑ No
D. Accidental needle stick ❑ Yes ❑ No

12. Was s/he:

A. Vaccinated or immunized for any reason in the past 12 months? ❑ Yes ❑ No
List type and when: _____

B. Vaccinated for Hepatitis B? ❑ Yes ❑ No

13. Did s/he have any history of:

A. Heart disease ❑ Yes ❑ No
B. High blood pressure ❑ Yes ❑ No
C. Chest pain ❑ Yes ❑ No
D. Varicose veins or poor circulation ❑ Yes ❑ No

14. Did s/he have any kidney related disease(s) and/or dialysis treatments? ❑ Yes ❑ No
List type, when, and how long: _____
_____
_____

15. Did s/he have a history of diabetes? ❑ Yes ❑ No
List type, how long, and name of medication: _____
_____
_____

16. Did s/he have a history of the following?

A. Digestive or intestinal problems ❑ Yes ❑ No
List type, how long, and treatment _____
_____

B. Bloody stools ❑ Yes ❑ No
C. Recent weight loss ❑ Yes ❑ No
How much? _____
D. Colectomy or colon recesection surgery ❑ Yes ❑ No

17. Has s/he ever had cancer (including skin cancer)? ❑ Yes ❑ No
Type of cancer: _____
Number of years without recurrence: _____

18. Has s/he ever been diagnosed with any type of autoimmune disease? ❑ Yes ❑ No
List type, when diagnosed, and treatment: _____
_____

19. Did s/he have a medical diagnosis of:

A. Osteoporosis ❑ Yes ❑ No
B. Arthritis ❑ Yes ❑ No
C. Broken bones ❑ Yes ❑ No
List when and location of break: _____

20. Did s/he have a history of skin infections such as leprosy, eczema, dermatitis, psoriasis, or inflammatory skin diseases? ❑ Yes ❑ No
List type, location, when, and treatment: _____
_____

21. In the past 12 months, has s/he been treated for any sexually transmitted disease such as syphilis, gonorrhea, genital herpes, or venereal warts? ❑ Yes ❑ No
List type, when, and treatment: _____
_____

22. Has s/he ever been in an inmate (confined to lockup, jail, or prison) for an extended period of time? ❑ Yes ❑ No
When and how long? _____
_____

23. **(FEMALE DONORS ONLY)** Has she ever had any of the following?

A. Hysterectomy ❑ Yes ❑ No
B. Tubal ligation ❑ Yes ❑ No
C. Cesarean section ❑ Yes ❑ No
D. Bladder surgery of any kind ❑ Yes ❑ No
Type? _____

24. Did s/he have a history of diseases, infections, or surgeries involving the eyes, such as glaucoma, cataracts, corneal disease, refractive surgery, and/or laser surgery? ❑ Yes ❑ No
List type, how long, treatment, and reason for surgery: _____
_____
_____

Questions 25 is for POTENTIAL NEUROLOGICAL AND PSYCHIATRIC RESEARCH
(Brain Tissue Studies)

25. Did s/he suffer from any type of neurological or brain disease such as:
For "yes" responses, please provide explanation

A. Alzheimer's or other dementia _____ ❑ Yes ❑ No
B. Encephalitis _____ ❑ Yes ❑ No
C. Parkinson's _____ ❑ Yes ❑ No
D. Degenerative Neurological Disease _____ ❑ Yes ❑ No
E. Multiple Sclerosis (MS) _____ ❑ Yes ❑ No
F. ALS (Lou Gehrig's Disease) _____ ❑ Yes ❑ No
G. Brain tumor _____ ❑ Yes ❑ No
H. Seizures _____ ❑ Yes ❑ No
I. Creutzfeldt-Jakob Disease (CJD) _____ ❑ Yes ❑ No
J. Periods of confusion, memory loss, or hallucinations _____ ❑ Yes ❑ No
_____
K. Unsteady walking or visual changes _____ ❑ Yes ❑ No
_____
L. Clinical Depression _____ ❑ Yes ❑ No
M. Bi-Polar Disorder _____ ❑ Yes ❑ No
N. Schizophrenia or psychosis _____ ❑ Yes ❑ No
O. ADD or ADHD _____ ❑ Yes ❑ No
P. Treated in a psychiatric facility in the past two years _____ ❑ Yes ❑ No
Facility name, reason, and when: _____
_____

If s/he is accepted for this research, would you be willing to receive a follow-up call from the Neurological or Psychiatric Research Departments? ❑ Yes ❑ No

Additional comments (please refer to question numbers when appropriate):