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## Donor Medical History

Date: \_\_\_\_\_

Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Blood Type: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_

Donor For: \_\_\_\_\_ Relationship: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Race: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Are you employed? Yes No If yes, where are you employed: \_\_\_\_\_

Are you a member of the Armed Services? Yes No If yes, what branch: \_\_\_\_\_

Children: Yes No If yes, ages and health of children: \_\_\_\_\_

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Do you have any allergies? Yes No If yes, what are you allergic to and describe the reaction:

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Have you had any recent hospitalizations? Yes No If yes, when and what hospital:

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Have you had any operations? Yes No If yes, what type of operations:

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Have you ever had a reaction to IV Contrast (dye used for radiology procedures)? Yes No

### Review of Medical Systems:

1. Do you have chronic headaches? Yes No Comment: \_\_\_\_\_

2. Do you have any loss of feeling in your arms or legs? Yes No  
If yes, where: \_\_\_\_\_

3. Have you ever had problems with bleeding? Yes No

4. Have you ever had a blood clot? Yes No  
If yes, where was it and how was it treated: \_\_\_\_\_

5. Do you have anemia? Yes No

6. Do you have high blood pressure? Yes No
7. Do you have thyroid disease? Yes No
8. Do you have a chronic cough? Yes No
- Wheezing? Yes No
- Bronchitis? Yes No
- Asthma? Yes No
- Tuberculosis? Yes No
- If yes, when and what treatment? \_\_\_\_\_
- Pneumonia? Yes No
9. Do you smoke or have you ever smoked? Yes No If yes, how much do you smoke: \_\_\_\_\_
- When did you quit smoking? \_\_\_\_\_
10. Do you drink beer, wine, or alcohol or have you in the past? Yes No If yes, how often: \_\_\_\_\_
- When did you stop drinking? \_\_\_\_\_
11. Have you ever had heart disease or a heart attack? Yes No
12. Have you ever had heart surgery? Yes No If yes, when and what hospital: \_\_\_\_\_
13. Have you ever had chest pain? Yes No
14. Do you have high cholesterol? Yes No
15. Do you have shortness of breath? Yes No
16. Do you use oxygen? Yes No
17. Do your feet, ankles, or legs swell? Yes No If yes, when: \_\_\_\_\_
18. Have you ever had gallbladder trouble? Yes No
19. Do you have diabetes? Yes No If yes, do you use insulin, oral medication, or diet control? \_\_\_\_\_
20. Have you ever been jaundiced? Yes No
21. Have you ever been told you have hepatitis? Yes No If yes, when and what type: \_\_\_\_\_
- \_\_\_\_\_
22. Have you ever been told you have liver disease? Yes No If yes, what type of liver disease: \_\_\_\_\_
- \_\_\_\_\_
23. Have you ever had problems with painful urination? Yes No
24. Have you ever had kidney stones? Yes No If yes, when and did you have treatment: \_\_\_\_\_
25. Have you ever had a urinary tract infection? Yes No If yes, when and did you have treatment and what type of treatment: \_\_\_\_\_
26. Have you ever had seizures? Yes No If yes, when and are you still being treated: \_\_\_\_\_
27. Have you ever been diagnosed with cancer? Yes No
- If yes, when, what type, and did you have treatment: \_\_\_\_\_
28. Have you ever consulted with a psychiatrist? Yes No
29. Have you ever felt the need to see a psychiatrist? Yes No
30. Do you have problems with anxiety? Yes No

31. Do you have any problems with depression? Yes No

**Questions only for Males:**

- 1. Do you have regular prostate exams? Yes No
- 2. Do you have any testicular swelling? Yes No
- 3. Do you have prostate problems? Yes No

**Questions only for Females:**

- 1. Do you have regular Pap Smears and Pelvic Exams? Yes No  
If yes, when was your last one? \_\_\_\_\_  
If yes, what were the results? \_\_\_\_\_
- 2. Do you have regular Mammograms? Yes No  
If yes, when was your last one? \_\_\_\_\_  
If yes, what were the results? \_\_\_\_\_
- 3. How many pregnancies have you had? \_\_\_\_\_  
If you had pregnancies, how many live births: \_\_\_\_\_ miscarriages: \_\_\_\_\_ abortions: \_\_\_\_\_
- 4. Did you have vaginal births or C-Sections? \_\_\_\_\_

Have you had any other medical problems that were not mentioned? Yes No If yes, please list and what treatments are you getting: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have a Primary Care Physician? Yes No If yes, please provide name and telephone number: \_\_\_\_\_  
\_\_\_\_\_

**Family Medical History:** (Please check all that apply)

	Father	Mother	Siblings	Maternal Grandparents	Paternal Grandparents
High Blood Pressure					
Stroke					
Heart Attack					
Chest Pain					
Diabetes					
Chest Pain					
Kidney Disease					
Liver Disease					
Age, if living					
Age at death					
Overall Health (Good or Bad)					