Duke University School of Medicine

Anatomical Gifts Program

Voluntary Personal Health History

Donor Name:_____ Date:_____

Thank you for taking the time to fill us in with information. This is not required, but it is appreciated. This information will be shared, in anonymity, with instructors to enhance learning opportunities for students. Please keep this information in your files and instruct your personal representatives to send it to us at the time of your death. Please note: this does not replace our call to medical professionals at the time of your death to screen for criteria.

1. **Childhood Illnesses (please circle if you've had any of the following):**

   Measles Mumps Rubella Chicken Pox Rheumatic Fever Polio
   Other_____

2. **Do you have any radioactive medical implants?** Circle one: Yes No
   If yes, date and location of implant:_____
   _____

3. **Do you have a pacemaker, brain stimulator or other electrical/magnetic device implanted?**
   (For knee/hip/skull/orthopedic work, see question #6) Circle one: Yes No
   If yes, date, type of device and location:_____
   _____

4. **Women only:**
   Have you had a hysterectomy? Circle one: Yes No
   How many live births have you had? _____
   Have you had any Cesarean births? Circle one: Yes No

5. **Please list any medical problem(s), and the age you were when it was diagnosed:** (Examples may include, but are not limited to: Diabetes I or II, Asthma, Congestive Heart Disease, COPD, Cancers, Hypertension, Congenital issues, Cirrhosis, Parkinson's, Muscular Dystrophy, Leukemia, Sickle Cell Anemia, ALS, Dementia, Alzheimer's, etc.):_____
   _____
   _____
   _____
   _____
   _____
   _____

6. **Please list and date any knee or hip replacements, or hardware in spine, extremities, skull, other, or amputations:**_____
   _____
   _____
   _____
   _____
   _____

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7. **Please list and date any other surgeries, including organ removals or transplants that you have experienced:**_____

_____
_____
_____
_____
_____
_____
_____
_____
_____

8. **Did your work or activities you engaged in during your life, or things you were exposed to, impact your health? In what ways?** _____

_____
_____
_____
_____
_____
_____
_____
_____
_____

9. **Special Notes:** Things you would like us to know about you (or include additional information from any prior section. Feel free to add additional sheets of paper, or records you feel important to share.) _____

_____
_____
_____
_____
_____
_____
_____
_____

10. To the best of my knowledge, this information is true and I am willing to share it with instructors and students at Duke School of Medicine to enhance the education of medical professionals so they can benefit from my gift.

_____ _____

Signature of Donor Date