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:**

   - ____________________________________________
   - ____________________________________________
   - ____________________________________________
   - ____________________________________________
   - ____________________________________________
   - ____________________________________________

Please note: During the COVID19 pandemic, we require donors to provide proof of a COVID test that is negative, or COVID vaccination in order for us to consider acceptance.
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
Information for Death Certificate for Funeral Home/Transport Service  
Body Donation to Duke Anatomical Gifts Program

Date this document first completed: ____________________________
Name of informant (donor/self or other) __________________________
Date & Time of Death (upon occurrence) __________________________

This document is to gather information prior to death in preparation, or at the time of death. Please keep a copy of this with your Body Donation Information for loved ones/your representative to assist at the time of death. Please give this to the funeral home/funeral transport service, if needed, upon death. Alternatively, your representatives can fax it to us, at 919-681-5520, and we will fax it to the funeral home/transport service.

Donor's Suffix: _______ First Name: _____________________________
Middle Name: ___________________ Last Name: ___________________________
Donor's Last name prior to first marriage: _____________________________
Donor's Gender: _____ Donor's Date of Birth: __________
Donor's Birthplace (County/State/Country): _____________________________
Donor's Marital Status: ________
  Donor's Surviving Spouse-if wife, give maiden name: ______________________
Donor's Usual Occupation: ____________________________________________
  Kind of Business/Industry: ____________________________________________
Donor's Social Security Number: _______________________________________
Is the Donor's Residence in a Foreign Country?: Yes / No
  If YES: which Country? _______________________________________
Residence County (or Province): _____________________ City or Town: __________
  Street Address: _______________________________ Inside City Limits: _____ Y / N
  State___________ Zip Code: ________________

Was Donor Ever in the Armed Forces?: Y /N. If yes, which branch?_________________
Donor's Education Level: _____________________________________________
Is Donor of Hispanic Origin?: _______ Donor's Race: _______________
Donor's Father's Name: ___________________________________________
Donor's Mother's Name Prior to First Marriage: ________________________
Informant's/Representative's Name: Self/Donor Y / N ?

Name of representative assisting with information for death certificate (if not the donor themselves) to assist at time of Death________________________ Relationship to donor/deceased: ___________
Representative's Mailing Address: _______________________________________
Representative's Phone Number: ____________________________
Representative's/Family member's Alternate Phone Number: ____________________
Information for Death Certificate for Funeral Home/Transport Service
Body Donation to Duke Anatomical Gifts Program

Date this document first completed: ____________________________
Name of informant (donor/self or other) __________________________
Date & Time of Death (upon occurrence) __________________________

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Donor’s Suffix: _______ First Name: ____________________________
Middle Name: ___________________ Last Name: __________________________
Donor’s Last name prior to first marriage: __________________________
Donor’s Gender: _____ Donor’s Date of Birth: __________
Donor’s Birthplace (County/State/Country): __________________________
Donor’s Marital Status: __________
  Donor’s Surviving Spouse-if wife, give maiden name: __________________________
Donor’s Usual Occupation: __________________________
  Kind of Business/Industry: __________________________
Donor’s Social Security Number: __________________________
Is the Donor’s Residence in a Foreign Country?: Yes / No
  If YES: which Country? __________________________
Residence County (or Province): __________________________ City or Town: __________________________
  Street Address: __________________________ Inside City Limits: ______ Y / N
  State___________ Zip Code: __________________________
Was Donor Ever in the Armed Forces?: Y / N. If yes, which branch? __________
Donor’s Education Level: __________________________
Is Donor of Hispanic Origin?: ______ Donor’s Race: __________________________
Donor’s Father’s Name: __________________________
Donor’s Mother’s Name Prior to First Marriage: __________________________
Informant’s/Representative’s Name: Self/Donor Y / N?
Name of representative assisting with information for death certificate at time of Death__________________
  Relationship to donor/deceased: __________________________
Representative’s Mailing Address: __________________________
Representative’s Phone Number: __________________________
Representative’s/Family member’s Alternate Phone Number: __________________________