



Anatomical GIFT PROGRAM

Health History
Questionnaire

All questions contained in this document are confidential and will become part of your registration file.

Donor Name: _____ Today's Date: _____

GENERAL PATIENT INFORMATION

In general, what is the quality of your health?

Outstanding Good Some chronic issues Poor

Do you exercise?

Sedentary (no exercise) Occasional vigorous (30 min. 2x/wk)
 Mild exercise (walk, golf) Regular vigorous (30 min. 4x/wk)

Donor's current weight: _____ Donor's current height: _____

What is your caffeine and alcohol intake?

No caffeine # of caffeinated drinks per day No alcohol # alcohol beverages a day

Do you use tobacco?

Cigarettes: _____ packs/day Chew: _____ #/day Pipe: _____ #/day Cigars: _____ #/day

Do you currently use recreational or street drugs?

Yes No

Have you ever given yourself street drugs with a needle?

Yes No

PERSONAL HEALTH HISTORY

Childhood illnesses: _____

Measles Mumps Rubella Chicken pox Rheumatic fever Polio

List any medical problems that doctors have diagnosed: _____

Have you ever had a blood transfusion? Yes No

Have you ever been treated with Human Growth Hormones? Yes No

Elon University Anatomical Gift Program Health History Questionnaire

Have you undergone brain surgery for head trauma or brain cancer? Yes No

Have you ever received a cornea transplant? Yes No

Do you have a medical diagnosis of early-onset cognitive decline? Yes No

If yes, at what age were you diagnosed? _____

Have you been rejected to donate blood? Yes No

If yes, why? _____

Have you tested positive for tuberculosis? Yes No When was your last test for tuberculosis? _____

Liver disease? Cirrhosis? Yes No

Hepatitis A, B or C? Yes No When was your last tet for Hepatitis A, B or C? _____

HIV? Yes No When was your last test for HIV? _____

SURGERIES AND OTHER HOSPITALIZATIONS:

Please list and date your surgeries: _____

Do you have a radioactive medical implant? Yes No Date and location of implant: _____

Please list and date other hospitalizations: _____

■ **WOMEN ONLY**

Have you had a hysterectomy or Cesarean? Yes No

Thank you!

Thank you for taking the time to complete this questionnaire. We pride ourselves in first patient approach and creating a culture of respect. The information you have provided will be kept in your donor registration file maintained in a secured environment in the Anatomical Gift Program office. The information you have provided will be most useful for informing our faculty and students. This document will be shared with authorized Elon University faculty and students. Certain answers may cause the need for your Health Care Practitioner to complete a follow-up form. Are you open to this? Yes No Donor's initials here: _____

Please take a few more minutes and tell us (below) what anatomical donation means to you. The noble gift of donating one's body after death is an important decision. All of us in the Anatomical Gift Program at Elon University respect and honor your decision. We thank you for the unique learning experience.

Dianne Person, Director

■ **WHAT WOULD YOU LIKE TO SHARE WITH OUR STUDENTS WHO WILL BENEFIT FROM YOUR GIFT? HOW DID YOU LEARN ABOUT OUR PROGRAM? WHY DID YOU CHOOSE ANATOMICAL DONATION AT ELON?**

■ **ARE YOU CURRENTLY OR HAVE YOU EVER BEEN A CLIENTS TO CLASS PATIENT AT ELON'S SCHOOL OF HEALTH SCIENCES? IF YES, PLEASE PROVIDE THE DATES AND THE NAME OF THE STUDENT(S) YOU WORKED WITH.**

Donors may choose to remain anonymous or select use of their first name, or surname for use by faculty and students who will work with them. Please write your choice here:

Would you like someone to contact you regarding your responses on this survey? Yes No