THE UNIVERSITY OF IOWA

Deeded Body Program
Medical History Form

Phone: (319) 335-7762 www.medicine.uiowa.edu/acb/dbp Fax: (319) 353-4394

Deeded Body Program
Department of Anatomy & Cell Biology
UI Carver College of Medicine
1-402 Bowen Science Building
Iowa City, IA 52242-1109

Potential Donor Name: _____
(First, Middle, Last Name)

Date of Birth: _____

Obtaining donor medical histories are an important part of our process and aids in the studies to which our donors are assigned. To help make the process successful please complete the information below to the best of your knowledge and check all that apply. ***Falsification of this document could lead to rejection at time of death:***

Gender:_____ Height:_____ft._____in. Weight:_____lbs. Age: _____

Has the donor had any of the following diseases or conditions?

☐ Childhood Diseases (specify): _____
☐ Active MRSA (Methicillin Resistant Staphylococcus Aureus) ☐ Active VRE (Vancomycin Resistant Enterococci)
☐ Dementia (____Years) ☐ Hepatitis ☐ HIV/AIDS ☐ TB (Tuberculosis) ☐ Decubitus Ulcers
☐ Jaundice ☐ Cancer: _____ Treatment(s)/Year(s): _____
☐ Other Contagious Disease(s): _____
☐ Feeding Tube ☐ Skeletal Anomalies: _____
☐ Substance Abuse List Substance(s): _____

Has the donor had any of the following surgeries?

☐ Heart Surgery Year: _____ ☐ Spine Surgery Year: _____
☐ Colostomy Year: _____ ☐ Gall Bladder Removed Year: _____
☐ Appendix Removed Year: _____ ☐ Tonsils Removed Year: _____
☐ Joint Replacement Surgery Joint/Year(s): _____
☐ Amputation(s): _____
☐ Other Surgical History: _____
_____

Female donors:

☐ Hysterectomy Year: _____ ☐ Cesarean Section Year(s): _____
☐ Number of Children Given Birth To: _____

Please list prolonged medications: _____
_____

For more information in the future, who may we contact?
Name/Relationship:_____Phone/E-mail: _____