# Medical Information

*If it is more convenient, you may e-mail the requested information in a PDF (or other) format to cli-labs@charter.net.*

Potential Donor Name _____ Date of Birth _____

*Donor medical histories are a very important part of the donation process. To aid us in obtaining a complete medical record, please fill in the information to the best of your knowledge and check all that apply below:*

Gender_____ Height_____ Weight_____

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

☐ Active MRSA (Methicillian Resistant Staphylococcus Aureus ☐ Active VRE (Vancomycin Resistant Enterococci)

☐ Dementia (____ Years) ☐ Hepatitis ☐ HIV/AIDS ☐ C. diff (Clostridium difficile)

☐ 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(s) / Year(s) _____

☐ Amputation(s) _____

☐ Other Surgical History _____

**Female Donors:**

☐ Hysterectomy Year _____ ☐ Cesarean Section- Year(s)_____

☐ Number of Children Given Birth To _____

**Please provide a list of medications:**

_____

_____

**Please list primary care providers and institutions from which the donor has received medical care:**

_____

_____

*Additionally, we request that you attach a copy of any medical records in your possession pertaining to the past physical condition of this individual. Thank. If you any questions, please call.*

**For more information in the future, whom can we contact?**

Name _____ Phone/Fax _____