THE TEXAS A&M UNIVERSITY SCHOOL OF MEDICINE
NEUROSCIENCE & EXPERIMENTAL THERAPEUTICS
WILLED BODY PROGRAM
8447 John Sharp Parkway, Suite 1005
Bryan, TX 77807-3260
(979) 436-0316

Voluntary Donor Personal Health History

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 course instructors to enhance learning opportunities for students. This form may be submitted with your donation paperwork, or your representative may send it to us at the time of your death. This does not replace our call to medical professionals at the time of your death to screen for acceptance criteria.

Name:_____ Date:_____

1. Childhood Illnesses (please circle if you've had any of the following): Measles Mumps Rubella Chicken Pox Rheumatic Fever Polio
Other_____

2. 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.):_____
_____
_____
_____
_____

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

5. 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

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

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

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.)
_____
_____
_____

To the best of my knowledge, this information is true and I give written permission to share this information it with instructors and students at the Texas A&M University School of Medicine to enhance the education of future medical professionals and increase their understanding of the effects of my medical conditions on my physical body.

_____
Printed Name

_____
Signature of Donor, Next-Of-Kin or Heath Care Power of Attorney

_____
Date