The Willed Body Program
The University of Texas Southwestern Medical Center

Medical History and Research Assessment Questionnaire

Donor Name: _____

Date form completed: _____

1. Current Weight and Height

_____ Weight.
_____ Height.

2. Have you:
   A. Been treated by a physician in the past two years? ☐ Yes ☐ No

   B. Been hospitalized in the past two years? ☐ Yes ☐ No
   Why? _____
   _____
   _____

3. Did you:
   A. Have any serious illnesses or infections in the past? ☐ Yes ☐ No
   What type and when? _____
   _____
   _____

   B. Have any surgical procedures in the past? ☐ Yes ☐ No
   What type and when? _____
   _____
   _____
   _____

4. Have you ever been diagnosed with the following contagious illnesses?
   A. HIV or AIDS ☐ Yes ☐ No
   B. Hepatitis B ☐ Yes ☐ No
   C. Hepatitis C ☐ Yes ☐ No
   D. Tuberculosis ☐ Yes ☐ No

5. Did you ever use non-prescribed drugs, "street" drugs or other substances, e.g. cocaine, marijuana, steroids, inhalants, heroin?
   List type used, how much, when, and by what route (injected, smoked, snorted, etc). _____ ☐ Yes ☐ No

6. Did you ever drink alcoholic beverages? ☐ Yes ☐ No
   List type, amounts, and length used: _____
   _____

7. Did you ever use tobacco products? ☐ Yes ☐ No
   Amount, and length used (very important for tobacco related studies):
   _____
   _____

8. Did you ever have sinus surgery? ☐ Yes ☐ No
   If so, when and why? _____

9. Did you ever have any joint surgeries or replacements? ☐ Yes ☐ No
   If so, when and why? _____

10. Were you ever diagnosed with scoliosis? ☐ Yes ☐ No

11. Were you:
   A. Vaccinated or immunized for any reason in the past twelve months? ☐ Yes ☐ No
      Type and when? _____
   B. Vaccinated for Hepatitis B? ☐ Yes ☐ No

12. Do you have any history of:
   A. Heart disease? ☐ Yes ☐ No
   B. High blood pressure? ☐ Yes ☐ No
   C. Chest pain? ☐ Yes ☐ No
   D. Varicose veins or poor circulation? ☐ Yes ☐ No

13. Did you have any kidney related disease(s) and/or dialysis treatments? ☐ Yes ☐ No
   Type, when, how long? _____
   _____

14. Do you have a history of diabetes? ☐ Yes ☐ No
   Type, how long, name of medication? _____
   _____

15. Do you have a history of:
   A. Digestive or intestinal problems? ☐ Yes ☐ No
      Type, how long, treatment? _____
      _____
   B. Bloody Stools? ☐ Yes ☐ No
   C. Recent weight loss? ☐ Yes ☐ No
      How much? _____
   D. Colectomy or colon recesection surgery? ☐ Yes ☐ No

16. Have you ever had cancer (including skin cancer)? ☐ Yes ☐ No
   Type of Cancer: _____
   Number of years without recurrence? _____

17. Have you ever been diagnosed with any type of autoimmune disease? ☐ Yes ☐ No
   Type, when diagnosed, treatment? _____
   _____

18. Do you have a medical diagnosis of:
   A. Osteoporosis? ☐ Yes ☐ No
   B. Arthritis? ☐ Yes ☐ No
   C. Broken Bones? ☐ Yes ☐ No
      When, location of break? _____

19. Do you have a history of skin infections such as leprosy, eczema, dermatitis, psoriasis, or inflammatory skin diseases? ☐ Yes ☐ No
Type, location, when, treatment? _____
_____

20. In the past twelve months have you been treated for any sexually transmitted disease such as syphilis, gonorrhea, genital herpes, or venereal warts? ☐ Yes ☐ No
Type, when, treatment? _____
_____

21. Have you ever been an inmate (confined to lockup, jail, or prison) for an extended period of time? ☐ Yes ☐ No
When, how long? _____
_____

Question 22 is for ONLY FEMALE DONORS

22. Have you ever had any of the following?
A. Hysterectomy ☐ Yes ☐ No
B. Tubal Ligation ☐ Yes ☐ No
C. Caesarean Section ☐ Yes ☐ No
D. Bladder Surgery of any kind? ☐ Yes ☐ No
Type_____

23. Do you have a history of diseases, infections, or surgeries involving the eyes such as glaucoma, cataracts, corneal disease, refractive surgery, and/or laser surgery? ☐ Yes ☐ No
Type, how long, treatment, reason for surgery? _____
_____

Question 24 is for POTENTIAL NEUROLOGICAL AND PSYCHIATRIC RESEARCH (Brain Tissue Studies)

24. Do you suffer from any type of neurological or brain disease such as:
For "yes" responses, provide explanation.

A. Alzheimer's or other dementia? ☐ Yes ☐ No
_____

B. Encephalitis? ☐ Yes ☐ No
_____

C. Parkinson's? ☐ Yes ☐ No
_____

D. Degenerative Neurological Disease? ☐ Yes ☐ No
_____

E. Multiple Sclerosis (MS)? ☐ Yes ☐ No
_____

F. ALS (Lou Gehrig's Disease)? ☐ Yes ☐ No
_____

G. Brain Tumor? ☐ Yes ☐ No
_____

H. Seizures? ☐ Yes ☐ No
_____

I. Creutzfeldt-Jakob Disease (CJD)? ☐ Yes ☐ No
_____

J. Periods of confusion, memory loss or hallucinations? ☐ Yes ☐ No

K. Unsteady walking or visual changes? ☐ Yes ☐ No

L. Clinical Depression? ☐ Yes ☐ No

M. Bi-Polar Disorder? ☐ Yes ☐ No

N. Schizophrenia or psychosis? ☐ Yes ☐ No

O. ADD or ADHD? ☐ Yes ☐ No

P. Ever treated in a psychiatric facility in the past two years? ☐ Yes ☐ No
Facility name, reason, when? _____

Additional Comments (Please refer to question numbers when appropriate):