



Carver College
of Medicine

Deeded Body Program Medical History Form

Phone: (319) 335-7762

<https://acb.medicine.uiowa.edu/deeded-body-program>

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: _____