BRIEF MEDICAL HISTORY ***Gift-of- Body or Next-of-Kin***

1. Name: _____
   First *Middle* *Last (Please Print)*
2. Date this form was completed (m/d/y): _____
3. Sex: ☐ Female ☐ Male Date of birth (m/d/y): _____
4. Weight (*lbs.*): _____ Height: _____
5. Congenital (born) abnormalities: _____

   _____
6. Major traumas or burns: _____

   _____
7. Major surgeries and approximate dates: _____

   _____
8. Check all the applicable medical conditions. Please include approximate dates.

   ☐Cancer (indicate the type) _____

   ☐Tuberculosis

   ☐HIV

   ☐Creutzfeldt-Jacob disease (or other transmissible spongiform encephalopathies)

   ☐Shingles (zoster virus)

   ☐Methicillin resistant staphylococcus aureus (MRSA))

   ☐Vancomycin-resistant enterococcus (VRE)

   ☐Hepatitis A

   ☐Hepatitis B

   ☐Hepatitis C

   ☐Malaria

   ☐Syphilis

   ☐Sepsis

   ☐Other infectious diseases not listed above: _____

   ☐_____ *(Please initial) To maximize the educational value of my donation following my death, I authorize any health care provider, from whom I received medical care, to allow the Anatomy Department of the A.T. Still University of Health Sciences, Kirksville College of Osteopathic Medicine to access any and all medical records concerning my health history. I release any such health care facility and physician from any and all responsibility or liability that may arise from this authorization.*

9. Signature _____ Date _____

The above information will remain confidential and will be used only at the discretion of the Department of Anatomy at the Kirksville College of Osteopathic Medicine, A.T. Still University.