**Body Donation Questionnaire**

It is standard practice to collect antemortem data from body donors in order for their remains to be used for scientific study and educational needs. A number of activities can affect decomposition as well as an individual’s skeleton. Knowledge about factors such as health conditions, medical procedures, and repeated activities like handedness allow for a better overall understanding of the biological impacts on an individual. These unique details provide an important resource for research and education.

Please complete the following to the best of your ability by filling in the blank and/or circling an option. You only need to record the information that you are comfortable providing. If you need more space, additional sheets may be attached. All of the information is confidential.

Full Legal Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_\_\_\_

First Middle Last Maiden

Sex (biological): \_female \_male

Gender (culturally expressed):

Ancestry:

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Place of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/ Country

Height:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (are you estimating? \_ yes \_ no)

Shoe Size:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (are you estimating? \_ yes \_ no)

Blood Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your weight changed recently?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you are obese, how long have you been obese?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Handedness: \_\_\_Right \_\_\_Left

Hair Color: (natural)

Eye Color: \_\_\_Blue \_\_\_Green \_\_\_Gray \_\_\_Brown \_\_\_Hazel \_\_\_Other

Tattoos: \_\_\_\_Yes \_\_\_\_No

If yes, description and location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Body Piercings: \_\_\_\_Yes \_\_\_\_No

If yes, location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Geographic History:**

Current Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your home within city limits?

Where did you spend the first 10 years of your life?

City/State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Start Date \_\_\_\_\_\_\_\_ End Date \_\_\_\_\_\_\_

City/State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Start Date \_\_\_\_\_\_\_\_ End Date \_\_\_\_\_\_\_

City/State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Start Date \_\_\_\_\_\_\_\_ End Date \_\_\_\_\_\_\_

City/State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Start Date \_\_\_\_\_\_\_\_ End Date \_\_\_\_\_\_\_

Where did you spend the last 20 years of your life?

City/State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Start Date \_\_\_\_\_\_\_\_ End Date \_\_\_\_\_\_\_

City/State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Start Date \_\_\_\_\_\_\_\_ End Date \_\_\_\_\_\_\_

City/State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Start Date \_\_\_\_\_\_\_\_ End Date \_\_\_\_\_\_\_

Dental History (Please indicate the year or approximate age for each)

Braces: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Bridge:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dentures: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dental Trauma: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe the above information and any other you feel may be important, including gum disease, tooth restorations, etc.

**Social History**

Marital Status: \_\_\_ Single \_\_\_ Married \_\_\_Widowed \_\_\_ Divorced \_\_\_ Remarried \_\_\_\_Other

Spouse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_\_\_\_

First Middle Last Maiden

Your Spouse is: \_\_\_Living \_\_\_\_Deceased \_\_\_ Unknown

Number of Children: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of full term pregnancies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Place of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First/ Middle/ Last/ Maiden City/State/ Country

Father’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Place of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First/ Middle/ Last City/ State/ Country

Education: \_\_\_\_8th Grade or Less \_\_\_\_9-12th Grade/No Diploma \_\_\_\_High School Graduate or GED

\_\_\_\_Some College Associate Degree \_\_\_\_Bachelor’s Degree \_\_\_\_Master’s Degree \_\_\_\_Doctorate/Professional \_\_\_\_Unknown

Childhood Socio-Economic Status: \_\_\_\_Lower \_\_\_\_Lower-Middle \_\_\_\_Middle \_\_\_\_Upper-Middle \_\_\_\_Upper

Adult Socio-Economic Status: \_\_\_\_Lower \_\_\_\_Lower-Middle \_\_\_\_\_Middle \_\_\_\_Upper-Middle \_\_\_\_Upper

Did you ever serve in the military? \_\_\_ yes \_\_\_ no \_\_\_ unknown

If yes, Branch: Serial # of discharge papers or adjusted service certificate:

Usual (Life-long) Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Business/Industry:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History** (please indicate the year or approximate age for each):

Surgery (general):

Plastic Surgery (indicate type and location):

Fractures:

Auto Accidents (traumatic):

Cancer (type):

Spinal Injuries:

Open heart surgery:

Amputations:

Prosthetics:

Diabetes: \_ \_\_Yes \_\_No Years?\_\_\_\_\_\_

Smoker: \_Yes \_ No Years?

Alcoholic: \_Yes \_No Years?\_\_\_\_ \_\_\_Other(incl. childhood disorders):

Habitual Activities (running, repetitive motion, life-long occupation, etc):

Please use the space below to further describe any medical history you feel may be important, including current medications, timing of injuries, the location of the trauma, etc.