# F218

# Registrant Personal/Medical History

*Created 03/02*

*Approved by* Ronald E. Filipy, Director
March 2002

*This form is provided in the Registrant packets and is completed by the Registrant when wishing to be considered for participation in the program or renewing their five-year agreement. This provides the Registries with important personal history that is useful when evaluating the donor's case.*

**PERSONAL/MEDICAL HISTORY**

***Personal History***

| | | | | |
|---|---|---|---|---|
| name | social security number | | date | |
| street address | city | | state | zip code |
| birth date | sex M F | retired yes no | height | weight |
| physician name | physician address/phone | | | |

***Employment History***

| job title/type of work | employer | adress or location | dates (from-to) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

***Radiation Exposure History***

| Have you ever been exposed to or worked with: (please check (✓) the appropriate boxes) | | | | | | | |
|---|---|---|---|---|---|---|---|
| | yes | no | dates (from-to) | | yes | no | dates (from-to) |
| Plutonium | | | | Americium | | | |
| Uranium | | | | Thorium | | | |
| Radium | | | | Other transuranics | | | |
| Strontium-90 | | | | Other radioactivity | | | |

| | yes | no | do not know |
|---|---|---|---|
| Do you have a documented deposition of radioactivity in your body?<br>If yes, what isotope(s)?<br>How much? | | | |
| Have you ever been routinely monitored for radioactivity in urinalyisis or in-vivo counting? | | | |
| Do you wear/have you worn a dosimeter (TLD, film badge) at work? | | | |
| Have you ever been exposed or contaminated in a radiation incident? | | | |
| Have you ever undergone radiation therapy or diagnosis?<br>If yes, please list physician and hospital. | | | |

### *Chemical Exposure History*

| Have you ever worked with or been exposed to any of the following: | yes | no | dates (from-to) | | yes | no | dates |
|---|---|---|---|---|---|---|---|
| Beryllium | | | | Asbestos | | | |
| Chlorinated Solvents | | | | Benzene, Toluene | | | |
| Other Toxic Chemicals | | | | | | | |

### *Smoking History*

| Have you ever smoked: | yes | no | dates (from-to) | packs/number per day |
|---|---|---|---|---|
| Cigarettes | | | | |
| Cigars | | | | |
| Pipes | | | | |

### *Family History*

| Relative | Age if living | If living, give state of health or diseases such as cancer, heart disease, etc. | Age at death | If deceased, cause of death |
|---|---|---|---|---|
| Father | | | | |
| Mother | | | | |
| Brothers | | | | |
| | | | | |
| | | | | |
| Sisters | | | | |
| | | | | |
| | | | | |

### *Medical History*

| | | | | |
|---|---|---|---|---|
| Indicated which of the following best describes your current health: | ☐ Excellent | ☐ Good | ☐ Fair | ☐ Poor |
| Have you ever had cancer or leukemia? | | ☐ Yes | ☐ No | |
| Are you human immunodeficiency virus (HIV) serum positive? | | ☐ Yes | ☐ No | |
| Have you had or been tested serum positive for hepatitis B or C (HBV,HCV)? | | ☐ Yes | ☐ No | |
| Have you ever had any other significant abnormalties or diseases? | | ☐ Yes | ☐ No | |
| Do you have any comments about your health or work history? | | ☐ Yes | ☐ No | |

| Dates | If you answered yes to any of the above, please explain below. Attach additional pages if necessary. |
|---|---|
| | |
| | |
| | |
| | |

| What medicines, drugs, or other remedies do you regularly take? |
|---|
| |
| |
| |