

F218

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Registrant Personal/Medical History

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Approved by

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This form is provided in the Registrant packets and is completed by the Registrant when wishing to be considered for participation in the program. 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		Date	
Street Address			City		State
Birth Date		Sex <input type="checkbox"/> M <input type="checkbox"/> F		Height	
Physician Name		Physician Address/Phone			
				Weight	

Employment History

Job Title/Type of Work	Employer	Address 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?			
If yes, what isotope(s)?			
How Much?			
Have you ever been routinely monitored for radioactivity in urinalysis or in-vivo counting?			
Do you wear/have 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?			
If yes, please list physician and hospital.			

Chemical Exposure History

Have you ever worked with or been exposed to any of the following:
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	Yes	No	Dates (From-To)		Yes	No	Dates (From-To)
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 disease such as cancer, heart disease, etc.	Age of death	If deceased, cause of death
Father				
Mother				
Brothers				
Sisters				

Medical History

Indicate which of the following best describes your current health: <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
Have you ever had cancer or leukemia?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you human immunodeficiency virus (HIV) serum positive?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had or been tested serum positive for hepatitis B or C (HBV, HCV)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had any other significant abnormalities or diseases?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any comments about your health or work history:	<input type="checkbox"/> Yes <input type="checkbox"/> 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?