

Medalist Information Questionnaire for Donation to Medical Research

Date: _____

| | | | |
|-----------------------|-------|-------------------------|-------------------|
| Name of Donor: _____ | | | |
| Address: _____ | | | |
| City | State | Zip Code | Home Phone (____) |
| Work Phone: () _____ | | Cell Phone: () _____ | |
| E-mail: _____ | | Date of Birth: __/__/__ | |

| | | | |
|---------------------------------|-------|-----------------------|-------------------|
| Contact Name/Next-of-Kin: _____ | | | |
| | | | Relationship |
| Address: _____ | | | |
| City | State | Zip Code | Home Phone (____) |
| Work Phone: () _____ | | Cell Phone: () _____ | |
| E-mail: _____ | | | |

How did you hear about NDRI? _____

Medical History:

1. Personal information:

| Age | Sex (circle) | Race | Height | Weight |
|-------|--------------|-------|--------------------|-----------|
| _____ | M F | _____ | ____ ft ____ in | _____ lbs |

2. Please fill all that apply:

| | Y or N | Frequency | Quantity |
|-------------|--------|-----------|----------------|
| Alcohol Use | | | Drinks per day |
| Tobacco Use | | | Packs per day |
| Drug Use | | | |

3. Have you been diagnosed with Type 1 diabetes? Y N Year? _____

4. What year did you receive your medal? _____

5. Treatment/therapy for Type 1 diabetes:

| Types of treatment | Medication | Length of time used | Frequency & Dosages |
|-----------------------------------|------------|---------------------|---------------------|
| Animal-derived insulin injections | | _____ to _____ | |
| Human-derived insulin injections | | _____ to _____ | |
| Insulin pump | | _____ to _____ | |

6. Have you experienced any complications related to your diabetes? Y N

If yes, please check all boxes that apply:

- | | |
|---|--|
| <input type="checkbox"/> Amputation | <input type="checkbox"/> Gastrointestinal problems |
| <input type="checkbox"/> Cardiovascular disease | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Diabetic nephropathy | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Diabetic neuropathy | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Diabetic retinopathy | <input type="checkbox"/> Other: _____ |

7. Have you been diagnosed with any other severe illnesses/chronic diseases? Y N

If yes, then please describe them and any treatments/therapies used to treat them:

| Illness(es) | Medication(s) | Length of time used | Frequency & Dosages |
|-------------|---------------|---------------------|---------------------|
| | | _____ to _____ | |
| | | _____ to _____ | |
| | | _____ to _____ | |
| | | _____ to _____ | |
| | | _____ to _____ | |
| | | _____ to _____ | |

8. Surgical history:

| Surgical Procedure | Date | Reason |
|--------------------|------|--------|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

9. Attending physician, specialist(s):

| | |
|-----------------------|--------------|
| _____ | |
| (Name) | |
| _____ | |
| (Specialty) | |
| _____ | |
| (Address) | |
| _____ | |
| (City/State/Zip Code) | |
| _____ | _____ |
| (Phone Number) | (Fax Number) |

| | |
|-----------------------|--------------|
| _____ | |
| (Name) | |
| _____ | |
| (Specialty) | |
| _____ | |
| (Address) | |
| _____ | |
| (City/State/Zip Code) | |
| _____ | _____ |
| (Phone Number) | (Fax Number) |

| | |
|-----------------------|--------------|
| _____ | |
| (Name) | |
| _____ | |
| (Specialty) | |
| _____ | |
| (Address) | |
| _____ | |
| (City/State/Zip Code) | |
| _____ | _____ |
| (Phone Number) | (Fax Number) |

| | |
|-----------------------|--------------|
| _____ | |
| (Name) | |
| _____ | |
| (Specialty) | |
| _____ | |
| (Address) | |
| _____ | |
| (City/State/Zip Code) | |
| _____ | _____ |
| (Phone Number) | (Fax Number) |

10. Local hospital:

Nursing care facility:

| |
|-----------------------------|
| _____ |
| (Name) |
| _____ |
| (Address) |
| _____ |
| (City/State/Zip Code) |
| _____ |
| (Phone Number) (Fax Number) |

| |
|-----------------------------|
| _____ |
| (Name) |
| _____ |
| (Address) |
| _____ |
| (City/State/Zip Code) |
| _____ |
| (Phone Number) (Fax Number) |

11. Funeral Home you will use (if known): _____

_____ Address City State Zip code

Phone number: () _____ Contact name: _____

12. Other Comments or significant health information: _____

13. Verification:

Print name

Signature

Date

As the above information changes, please notify NDRI.

Thank you for your kindness.

If you have any questions or concerns, please call us.

800-222-NDRI (6374)

To be filled by NDRI:

Reviewed by: _____
Signature of Private Donor Coordinator Date

Verified by: _____
Signature of Private Donor Manager/Director Date