



**Forensic Anthropology Center
University of Tennessee, Knoxville**
Body Donation Questionnaire



Please complete the following information by filling in the blank and/or circling an option.
If you need more space, additional sheets may be attached.
All of the information will be considered confidential.

Name _____ / _____ / _____ **Sex:** male ___ female ___
Last First Middle

Social Security # _____ — _____ — _____ **Race:** White / Black / Hispanic / Other _____
(circle one)

Date of Birth ____ / ____ / ____ **Age** ____ **Place of Birth (city/state)** _____

Home Address _____

City _____ **County** _____ **State** ____ **Zip** _____

Phone Number _____ **Inside City Limits:** yes ___ no ___

Mother's Name (include maiden) _____ **Place of Birth** _____

Father's Name _____ **Place of Birth** _____

Height _____ **Weight** _____ *If estimating height and weight, please indicate: ___ yes ___ no

Handedness: Right ___ Left ___ **Shoe size** ____ **Blood Type** _____ **Hair Color** _____
(natural)

Marital Status: (circle one) Never Married Married Widowed Divorced Unknown Other

Spouse: _____ / _____ / _____ Living ___ Deceased ___ Unknown ___
Last (include maiden) First Middle

Number of Children: _____

Highest Education Level (indicate number of years) **Military Service:** yes ___ no ___
Elem/Second (0-12): _____ College (1-4; 5+): _____

Childhood Socio-Economic Status: (circle one) Lower Lower Middle Middle Upper Middle Upper

Usual (life-long) Occupation _____ **Business/Industry** _____

Residence History (list additional locations as necessary)

Childhood Hometown (0-15 years of age):

City _____ State _____ Start Date _____ End Date _____

City _____ State _____ Start Date _____ End Date _____

City _____ State _____ Start Date _____ End Date _____

Location as an Adult (any place you have lived for more than 1 year)

City _____ State _____ Start Date _____ End Date _____

City _____ State _____ Start Date _____ End Date _____

City _____ State _____ Start Date _____ End Date _____

City _____ State _____ Start Date _____ End Date _____

PLEASE CONTINUE ON NEXT PAGE

Name _____ / _____ / _____
Last First Middle

Dental History – Check all that apply

- | | | |
|---|---|-------------------------------|
| <input type="checkbox"/> Extensive Dental work | <input type="checkbox"/> Most/all teeth | Teeth Missing |
| <input type="checkbox"/> Lower Dentures: When _____ | <input type="checkbox"/> Bridge | <input type="checkbox"/> Few |
| <input type="checkbox"/> Upper Dentures: When _____ | <input type="checkbox"/> Gum Disease | <input type="checkbox"/> Many |
| <input type="checkbox"/> Upper and Lower Dentures: When _____ | <input type="checkbox"/> Dental Disease | <input type="checkbox"/> All |
| <input type="checkbox"/> Partial Plate | <input type="checkbox"/> Other | |
| <input type="checkbox"/> Braces | | |

Medical History (please indicate the approximate year for each). Please do not provide just a Doctor's name.

- | | |
|--|---|
| <input type="checkbox"/> Surgery (general) | <input type="checkbox"/> Plastic Surgery (indicate type and location) _____ |
| <input type="checkbox"/> Fractures _____ | |
| <input type="checkbox"/> Auto Accident (traumatic) | <input type="checkbox"/> Cancer (type) _____ |
| <input type="checkbox"/> Spinal Injuries | Treatment - _____ |
| <input type="checkbox"/> Open Heart Surgery | <input type="checkbox"/> Smoker If yes, how long? |
| <input type="checkbox"/> Amputations | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Prosthetics | <input type="checkbox"/> Other (Including childhood disorders) _____ |
| <input type="checkbox"/> Diabetes | |

Medical History (continued) – Please describe the above and any other information you feel may be important, including current medications, timing of injuries, the locations of traumatic injuries, or a family history of an illness, etc. Please attach additional pages as necessary.

Habitual Activities (i.e., jogging, repetitive motions, life-long occupation activities, etc.) -

Eye Color Blue Green Gray Brown Hazel Other _____

Tattoo(s) Yes If yes, Description: _____
 No Body Location: _____

Body Piercing(s) Yes If yes, Description: _____
 No Body Location: _____

PLEASE CONTINUE ON NEXT PAGE

Name _____ / _____ / _____
Last First Middle

Informant Information (if other than donor)

Name _____ Relationship _____
Address _____ Phone number _____
City _____ State _____ Zipcode _____ email: _____

DO NOT CONTINUE IF YOU ARE A LIVING DONOR

Location of death (if applicable) **Date of Death** _____

Institution/Hospital _____

Address _____

City _____ County _____ State _____ Zip code _____

Thank you for taking the time to fill out this questionnaire.
If we can be of further assistance, please feel free to contact us.

Return completed forms to:

Dr. Lee Meadows Jantz
Department of Anthropology
250 South Stadium Hall, Knoxville, TN 37996-0720
email: donateinfo@utk.edu
phone: (865) 974-4408 fax: (865) 974-2686
