Lucile Salter Packard Children's Hospital

Stanford MEDICINE

Fertility and Reproductive Health

Medical Record Number

Patient Name

CLINIC • REI FEMALE DONOR PHYSICAL EXAM

Addressograph or Label - Patient Name, Medical Record Number

Donor Name or Number_____ Date of Birth_____

Date of Examination_____

Height _____ Weight_____ BMI_____ Temperature _____ Pulse_____ Respiration_____ BP_____ LMP_____

Neurological ☐ **Normal (no signs of dementia)** ☐ **Abnormal**_____

Eyes ☐ **Normal** ☐ **Abnormal**_____

☐ **Yes** ☐ **No** Any infection or redness of the eyes related to possible cornea abrasion or scarring consistent with vaccinial keratitis

☐ **Yes** ☐ **No** Icterus? (if yes, answer may not result in donor ineligibility if cause of Icterus is other than infectious disease)

Throat ☐ **Normal** ☐ **Abnormal**_____

☐ **Yes** ☐ **No** Any oral thrush, white spots or unusual blemishes?

Lungs ☐ **Normal** ☐ **Abnormal**_____

☐ **Yes** ☐ **No** Any Fever for more than 10 days?

☐ **Yes** ☐ **No** Any unexplained cough or shortness of breath

Heart ☐ **Normal** ☐ **Abnormal**_____

☐ **Yes** ☐ **No** Any Tachycardia, tachypnea or hypotension?

Lymph nodes ☐ **Normal** ☐ **Abnormal**_____

☐ **Yes** ☐ **No** Any swollen lymph nodes in the neck, axilla, or groin or evidence of disseminated lymphadenopathy?

Abdomen ☐ **Normal** ☐ **Abnormal**_____

☐ **Yes** ☐ **No** Any tenderness or hepatomegaly? (if yes, answer may not result in donor ineligibility if cause of hepatomegaly is other than infectious disease)

Breasts ☐ **Normal** ☐ **Abnormal**_____

External Genitalia ☐ **Normal** ☐ **Abnormal**_____

Vagina / pelvic support ☐ **Normal** ☐ **Abnormal**_____

Cervix ☐ **Normal** ☐ **Abnormal**_____

Uterus ☐ **Normal** ☐ **Abnormal**_____

Bladder ☐ **Normal** ☐ **Abnormal**_____

Urethral Meatus ☐ **Normal** ☐ **Abnormal**_____

Urethra ☐ **Normal** ☐ **Abnormal**_____

☐ **Yes** ☐ **No** Any redness, edema, or physical evidence of genital ulcerative disease, herpes simplex, syphilis, genital warts, or chancroid?

☐ **Yes** ☐ **No** Any physical evidence of anal intercourse, insertion trauma, or perianal condyloma?

Print Name

Skin ☐ **Normal** ☐ **Abnormal**_____

☐ **Yes** ☐ **No** Evidence of non-medical percutaneous drug use?

☐ **Yes** ☐ **No** Any needle tracks?

☐ **Yes** ☐ **No** Purple/blue spots consistent with Kaposi's Sarcoma

☐ **Yes** ☐ **No** Jaundice (if yes, answer may not result in donor ineligibility if cause of Jaundice is other than infectious disease)

☐ **Yes** ☐ **No** Evidence of Icterus

☐ **Yes** ☐ **No** Rashes

☐ **Yes** ☐ **No** Large scab or necrotic lesion consistent with recent smallpox vaccination or vaccinia necrosum

☐ **Yes** ☐ **No** Lesions or eczema vaccinatum

Tattoo (s) ☐ **Yes** ☐ **No**

☐ **Yes** ☐ **No** Any evidence or recent tattoo or home produced tattoo? (within past 12 months)

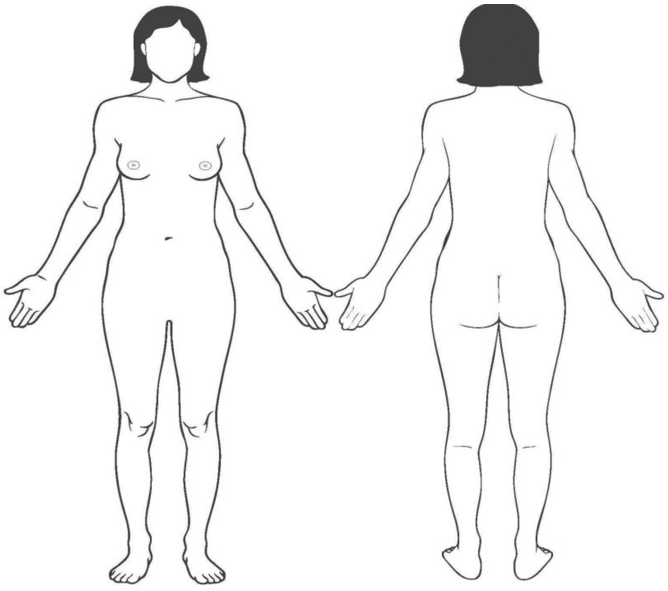
☐ **Yes** ☐ **No** If yes, ask donor whether "sterile instruments" were used.

Body or Ear Piercing ☐ **Yes** ☐ **No**

☐ **Yes** ☐ **No** Any evidence of recent body piercing? (within past 12 months)

☐ **Yes** ☐ **No** If yes, ask donor whether "sterile instruments" were used.

Donor Physical Examination



Please mark the location of any rashes, scars, lesions, tattoo (s), piercing (s), needle tracks or hematomas.

Authorized Medical Provider Completing Form:

_____ _____

Date Time

_____ _____ _____

Provider Signature/Title Print Name Pager