Lucile Salter Packard Children's Hospital

Stanford MEDICINE

Fertility and Reproductive Health

Medical Record Number

Patient Name

CLINIC • REI MALE DONOR PHYSICAL EXAM

Addressograph or Label - Patient Name, Medical Record Number

Donor Name/Number_____ Date of Birth_____

Date of Examination_____

Height _____ Weight_____ BMI_____ Temperature _____ Pulse_____ Respiration_____ BP_____

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)

Uro-Genital ☐ **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?

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**

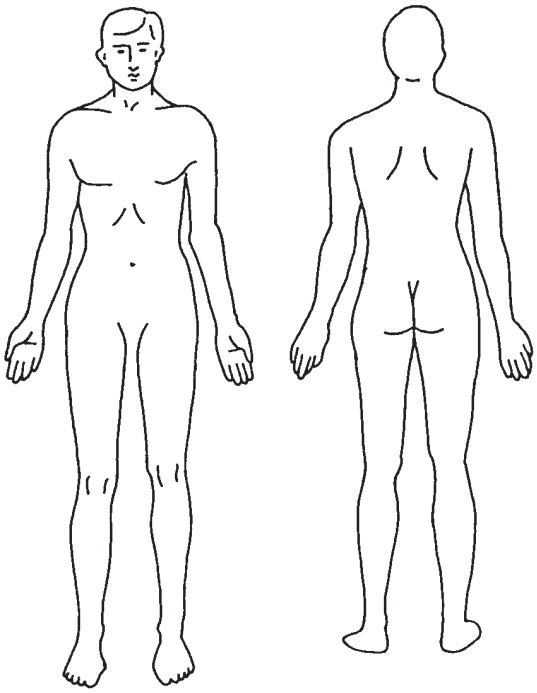
☐ **Yes** ☐ **No** Any evidence or recent tattoo or home produced tattoo? (within past 12 months)

☐ **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.



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

Authorized Medical Provider Completing Form:

_____ _____

Date Time

_____ _____ _____

Provider Signature/Title Print Name Pager