DONOR APPLICATION & MEDICAL/GENETIC HISTORY

To: Prospective Donor

Thank you for your interest in becoming a donor of reproductive tissue. All prospective donors must complete this application and the medical/genetic history questionnaire. We thank you for your honesty in supporting our efforts to maintain a safe donor population for our community.

The undersigned agrees that, to the best of his/her knowledge and belief, the information provided in this application is complete and correct. The undersigned furthermore agrees to report to our clinic any significant changes in the status of his/her health, especially in regards to sexually transmitted disease.

I certify that, to the best of my knowledge and belief, the following information provided by me in this document is complete and correct.

_____

Donor Name (Printed) Donor Signature

Date

……

Donor Application Number (Clinic will complete):_____

_____

Reviewed By **[Clinic Physician Name]**

Date

_____

Reviewed By **[Other Clinic Representative]** Date

_____

Reviewed By **[Other Clinic Representative]** Date

INSTRUCTIONS: Please print all of the requested information. Write "NA" in blanks that are not applicable. Please be specific. Avoid expressions such as "natural" or "old age" for causes of death. List any health problems as specifically as possible. Give ages to your best approximation. List exact relationships, such as "first cousin through my mother's sister." Please provide information on all relatives requested. You do not need to list names. If you have questions, please contact the clinic at 317-595-3665.

PERSONAL INFORMATION

Name _____

Address _____

_____

Phone

_____

Home Cell Work

Date of Birth _____ **Place of Birth** _____**Social Security Number**_____

Nationality (i.e.: German, Irish, etc) of Mother _____ **of Father**_____

Are you adopted? Yes No

Hair color: Black Dark Brown Brown Light Brown Blonde Auburn Red

Hair texture: Straight Wavy Curly Kinky

Eye color: Blue Brown Hazel Green Blue-Green Blue-Grey Black

Height: _____inches **Weight:** _____pounds

Bone size: Small Small-Medium Medium Medium-Large Large

Complexion: Very Fair Fair Medium Olive Dark

Baldness: Yes No **Baldness in Family:** Yes No

Current Occupation:

_____

Highest Degree earned: High School Vo-Tech AA Bachelors Masters Doctorate:_____

Specify Degree(s): _____

PERSONAL INFORMATION CONTINUED

Race: Native American Black, Non-Hispanic White, Non-Hispanic Latino /Hispanic Asian/Pacific Islander East Indian Multi Racial

Religion: Protestant Catholic Jewish Other (Specify):_____

Current hobbies and interests: _____

Marital Status: Married Single Divorced

How many children do you have? _____

Have you ever been convicted of a crime: Yes No

If yes, for what reason _____

If yes, did you spend any time in jail/prison: Yes No Length of time _____

DONOR RISK BEHAVIOR ASSESSMENT – PART 1

Donor Name: _____ **Donor Number:** _____

1. **Are you a male who has had sex with another male in the preceding five years?**

   ☐ Yes

   ☐ No

2. **Have you injected drugs for non-medical reason in the preceding five years, including intravenous, intramuscular, or subcutaneous injections?**

   ☐ Yes

   ☐ No

3. **Do you have hemophilia or other related clotting disorders and have received human-derived clotting factor concentrates in the preceding five years, not including receiving clotting factors once to treat an acute bleeding event more than 12 months ago?**

   ☐ Yes

   ☐ No

4. **Have you engaged in sex in exchange for money or drugs in the preceding five years?**

   ☐ Yes

   ☐ No

5. **Have you had sex in the preceding 12 months with any person who would have answered yes to any of the four previous items or with any person known or suspected to have HIV infection, including any person who has had a positive or reactive test for HIV virus hepatitis B (HBV) infection or clinically active (symptomatic) hepatitis C (HCV) infection?**

   ☐ Yes

   ☐ No

Donor Name: _____ **Donor Number:** _____

6. **Have you been exposed in the preceding 12 months to known or suspected HIV, HBV, and/or HCV infected blood through percutaneous inoculation (e.g., needle-stick) or through contact with an open wound, non- intact skin, or mucous membrane?**

   ☐ Yes

   ☐ No

7. **Have you been in juvenile detention, lock up, jail or prison for more than 72 consecutive hours in the preceding 12 months?**

   ☐ Yes

   ☐ No

8. **Have you, anyone in your household or any of your intimate contacts ever been diagnosed with any form of hepatitis?**

   ☐ Yes

   ☐ No

9. **Have you lived with (resided in the same dwelling) another person who has hepatitis B or clinically active (symptomatic) hepatitis C infection in the preceding 12 months?**

   ☐ Yes

   ☐ No

10. **Within the preceding 12 months, have you undergone tattooing, ear piercing, or body piercing in which sterile procedures were not used e.g., contaminated instruments and/or ink were used, or shared instruments that had not been sterilized between procedures were used?**

    ☐ Yes

    ☐ No

11. **Have you had a past diagnosis of clinical, symptomatic viral hepatitis after your eleventh birthday, unless evidence from the time of illness documents that the hepatitis was identified as being caused by hepatitis A virus (e.g., a reactive IgM anti-HAV test), Epstein-Barr Virus (EBV), or cytomegalovirus (CMV)?**

    ☐ Yes

    ☐ No

Donor Name: _____ **Donor Number:** _____

12. Do you have or suspect that you have sepsis (systemic infection) at this time?

☐ Yes

☐ No

13. Have you or any of your close contacts had a smallpox vaccine within the past eight weeks?

☐ Yes

☐ No

14. If you have had a smallpox vaccination (vaccinia virus) in the preceding eight weeks, has your scab separated spontaneously?

☐ N/A- I have not had a smallpox vaccination in the preceding eight weeks.

☐ Yes - My scab has not separated spontaneously.

☐ N/A- I did not acquire a scab as a result of my smallpox vaccination.

☐ No - My scab has not separated spontaneously.

15. If you have had a smallpox vaccination (vaccinia virus) in the preceding eight weeks, has it been 21 days post- vaccination?

☐ N/A- I have not had a smallpox vaccination in the preceding eight weeks.

☐ Yes

☐ No

16. If you have had a smallpox vaccination (vaccinia virus) in the preceding eight weeks and have had complications as a result of that vaccine, have your complications been completely resolved for at least fourteen days?

☐ N/A- I have not had a smallpox vaccination in the preceding eight weeks.

☐ N/A- I did not have any complications from my smallpox vaccination.

☐ Yes

☐ No

Donor Name: _____ **Donor Number:** _____

17. Have you been diagnosed with clinically recognizable vaccinia virus infection and developed scabs or skin lesions acquired by close contact with someone who received the smallpox vaccine (i.e., touching the vaccination area or the scab, including the covering bandages, or touching clothing, towels, or bedding that might have come into contact with an unbandaged vaccination area or scab) and the resulting scab has since spontaneously separated?

- ☐ N/A- I have not been diagnosed with clinically recognizable vaccinia virus infection.
- ☐ N/A- I did not have any complications, scabs or lesions as a result of my diagnosis.
- ☐ Yes - My scab has since separated spontaneously.
- ☐ No - My scab did not separate spontaneously, but it has been three or more months since the date of the vaccination of the vaccine recipient with whom I had close contact.
- ☐ No - My scab has not yet separated.
- ☐ No - My scab did not separate spontaneously, and it has been less than three months since the date of the vaccination of the vaccine recipient with whom I had close contact.

18. Have you been diagnosed with clinically recognizable vaccinia virus infection and developed other complications of vaccinia infection acquired by close contact with someone who received the smallpox vaccine (i.e., touching the vaccination area or the scab, including the covering bandages, or touching clothing, towels, or bedding that might have come into contact with an unbandaged vaccination area or scab)?

- ☐ N/A- I have not been diagnosed with clinically recognizable vaccinia virus infection.
- ☐ Yes – but my complications have been resolved for at least fourteen days.
- ☐ No – I had no complications as a result of my diagnosis.
- ☐ Yes – but my complications have not been resolved for at least fourteen days.

Donor Name: _____ **Donor Number:** _____

19. Have you ever tested positive for or been treated for West Nile Virus?

☐ Yes

☐ No

20. Have you had a medical diagnosis, onset of illness, or suspicion of WNV (West Nile Virus) infection (including diagnosis based on symptoms and/or laboratory results or confirmed WNV viremia) in the preceding 120 days?

☐ Yes

☐ No

21. Have you tested positive or reactive for WNV infection using an FDA-licensed or investigational WNV NAT donor screening test in the preceding 120 days?

☐ Yes

☐ No

22. Have you ever tested positive or been treated for a sexually-transmitted disease?

☐ Yes

☐ No

23. Have you been treated for or had syphilis within the preceding 12 months?

☐ Yes

☐ No

24. Have you been treated for or had Chlamydia trachomatis or Neisseria gonorrhea infection in the preceding 12 months?

☐ Yes

☐ No

Donor Name: _____ **Donor Number:** _____

25. Have you or any of your blood relatives ever been diagnosed with Creutzfeldt-Jakob disease (CJD)?

☐ Yes

☐ No

26. Have you ever been diagnosed with vCJD or any other form of Creutzfeldt-Jakob disease (CJD)?

☐ Yes

☐ No

27. Have you been diagnosed with dementia or another neurological disease of unknown cause?

☐ Yes

☐ No

28. Have you ever been diagnosed with dementia or any degenerative or demyelinating disease of the central nervous system or other neurological disease of unknown etiology?

☐ Yes

☐ No

29. Have you received a non-synthetic dura matter transplant, received human pituitary derived growth hormone, and/or have one or more blood relatives diagnosed with CJD that was not subsequently found to be an incorrect diagnosis, found to be iatrogenic, or that laboratory testing (gene sequencing) shows that you do not have a mutation associated with CJD?

☐ Yes

☐ No

30. Since 1977, have you or any of your intimate contacts ever traveled to or lived in Europe or Africa?

☐ Yes

☐ No

Donor Name: _____ **Donor Number:** _____

31. Have you spent 3 months or more, cumulatively, in the UK (England, Northern Ireland, Scotland, Wales, the Isle of Man, the Channel Islands, Gibraltar, or the Falkland Islands) from the beginning of 1980 through the end of 1996?

☐ Yes

☐ No

32. Are you a current or former US military member, civilian military employee, or dependent of a military member or civilian employee, who has resided at US military bases in northern Europe (Germany, Belgium, and Netherlands) for 6 months or more cumulatively from 1980 through 1990, or elsewhere in Europe (Greece, Turkey, Spain, Portugal, or Italy) for 6 months or more cumulatively from 1980 through 1996?

☐ Yes

☐ No

33. Have you lived cumulatively for 5 years or more in Europe (Albania, Austria, Belgium, Bosnia-Herzegovina, Bulgaria, Croatia, Czech Republic, Denmark, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Liechtenstein, Luxembourg, Macedonia, Netherlands, Norway, Poland, Portugal, Romania, Slovak Republic, Slovenia, Spain, Sweden, Switzerland, England, Northern Ireland, Scotland, Wales, Isle of Man, Channel Islands, Gibraltar, Falkland Islands, and Yugoslavia) from 1980 until present?

☐ Yes

☐ No

34. Have you received any transfusion of blood or blood components in the UK (England, Northern Ireland, Scotland, Wales, Isle of Man, Channel Islands, Gibraltar, Falkland Islands) or France between 1980 and the present?

☐ Yes

☐ No

35. Were you or any of your sexual partners born in or have you or any of your sexual partners lived in Cameroon, Central African Republic, Chad, Congo, Equatorial Guinea, Gabon, Niger, or Nigeria after 1977?

☐ Yes

☐ No

Donor Name: _____ **Donor Number:** _____

36. Have you received a blood transfusion or any medical treatment that involved blood in Cameroon, Central African Republic, Chad, Congo, Equatorial Guinea, Gabon, Niger, or Nigeria after 1977?

☐ Yes

☐ No

37. Have you or any of your intimate contacts ever undergone a medical procedure involving non-human (animal) cells, tissues or organs?

☐ Yes

☐ No

38. Have you been the recipient of a xenotransplantation product (transplantation, implantation, or infusion) of either cells, tissues or organs from a nonhuman animal source (this includes human bodily fluids, cells, or organs that have had ex-vivo contact with live nonhuman animal cells, tissues, or organs)?

☐ Yes

☐ No

39. Has anyone you have had close contact with (e.g., intimate or living in the same household, where sharing of kitchen and bathroom facilities occurs regularly) been the recipient of a xenotransplantation product (transplantation, implantation, or infusion) of either cells, tissues or organs from a nonhuman animal source (this includes human bodily fluids, cells, or organs that have had ex-vivo contact with live nonhuman animal cells, tissues, or organs) not including the product Epicel?

☐ Yes

☐ No

40. Does your medical history or medical records show any evidence of a diagnosis or a prior positive or reactive screening test result for HIV?

☐ Yes

☐ No

Donor Name: _____ **Donor Number:** _____

41. Have you ever had unexplained weight loss?

☐ Yes

☐ No

42. Have you ever had unexplained night sweats?

☐ Yes

☐ No

43. Have you ever had blue or purple spots on or under the skin or mucous membranes typical of Kaposi's sarcoma?

☐ Yes

☐ No

44. Have you ever had disseminated lymphadenopathy (swollen lymph nodes) for longer than one month?

☐ Yes

☐ No

45. Have you ever had an unexplained temperature of greater than 100.5 F (38.6 C) for more than 10 days?

☐ Yes

☐ No

46. Have you ever had unexplained persistent cough or shortness of breath?

☐ Yes

☐ No

47. Have you ever had opportunistic infections (infection that takes advantage of a weakened immune system)?

☐ Yes

☐ No

Donor Name: _____ **Donor Number:** _____

48. Have you ever had unexplained persistent diarrhea?

☐ Yes

☐ No

49. Have you ever had unexplained persistent white spots or unusual blemishes in the mouth?

☐ Yes

☐ No

50. Does your medical history or medical records show any evidence of a diagnosis or a prior positive or reactive screening test result for Hepatitis B Virus or Hepatitis C Virus?

☐ Yes

☐ No

51. Have you ever had unexplained jaundice?

☐ Yes

☐ No

52. Have you ever had unexplained hepatomegaly (enlarged liver)?

☐ Yes

☐ No

53. Have you had a past diagnosis of clinical, symptomatic viral hepatitis after your eleventh birthday that was not later identified as being caused by hepatitis A virus, Epstein Barr Virus, or cytomegalovirus?

☐ Yes

☐ No

Donor Name: _____ **Donor Number:** _____

54. Within the past 120 days, have you experienced unexplained fever, headache, body aches, or eye pain that may have been accompanies by skin rash on the trunk of the body or by swollen lymph glands?

☐ Yes

☐ No

55. Within the past 120 days, have you been diagnosed with a severe illness such as encephalitis, meningitis, meningoencephalitis, or acute flaccid paralysis?

☐ Yes

☐ No

56. Within the past 120 days, have you had signs and symptoms of severe illness, including headache, high fever, neck stiffness, stupor, disorientation, coma, tremors, convulsions and muscle weakness or paralysis?

☐ Yes

☐ No

57. Have you, in the last 12 months, been diagnosed with sepsis (including bacteremia, septicemia, sepsis syndrome, systemic infection, systemic inflammatory response syndrome (SIRS) or septic shock)?

☐ Yes

☐ No

58. Have you ever had clinical evidence of infection with two or more of the following systemic responses to infection if unexplained: temperature of greater than 100.4 F (38C), elevated heart rate, elevated respiratory rate or elevated white blood cell count?

☐ Yes

☐ No

Donor Name: _____ **Donor Number:** _____

59. Have you, in the last 12 months, experienced more severe signs of sepsis including unexplained hypoxemia, elevated lactate, oliguria (less than normal urination), altered mentation and hypotension (low blood pressure)?

☐ Yes

☐ No

60. Have you, in the last 12 months, had a blood test that resulted in a positive blood cultures associated with the conditions in the previous question?

☐ Yes

☐ No

61. Does your medical history or medical records show any evidence of a diagnosis or a prior positive or reactive screening test result for HTLV?

☐ Yes

☐ No

62. Have you ever experienced unexplained paraparesis (weakness in the lower extremities)?

☐ Yes

☐ No

63. Have you ever been diagnosed with adult T-cell leukemia?

☐ Yes

☐ No

Comments (to be added by Family Beginnings only):

DONOR RISK BEHAVIOR ASSESSMENT - PART 2

Donor Name: _____ **Donor Number:** _____

1. Are you presently taking any prescribed medications? Yes No
   If yes, please specify what and why: _____

2. Did you take any prescribed medications within the last six weeks? Yes No
   If yes, please specify what and why: _____

3. Have you ever used marijuana or other illegal drugs? Yes No
   If yes, what, when and how often? _____

4. Do you smoke cigarettes? Yes No

5. Have you ever had or been treated for any form of sexually transmitted disease, including syphilis or gonorrhea? Yes No
   If yes, specify:_____

6. Did you exhibit any of the following conditions within the preceding 12 months?
   Dysuria (painful urination) Yes No
   Urethral Discharge Yes No
   Genital Ulcer Yes No

7. In the preceding six months, did you have a sexual partner who had a Trichomonas infection? Yes No

8. Have you ever experienced any of the following conditions?
   Genital Herpes Yes No
   If yes, list date _____
   Genital Warts Yes No If yes, list date _____
   Hepatitis Yes No If yes, list date _____

9. In the preceding 12 months, did you have sex or close contact (e.g., living in the same household, where sharing of kitchen and bathroom facilities occurred regularly) with anyone who has had?
   Genital Herpes Yes No
   Genital Warts Yes No
   Chronic Hepatitis (carrier) Yes No

10. Do you have any tattoos? Yes No If yes, list date received: _____

11. Have you ever had acupuncture/ear piercing/body piercing? Yes No
    If yes, identify type and list date(s): _____

Donor Name: _____ **Donor Number:** _____

12. Have you ever been previously excluded from blood donation? Yes No
If yes, identify the reason and date(s): _____

13. Have you ever been treated with human pituitary-derived growth hormone (pit-hGH)? Yes No
If yes, explain _____

14. Did you have a blood transfusion in the preceding 12 months? Yes No
If yes, explain _____

15. Were you bitten by an animal suspected of rabies in the preceding 12months?
Yes No If yes, when:_____ explain _____

16. Did you have a vaccination or immunization in the preceding 12 months?
Yes No If yes, explain_____

PERSONAL MEDICAL HISTORY

Allergies (medicines, food, pollen, etc)? Yes No
If yes, please list substance and reaction caused: _____

List any childhood allergies that you have outgrown: _____

Do you wear glasses or contact lenses or have you had laser surgery? Yes No
If yes, are/were you: ____Nearsighted _____Farsighted ____Other, please list:_____
_____

Do you have normal hearing? Yes No
If no, please explain: _____

Condition of your teeth: _____Poor _____Fair _____Good

What is your usual weight?_____lbs.

Recent loss or gain? Yes No If yes _____ lbs gain/loss (circle one)

Your diet is: _____Vegetarian _____Non-vegetarian

Your diet is: _____Poor diet _____Average diet_____Excellent diet

How much exercise do you get? ____None ____Occasional ____Regular

What type of exercise? _____

Donor Name: _____ **Donor Number:** _____

Have you had any serious illness or surgical procedures in the past? Yes No
If yes, please explain: _____

Have you had any operations? Yes No
If yes, please list the year and the type of operation:

_____

_____

_____

Have you had any hospitalizations other than for surgery? Yes No
If yes, please list the year and type of illness:

_____

_____

_____

Have you ever had any broken bones? Yes No
If yes, please explain: _____

Have you ever had any serious illness? Yes No
If yes, please explain: _____

How many days in the preceding 12 months did you miss work because of illness, etc. (colds, flu, accidents, surgery, etc)? _____

Are you currently under a physician's care for any reason? Yes No
If yes, please explain: _____

List all drugs you had taken in the preceding 12 months (prescription, nonprescription, herbal & sports supplements, recreational):

Medication	How Often	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Donor Name: _____ **Donor Number:** _____

List all current medications (include vitamins, aspirin, antacids, laxatives, herbal & sports supplements, etc.)

Medication	How Often	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever taken anti-malarial drugs or had malaria? Yes No
If yes, please explain: _____

Have you had any major radiation exposure or X-ray exposure? Yes No
If yes, please explain: _____

Have you ever had or been treated for syphilis? Yes No
If yes, when: _____ How many times? _____When was the last time? _____

Have you ever had or been treated for gonorrhea? Yes No
If yes, when: _____ How many times?_____
When was the last time? _____

Sexual Orientation: Homosexual Heterosexual Both Neither

Have you or any of your sexual partners ever had:

NSU (non specific urethritis)	Myself:	Yes	No	
If yes, when_____				
	Partner:	Yes	No	If yes, when_____
Chlamydia	Myself:	Yes	No	If yes, when_____
	Partner:	Yes	No	If yes, when_____
Venereal warts	Myself:	Yes	No	If yes, when_____
	Partner:	Yes	No	If yes, when_____
Herpes	Myself:	Yes	No	If yes, when_____
	Partner:	Yes	No	If yes, when_____
Other STDs	Myself:	Yes	No	If yes, when_____
	Partner:	Yes	No	If yes, when_____

Have you ever had any major illnesses such as amoebic dysentery, hepatitis, pneumonia, mononucleosis, etc? Yes No
If yes, please explain: _____

Donor Name: _____ **Donor Number:** _____

Has anyone in your family, including yourself, experienced recurring and/or chronic physical symptoms that have not been evaluated by a physician? (Please include those symptoms that you may not consider serious.) Yes No
If yes, please explain:_____

Did you travel outside the United States (except Canada) in the preceding three years?
Yes No
If yes, when and where? _____

Have you ever been exposed to "agent orange" or any other herbicides or chemicals in military action or elsewhere? (forest service, highway maintenance, etc.)
Yes No
Which substance(s)? _____
If yes, when: _____Where? _____

Have you ever used or do you currently use any of the following drugs?

Marijuana Yes No If yes, Frequency/Year(s) _____How Used_____

Cocaine Yes No If yes, Frequency/Year(s) _____How Used_____

Barbiturates Yes No If yes, Frequency/Year(s) _____How Used_____

Narcotics/Opiates (Heroin, Methadone, Opium, Morphine, Codeine)
Yes No If yes, Frequency/Year(s) _____How Used_____

Amphetamines Yes No If yes, Frequency/Year(s) _____How Used_____

Hallucinogens Yes No If yes, Frequency/Year(s) _____How Used_____

Tranquilizers Yes No If yes, Frequency/Year(s) _____How Used_____

PCP Yes No If yes, Frequency/Year(s) _____How Used_____

Donor Name: _____ **Donor Number:** _____

Inhalants Yes No If yes, Frequency/Year(s) _____How Used_____

Steroids Yes No If yes, Frequency/Year(s) _____How Used_____

Do you drink alcoholic beverages: Yes No
If yes, which kinds? _____Beer _____Wine _____Liquor
Approximately how many drinks per day or week do you consume?
_____
If you drink less than 3 drinks per day, was there ever a time when you drank more?
Yes No
If yes, how much _____ When (give years) _____

Do you have any relatives with alcoholism? Yes No
If yes, who? _____

Do you use tobacco products? Yes No
If cigarettes, how many packs a day? _____
How long have you been smoking regularly?_____

Do you use other tobacco products? Yes No Type? _____
If you did smoke but quit, when did you last smoke?_____

What is your current or most recent occupation?_____

Please list all the jobs you have had in the preceding five years and your possible exposure to chemicals, drugs and gases. Please consider carefully.

Jobs/Duties	Dates of Employment		Exposed to which chemicals, drugs or gases.
	Year Began	Year Ended	
1.			
2.			
3.			
4.			
5.			

Donor Name: _____ **Donor Number:** _____

In the preceding six months, were you exposed to any EXCESSIVE amounts of the following in your living environment or while involved in hobbies? If yes to any of these, give dates and how often you have been exposed. Please consider carefully.

Exposed to	Yes/No	When	How Often
Toxic Chemicals or Substances	Yes No		
Sprays	Yes No		
Fumes/Exhaust	Yes No		
Radiation	Yes No		
Flea powder/sprays	Yes No		
Lead/Lead products	Yes No		
Asbestos/Asbestos products	Yes No		
Cleaning solutions/solvents	Yes No		

Do you have any brothers or sisters who died in infancy or childhood? Yes No
If yes, what was the cause?
_____

Are there any known genetic diseases or conditions that run in your family? Yes No
If yes, what are they?
_____

Family Fertility History: Please list below any family members who experienced miscarriages:

Family Member (Sister, Aunt, etc.)	Paternal or Maternal	Age	Number of Miscarriages
1.			
2.			
3.			
4.			

Donor Name: _____ **Donor Number:** _____

Were you vaccinated for any reason in the preceding 12 months? Yes No
If yes, why, when and for what? _____

Please indicate with a check mark (✓) whether you currently have, have had in the past, or have ever been treated for:

Yes	No		Yes	No	
_____	_____	blood transfusion	_____	_____	frequent urinating
_____	_____	prolonged fever	_____	_____	waking at night to urinate
_____	_____	urethral discharge	_____	_____	cancer
_____	_____	renal disease	_____	_____	sores or discharge
_____	_____	psychiatric disorders	_____	_____	bleeding or bruising
_____	_____	rashes, color change	_____	_____	poor appetite
_____	_____	itching	_____	_____	gas, cramps, pains
_____	_____	warts, moles	_____	_____	heartburn, indigestion
_____	_____	eczema, lumps, hives	_____	_____	nausea, vomiting, constipation, diarrhea
_____	_____	very dry skin	_____	_____	diabetes
_____	_____	excessive sweating	_____	_____	yellow jaundice, hepatitis B or C
_____	_____	minor injury	_____	_____	hemorrhoids
_____	_____	anemia	_____	_____	hernia
_____	_____	lymph node or gland swelling	_____	_____	gall bladder problems
_____	_____	ear trouble, infections	_____	_____	pains in joints, arthritis
_____	_____	blood in stool or black stool	_____	_____	swollen joints
_____	_____	hearing loss, ringing in ear	_____	_____	back pain, neck pain
_____	_____	eye problems	_____	_____	head injury, concussion
_____	_____	nosebleeds	_____	_____	headaches

Yes	No		Yes	No	
_____	_____	sore throats	_____	_____	dizziness, fainting
_____	_____	stuffy nose, sinus trouble, hay fever	_____	_____	convulsions, seizures, fits
_____	_____	high blood pressure	_____	_____	shaking, tremor
_____	_____	hoarseness	_____	_____	weakness, paralysis
_____	_____	dental or gum problems	_____	_____	numbness, tingling
_____	_____	enlarged or painful breasts	_____	_____	difficulty walking, coordination
_____	_____	breast lumps	_____	_____	poor circulation, varicose veins
_____	_____	discharge from nipples	_____	_____	depression, anxiety
_____	_____	shortness of breath	_____	_____	poor sleeping
_____	_____	cough, chest colds	_____	_____	nervousness, tension
_____	_____	wheezing, asthma	_____	_____	trouble thinking, memory
_____	_____	chest pain, pleurisy	_____	_____	crying, upset, worrying
_____	_____	Tuberculosis or exposure to Tb	_____	_____	sexual problems
_____	_____	fevers, sweats, chills	_____	_____	goiter, thyroid problems

Donor Name: _____ **Donor Number:** _____

Please indicate with a check mark (✓) whether you currently have, have had in the past, or have ever been treated for:

Yes	No		Yes	No	
_____	_____	pneumonia	_____	_____	blood clots
_____	_____	previous heart trouble	_____	_____	murmurs or rheumatic fever
_____	_____	fast or irregular heartbeat	_____	_____	waking short of breath
_____	_____	chest pain, tightness, pressure	_____	_____	swelling of feet or ankles
_____	_____	trouble breathing when lying down	_____	_____	trouble swallowing
_____	_____	endometriosis	_____	_____	genital warts or papillomavirus
_____	_____	pelvic infection (PID)	_____	_____	vaginal bleeding other than menses
_____	_____	diabetes	_____	_____	urethritis
_____	_____	cervical polyps	_____	_____	abnormal Pap test

If yes for any of the above, please explain:_____

_____

_____

_____

_____

_____

_____

Donor Name: _____ **Donor Number:** _____

Donor Fertility\Social History (females only)

Age at onset of menses _____

Average # of days from beginning of one cycle to the next naturally:_____

# of days from beginning of one cycle to the next if on Birth Control Pills_____

Number of current sexual partners:_____

Number of sexual partners during last six months:_____

Number of total past sexual partners:_____

Pregnancy History:

# of times you have had a confirmed pregnancy: _____

# of losses: _____ Spontaneous: _____ Elective: _____

# of living children: _____

Length of time it took you to get pregnant: Shortest _____ Longest _____

Contraceptive History:

Currently use: _____IUD _____Diaphragm _____Condom _____Birth Control Pills

_____Rhythm _____Spermicide _____Depo-Provera

If Birth Control Pills, list the name_____

How long on Birth Control Pills_____

Why did you start taking Birth Control Pills?_____

If Depo-Provera when was your last injection?_____

Egg Donation History (females only)

Have you applied or been screened to be an egg donor before? Yes No
If yes, list name and location of egg donor program(s): _____

_____

Donor Name: _____ **Donor Number:** _____

Were you accepted as an egg donor? Yes No

If yes, how many times did you cycle? _____
Are you currently enrolled as an egg donor in another program? Yes No

DONOR GENETIC HISTORY

Were you born with any birth defects (heart defect, cleft lip or palate, club feet, other)? Yes No
If yes, explain:
_____

Are there any known genetic conditions or birth defects in your family? Yes No
If yes, explain:
_____

Are you of Jewish ancestry? Yes No Unknown
If yes, please check: _____ Ashkenazi _____ Sephardic _____ Other

Have you been tested as a carrier for any of the following diseases:

Tay Sachs:	Yes	No
Gaucher:	Yes	No
Canavan:	Yes	No
Fanconi Anemia Group C:	Yes	No
Niemann-Pick type A:	Yes	No
Mucolipidosis type IV:	Yes	No
Familial Dysautonomia:	Yes	No
Blooms Syndrome:	Yes	No

If yes, result(s):

Tay Sachs:	___carrier	___not carrier	___unknown
Gaucher:	___carrier	___not carrier	___unknown
Canavan:	___carrier	___not carrier	___unknown
Fanconi Anemia Group C:	___carrier	___not carrier	___unknown
Niemann-Pick type A:	___carrier	___not carrier	___unknown
Mucolipidosis type IV:	___carrier	___not carrier	___unknown
Familial Dysautonomia:	___carrier	___not carrier	___unknown
Blooms Syndrome:	___carrier	___not carrier	___unknown

Are you of African ancestry? Yes No Unknown
If yes, have you been tested as a carrier of sickle cell disease? Yes No Unknown
If yes, result: ____carrier ____not carrier ____unknown

Are you of Mediterranean, Chinese or Southeast Asian ancestry? Yes No Unknown
If yes, have you been tested as a carrier of Thalassemia? Yes No
If yes, result: ____carrier ____not carrier ____unknown

Donor Name: _____ **Donor Number:** _____

FAMILY HISTORY

A. Please list the requested information below:

Relative	Eye Color	Hair Color	Complexion*	Height	Bone Size**	Ethnic Origin
Mother						
Father						
Maternal Grandfather						
Maternal Grandmother						
Paternal Grandfather						
Paternal Grandmother						

* Fair, Fair-Medium, Medium, Olive, Dark
** Small, Small-Medium, Medium, Medium-Large, Large

B. Fill in the appropriate space for each of the following relatives. List all specific health problems, operations, and/or causes of death (include stillborns, infant deaths and childhood deaths) for each individual. Please use the "Specific Conditions listed below to aid in the completion of this segment. Do not use "old age" or "natural causes."
For all relative, indicate if they are L= Living or D=Deceased.

Your Mother

Current Age or Age at Death	Health Problem	Age Diagnosed
_____ (L / D)	_____	_____
	_____	_____

Your Father

Current Age or Age at Death	Health Problem	Age Diagnosed
_____ (L / D)	_____	_____
	_____	_____

Donor Name: _____ **Donor Number:** _____

Your Brothers

Current Age or Age at Death		Health Problem	Age Diagnosed
_____	(L / D)	_____	_____
_____	(L / D)	_____	_____
_____	(L / D)	_____	_____

Your Sisters

Current Age or Age at Death		Health Problem	Age Diagnosed
_____	(L / D)	_____	_____
_____	(L / D)	_____	_____
_____	(L / D)	_____	_____

Your Daughters

Current Age or Age at Death		Health Problem	Age Diagnosed
_____	(L / D)	_____	_____
_____	(L / D)	_____	_____
_____	(L / D)	_____	_____

Your Sons

Current Age or Age at Death		Health Problem	Age Diagnosed
_____	(L / D)	_____	_____
_____	(L / D)	_____	_____
_____	(L / D)	_____	_____

Donor Name: _____ **Donor Number:** _____

<u>Your Maternal Grandfather</u> (your mother's father)

Current Age or Age at Death	Health Problem	Age Diagnosed
_____ (L / D)	_____	_____
_____ (L / D)	_____	_____
_____ (L / D)	_____	_____

<u>Your Maternal Grandmother</u> (your mother's mother)

Current Age or Age at Death	Health Problem	Age Diagnosed
_____ (L / D)	_____	_____
_____ (L / D)	_____	_____
_____ (L / D)	_____	_____

<u>Your Maternal Aunts</u> (your mother's sisters)

Current Age or Age at Death	Health Problem	Age Diagnosed
_____ (L / D)	_____	_____
_____ (L / D)	_____	_____
_____ (L / D)	_____	_____

<u>Your Maternal Uncles</u> (your mother's brothers)

Current Age or Age at Death	Health Problem	Age Diagnosed
_____ (L / D)	_____	_____
_____ (L / D)	_____	_____
_____ (L / D)	_____	_____

Donor Name: _____ **Donor Number:** _____

Your Paternal Grandfather (your father's father)

Current Age or Age at Death	Health Problem	Age Diagnosed
_____ (L / D)	_____	_____
_____ (L / D)	_____	_____
_____ (L / D)	_____	_____

Your Paternal Grandmother (your father's mother)

Current Age or Age at Death	Health Problem	Age Diagnosed
_____ (L / D)	_____	_____
_____ (L / D)	_____	_____
_____ (L / D)	_____	_____

Your Paternal Aunts (your father's sisters)

Current Age or Age at Death	Health Problem	Age Diagnosed
_____ (L / D)	_____	_____
_____ (L / D)	_____	_____
_____ (L / D)	_____	_____

Your Paternal Uncles (your father's brothers)

Current Age or Age at Death	Health Problem	Age Diagnosed
_____ (L / D)	_____	_____
_____ (L / D)	_____	_____
_____ (L / D)	_____	_____

Donor Name: _____ **Donor Number:** _____

Look through the following list of medical problems and indicate (check) which ones you or one of your relatives have had. Please consider each condition carefully for each family member. Explain any conditions you check below, indicating which side of the family (maternal/paternal), the age of the family member at the onset of the condition/problem, and any other pertinent information. If you and none of your indicated family members have a history of the specific medical condition, you must check "None."

Donor Name: _____	Donor Number: _____

Medical Problem	None	Self	Mother	Father	Sibling	Child	Grand parents	Aunt/ Uncle	Cousin	Explain which side of family, age at onset, etc
1. Heart										
Stroke										
Heart Attack										
Congenital Heart Disease										
Heart Disease										
High Blood Pressure										
2. Blood										
Anemia										
Sickle-cell anemia										
Hemophilia or other bleeding problem										
Leukemia										
Immune deficiency										
Polyarteritis nodosa										
Other blood disorder										

Donor Name: _____	Donor Number: _____

Medical Problem	None	Self	Mother	Father	Sibling	Child	Grand parents	Aunt/ Uncle	Cousin	Explain which side of family, age at onset, etc
3. Respiratory (lungs)										
Hay fever										
Asthma										
Emphysema										
Tuberculosis										
Lung Cancer										
Pneumonia										
Cystic fibrosis										
Alpha-1 antitrypsin disorder										
Other lung disease										
4. Gastrointestinal										
Ulcer of stomach/ duodenum										
Gallstones										
Hepatitis A (infectious)										
Hepatitis B (serum)										
Other liver disease										
Ulcerative colitis										
Pyloric stenosis										
Crohn's disease										
Intestinal cancer										
Inflammatory bowel disease										
Rectal disorder										

Donor Name: _____						Donor Number: _____				
Medical Problem	**None**	**Self**	**Mother**	**Father**	**Sibling**	**Child**	**Grand parents**	**Aunt/ Uncle**	**Cousin**	**Explain which side of family, age at onset, etc**
Any other cancer/ problem of the digestive system										
5. Metabolic/ Endocrine										
Diabetes mellitus requiring insulin therapy										
Diabetes not requiring insulin therapy										
Hypoglycemia										
Thyroid cancer										
Thyroid disease										
Goiter										
Adrenal dysfunction or Disorder										
Hyperactivity										
PKU or inherited metabolism disorder										
6. Urinary										
Progressive kidney disease										
Polycystic kidney disease										
Other disease of urinary tract (urethra, bladder, ureter)										

Donor Name: _____						Donor Number: _____				
Medical Problem	**None**	**Self**	**Mother**	**Father**	**Sibling**	**Child**	**Grand parents**	**Aunt/ Uncle**	**Cousin**	**Explain which side of family, age at onset, etc**
7. Genital/Reproductive System										
Uterine fibroids										
Ovarian cysts										
Cancer of cervix, ovaries or uterus										
Miscarriage or Stillborn										
Herpes Simplex Virus, Genital										
8. Neurological										
Migraines										
Mental retardation										
Senility or mental deterioration before age 50										
Multiple sclerosis										
Cerebral palsy										
Epilepsy/seizures										
Neural tube defects (open spine or hydrocephalus/ water on the brain)										
Disorders of the spinal cord										
Gaucher's disease										
Wilson's disease										
Creutzfeldt-										

Donor Name: _____	Donor Number: _____

Medical Problem	None	Self	Mother	Father	Sibling	Child	Grand parents	Aunt/ Uncle	Cousin	Explain which side of family, age at onset, etc
Jakob disease										
Huntington's disease										
Tuberous Sclerosis										
Neurofibromatosis										
Dementia or degenerative disorder										
Alzheimer's										
Parkinson's disease										
Brain tumor										
Myasthenia Gravis										
Down's syndrome/ mongolism										
Transmissible Spongiform Encephalopathy										
Other diseases of nervous system										
9. Mental Health										
Schizophrenia										
Manic depressive psychosis										
10. Muscles/Bones /Joints										
Muscular dystrophy										
Other chronic muscle disease										
Loss of muscle coordination										
Spinal muscular										

Donor Name: _____	Donor Number: _____

Medical Problem	None	Self	Mother	Father	Sibling	Child	Grand parents	Aunt/ Uncle	Cousin	Explain which side of family, age at onset, etc
atrophy										
Systemic Lupus										
Deformity of spine										
Osteoporosis										
Dwarfism										
Hereditary low back disorder										
Rheumatoid Arthritis										
Reiter's disease										
Gout										
Club foot										
Metabolic bone disease										
11. Sight/Sound/ Smell										
Deafness before age 60										
Deformity of the ear										
Cataracts before age 60										
Blindness in both eyes before age 60										
Color Blindness										
Glaucoma										
Deviated septum										
Any other sight/ Sound /smell disorder										
12. Skin										

Donor Name: _____	Donor Number: _____

Medical Problem	None	Self	Mother	Father	Sibling	Child	Grand parents	Aunt/ Uncle	Cousin	Explain which side of family, age at onset, etc
Acne										
Eczema										
Psoriasis										
Pigmentation disorders										
Albinism										
Infectious skin disease										
More than 5 purple- or coffee-colored spots on skin (size of a quarter or larger)										
Numerous lumps under the skin										
Other skin disorders										
13. Other										
Alcoholism										
Drug abuse, misuse, or addiction										
Breast cancer										
Any cancer not mentioned above										
Cleft palate or cleft lip										
Serious birth defects										
Inguinal hernia										
Early Death (less										

Donor Name: _____	Donor Number: _____

Medical Problem	None	Self	Mother	Father	Sibling	Child	Grand parents	Aunt/ Uncle	Cousin	Explain which side of family, age at onset, etc
than age 50)										
Sarcoidosis										
Premature degeneration of any organ system										
Any other condition not mentioned above										

Thank your for providing the information above. Please feel from to contact us if you have any questions.

Family Beginnings, PC