

UNIFORM DONOR APPLICATION FORM

Date filled out: ____/____/____ (Month/Day/Year)

To become a sperm or egg donor, we need to learn some information about your personal and medical history. Your responses to these questions will help us to make sure that your health and medical history are compatible with the donation process and in particular for egg donors that it will not involve any increased risks for you. This effort will also help us to match you to an appropriate recipient.

Please provide complete and accurate information to these questions. If you do not know the answer, ask a parent or family member. Any information you provide during the donation process, will remain completely confidential. Some of the information from this questionnaire will be given to the recipient(s) as noted but all identifying information is removed.

A "yes" response will not necessarily eliminate you as a potential donor. Most people will have at least one of these conditions in themselves or a family member. The accuracy of the information you will be giving will provide information to potential families you may help to create.

Instructions:

1. **Please fill in all blanks completely.** Please complete all questions and write "N/A" if not applicable.
2. Please be specific. Avoid expressions such as "natural" or "old age" (for causes of death). List any health problems as specifically as possible. If you do not know the age, put the approximate age or ask a relative to help you. List exact relationships such as "first cousin through my mother's sister".
3. Please provide information on all the relatives requested. Do not write their names.
4. If you have any questions, please call your donor coordinator.

Last name: _____ First name: _____ Middle Initial: _____

Sex: Male _____ Female _____ Age: _____

Date of Birth: ____/____/____ Place of Birth: _____

Soc. Security #: _____ - _____ - _____ Are you a US citizen or permanent resident? Yes No

Driver's License #: _____ State: _____

Marital Status: ____single ____married ____divorced ____widowed ____engaged ____partnered

Length of Current Relationship: _____ years

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DEMOGRAPHICS

MAILING ADDRESS:

Street: _____ City: _____

State/Province: _____ Zip/ Postal code: _____ Country: _____

OK to leave message?

Home Phone Number: () _____ - _____ Yes No

Work Phone Number: () _____ - _____ Yes No

Cell Phone Number: () _____ - _____ Yes No

Email Address: _____

Do you have medical insurance? ___ Yes ___ No

If yes, name of carrier: _____ ID #: _____ Group # _____

Employer: _____

DONATION HISTORY:

Have you applied or been screened to be an egg or sperm donor before? ___ Yes ___ No

If yes, list name and location of donor program (s): _____

Have you donated before? ___ Yes ___ No If yes, how many times did you donate or cycle? ___

Are you currently enrolled as an egg or sperm donor in another program? ___ Yes ___ No

How did you hear about our program?

- Radio (which station) _____
- Newspaper (which one) _____
- Website (which one) _____
- Friend (name) _____
- Magazine (which one) _____
- Other (specify) _____

Did you consult with your family when completing your family medical history? ___ Yes ___ No

I hereby attest that all information disclosed in this application is accurate, true, and up-to-date to the best of my knowledge. _____

(Signature of Applicant)

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PERSONAL HEALTH HISTORY

Are you currently under a physicians care for any reason? ____Yes ____No

If yes, please explain: _____

Have you ever had any major illnesses such as amoebic dysentery (infection of the intestine), hypertension, blood clots, pneumonia, mononucleosis, etc.? ____Yes ____No

If yes, when? _____

Have you had any serious illness in the past? ____ Yes ____ No

If yes, please describe: _____

Did you have any complications or concerns with anesthesia? _____

Have you had any hospitalization(s) not mentioned above? _____

Please list any surgical procedures:

Have you ever had any broken bones? ____Yes ____ No If yes, please list: _____

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

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 describe: _____

Have you ever been seen by psychiatrist, psychologist, social worker, counselor, or any other mental health professional for any reason? ____Yes ____No
If yes, when, for how long and for what reason? _____

Have you ever used medications such as antianxiety or antidepressants to treat an emotional or psychological problem? ____Yes ____No
If yes, list why and date last used _____

Have you been vaccinated in the last 6 months? ____Yes ____No
If yes, what were you vaccinated for? _____

List all medications that you have taken in the proceeding 12 months (prescription):

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

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PERSONAL HEALTH HISTORY (continued)

List all current over-the-counter medications (include hormones, vitamins, aspirin, antacids, laxatives, herbal & sports supplements, performance-enhancing supplements including steroids, etc.)

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

Have you ever taken anti-malarial drugs or had malaria? Yes No

Have you had a blood transfusion? Yes No If yes, when? _____

Have you ever been refused or denied as a blood donor? Yes No If yes, why? _____

Are you eligible to work in the United States? Yes No Is your work schedule flexible? Yes No

List all the jobs you held in the past five years:

Jobs/Duties	Year Began	Year End

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

Have you ever been exposed to "agent orange" or any other herbicides or chemicals (military, forestry, highway service, or elsewhere)? Yes No
 If yes, which substance(s)? _____
 When? _____ Where? _____

In the preceding six months, were you exposed to the following in your job, 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:	Response		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		
Pesticides/Herbicides	Yes	No		
Cleaning solutions/solvents	Yes	No		

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PERSONAL HEALTH HISTORY (continued)

Do you take hot baths, saunas, hot tubs, or steam baths? _____Daily _____Weekly _____Occasionally _____Never

Within the past 6 months have you been exposed to UV rays in a tanning booth? _____ Yes _____ No

What is your caffeine usage? Number cups of coffee: _____ Soda _____ Tea _____ Energy Drinks _____

Do you currently smoke cigarettes? Daily Occasionally Rarely Never If yes, how many per day? _____

Have you ever smoked cigarettes? _____Yes _____No

If yes, how many cigarettes per day? _____

If no, what year/month did you stop? _____

How many years did you smoke? _____

What best describes your alcohol consumption? _____Never drink

_____ Rarely drink/Drink in small amounts _____Even amounts through the week _____Drink in concentrated periods

What type of alcohol do you usually consume? _____Beer _____ Wine _____Liquor

If you do drink, how many drinks do you usually consume in a week? _____ 1-3 _____ 4-9 _____ 10-15 _____ 16 or more

Have you ever used recreational or illicit drugs (cocaine, marijuana, LSD, heroin, barbiturates, narcotics, opiates, amphetamines, hallucinogens, tranquilizers, PCP, steroids, or etc.)? _____ Yes _____ No

If yes, which one (s) and when did you last use them? _____

Do you sleep well? _____Yes _____ No If no, how do you manage this? _____

Have you had acupuncture, ear and/or body piercing or tattooing in which sterile procedures may not have been used? _____Yes _____No

Please list and describe all of your tattoos and body piercings:

Date Received:	Description:	Location on Body:	Sterile Needles Used?

Have you ever had any problems with the law (i.e. DUI, custody issues, lawsuits)? _____Yes _____No

If yes, please explain _____

Please list any arrests, convictions, sentences, etc.: _____

Have you ever been incarcerated? If yes, please describe: _____

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SEXUAL AND CONTRACEPTIVE HISTORY

Sexual Orientation (please circle): Homosexual Heterosexual Bisexual

Number of current sexual partners: _____ Number of sexual partners during the last six months: _____

Total number of past sexual partners: _____

In the last 6 months have you had unprotected sex (intercourse without a condom) with a new partner? ___Yes ___No

Have you ever injected drugs or had a sexual partner who did so? ___Yes ___No

CONTRACEPTIVE HISTORY:

Currently use: IUD Type _____ Diaphragm _____ Condom _____ Birth Control Pills _____

Rhythm _____ Spermicide _____ Depo-Provera _____ Tubal Ligation _____ None _____

If Birth Control Pills: _____ (name) How long on Birth Control Pills? _____

Why did you start taking Birth Control Pills? _____

If Depo-Provera, when was your last injection? _____

To your knowledge, have you or any of your sexual partners been in contact with anyone or have you been personally tested or been treated for any of the following:

	Self	Partner	If yes, when:	How many times?	When was the last time?
HIV (AIDS)					
NSU (non specific urethritis)					
Syphilis					
Gonorrhea					
Chlamydia					
Trichomonas					
Venereal Warts					
Herpes, Genital					
Viral Hepatitis B or C					
Genital Sores					
Penis Discharge					
Other sexually transmissible diseases					

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MENSTRUAL AND REPRODUCTIVE HISTORY: FOR EGG DONORS

Age at onset of menses: _____ Date of Last Menstrual Period: _____

Are your menstrual periods regular: ____Yes ____No

How long is your monthly cycle (first day of one period to first day of the next)? _____days

Are you periods regular when you are not on any type of hormonal birth control such as the pill, etc.? ____Yes ____No

If no, how many times per year do you menstruate? _____

How many days does your period usually last? _____ days

Do you bleed or spot between periods? ____Yes ____No

Do you get menstrual cramps before, during, or after your period? ____Yes ____No

If yes, are your cramps: mild moderate severe?

If yes, do you use medication alleviate the pain? ____Yes ____No

If yes, what medications do you use? _____

Have you ever had any medical treatment for menstrual problems? _____

Date of last Pap Smear: _____ Result: _____

Have you ever had an abnormal PAP: _____ If yes, when & why: _____

Have you ever been told you were infertile: _____ If yes, when & why: _____

Have you ever had a pelvic infection requiring treatment with antibiotics ____Yes ____No

Do you want children in the future? ____Yes ____No

REPRODUCTIVE HISTORY (or partner for sperm donors)

FERTILITY HISTORY:

Number of pregnancies: _____

Number of miscarriages: _____

Number of ectopic pregnancies: _____

Number of abortions: _____

Number of stillbirths: _____

Number of children: _____

Length of time it took you or your partner to get pregnant. Shortest _____ Longest _____

Date(s) of miscarriages: _____

Date(s) of ectopic pregnancy: _____

Date(s) of abortions _____

Date(s) of each stillbirth: _____

Are you Currently Breastfeeding? ____Yes ____No

Pregnancy # Boy/Girl	Delivery Date	Type of Delivery (Vaginal or C-Section)	Complications	Weeks pregnant when delivered (prematurity)	Height / Weight
1					
2.					
3.					
4.					

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Please note that the remaining portion of this application will be shared and viewed by recipients.

PHYSICAL CHARACTERISTICS

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Are you adopted? ___Yes ___No Blood Type if known: _____

Height: _____ Weight: _____

Recent weight loss/gain? ___Yes ___No If yes _____ lbs loss/gain (circle one)

What was your weight at age 21? _____

Please circle responses that best describe you below:

Right Handed Left Handed Ambidextrous

Bone Structure: Small Medium Large Very Large

Complexion: Very Fair Fair Light Medium Olive Light Brown Dark Brown Ebony

Tan ability: None Slight Medium Easy Freckle

Skin Condition: Oily Medium Dry Combination **Dimples?** ___Yes ___No

Eye Color: Blue Brown Lt. Brown Dark Brown Green Hazel

Eye set: Narrow Average Wide **Eye Size:** Small Average Large **Shape:** Round Oval Almond

Natural Hair Color: Black Light Blonde Medium Blonde Dark Blonde Light Brown Medium Brown
Dark Brown Red

Hair Type: Curly Wavy Straight **Hair Texture:** Fine Medium Coarse **Fullness:** Thin Medium Thick

Baldness: ___Yes ___No **Baldness in Family:** ___Yes ___No

Premature Graying: ___Yes ___No If yes, at what age _____

Body and Facial Features: Small Medium Large

Condition of your teeth: Poor Fair Good Excellent

Have you had any periodontal or orthodontic work? ___Yes ___No If yes, at what age? _____

Hearing (without corrective aids): Poor Fair Good Excellent

Vision (without corrective lenses): Poor Fair Good Excellent Prescription (If known): _____

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PERSONAL HEALTH HISTORY
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Do you wear glasses or contacts or have you had laser surgery? Yes No

If yes, are/were you: Nearsighted Farsighted Other (specify): _____

Do you have astigmatism (blurred vision due to an irregularity in the curvature of the cornea)? Yes No
If yes, age diagnosed _____.

Do you have any Allergies? Yes No

If yes, are they to: Food(s) Medication(s) Environmental Latex

Please list any childhood allergies that you have outgrown: _____

For each medication allergy, describe specific substance and reaction(s) and age first noticed:

Substance: _____ Reaction(s): _____ Age: _____
 Substance: _____ Reaction(s): _____ Age: _____
 Substance: _____ Reaction(s): _____ Age: _____

SOCIAL HISTORY AND HABITS
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Religion Born Into: _____ Religion Practiced: _____

Grade Point Average (GPA): _____ SAT Scores: Verbal _____ Math _____ ACT Score: _____

Education: Did not Complete High School
 Received GED
 Completed high school
 Currently in college, pursuing degree in _____
 Completed college, degree in _____ GPA: _____
 Currently pursuing an advanced degree in _____
 Completed advanced degree in _____

Did you have any learning disabilities or weaknesses in school? If yes, describe: _____

Academic Strengths (i.e. math, reading): _____

How many languages do you speak? _____ Which one (s): _____

Musical Talent or Instrument: _____ Years Experience _____

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SOCIAL HISTORY AND HABITS (continued)
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Artistic Talent: _____

Athletic Skills / Favorite Sports: _____

Other skills/hobbies/talents/interests do you have (i.e. writing, reading, ability to do games or crossword puzzles, handcrafts)? Describe: _____

Current Occupation: _____ How long have you been at your current job? _____

HABITS:

Exercise Habits: _____ None _____ Occasional _____ Regular Type of Exercise: _____

Your diet is: _____ Vegetarian _____ Non-vegetarian Your diet is: poor average excellent

Do you have any dietary restrictions? _____

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REPRODUCTIVE HISTORY
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YOUR CHILDREN	1	2	3	4
Age				
Sex				
Eye color				
Hair Color				
Frame size				
Grade in school				
Personality				
Artistic ability				
Intelligence				
Distinguishing characteristics				
Wears eye glasses				
Discipline problems				
Any medication				
Dyslexia				
Reading difficulties				
Speech difficulties				
Any special services at school				
Seen by Social worker/ psychiatrist				
Grade functional level: Normal / Above/ Below Average				

FAMILY HEALTH HISTORY
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How many blood siblings are in your immediate family (including yourself and half siblings)? _____

Number of Brothers _____ Number of Sisters _____

Number of Maternal Aunts _____ Number of Maternal Uncles _____

Number of Paternal Aunts _____ Number of Paternal Uncles _____

Do you have any brothers or sisters that died in infancy or childhood? ____ Yes ____ No

If yes, what was the cause? _____

Are there any members of your family with a history of learning disabilities or autism? ____ Yes ____ No

If yes, please explain _____

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FAMILY HEALTH HISTORY (continued)
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Describe genetic family members according to the following characteristics. Use natural eye and hair color; fair/dark, etc. complexion. If they are deceased, please list cause of death. Please do not put "natural" as a cause of death. If unknown, write "unknown."

	Eye Color	Hair Color	Complexion	Height	Weight	Bone Structure	Occupation/ Education	Age if living	Age at time of death	Cause of death
Sister(s)										
Brother(s)										
Mother										
Father										
Maternal Grandmother										
Maternal Grandfather										
Paternal Grandmother										
Paternal Grandfather										

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FAMILY HEALTH HISTORY (continued)
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Carefully review the following list of medical problems and identify which ones you or one of your genetic relatives have or had. Please consider each condition carefully for each family member. Explain any conditions you check below, indicating which side of the family (maternal or paternal), the age at the time of onset, and any other pertinent information. If you and none of your indicated family members have a history of the specific medical condition, please indicate none.

***PLEASE REFER TO THE GLOSSARY ON THE LAST PAGES OF THIS FORM FOR DEFINITIONS**

	None	Self	Mother	Father	Sibling	Grand- parents	Aunt/ Uncle	Cousin	Explanation (which side of family, age of onset, etc.)
CANCER									
Breast									
Colon or Intestinal									
Lung									
Ovarian or Uterine									
Prostate or Testicular									
Skin									
Stomach									
Thyroid									
Blood (e.g. leukemia)									
Other									
HEART									
Stroke									
Heart Attack									
Congenital Heart Disease									
Heart Disease or Defect									
Hardening of the Arteries									
High Blood Pressure									
High cholesterol level									

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	None	Self	Mother	Father	Sibling	Grand- parents	Aunt/ Uncle	Cousin	Explanation (which side of family, age of onset, etc.)
BLOOD									
Anemia									
Sickle-Cell Anemia									
Factor V Leiden thrombophilia (Blood clots or strokes)									
Hemophilia or other Bleeding/Clotting Disorders such as Von Willebrand's Disease									
Immune Deficiency									
Leukemia									
Lymphoma or Swollen Lymph Nodes									
HIV									
Thalassemia									
Polyarteritis Nodosa									
Other Blood Disorder									
RESPIRATORY									
Asthma									
Hay Fever									
Emphysema									
Tuberculosis									
Pneumonia									
Alpha-1 antitrypsin Disorder									
Blood in Sputum									
Other Lung Disease									

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	None	Self	Mother	Father	Sibling	Grand- parents	Aunt/ Uncle	Cousin	Explanation (which side of family, age of onset, etc.)
GASTRO- INTESTINAL									
Appendicitis									
Ulcer of Stomach or Duodenum									
Gallstones									
Hepatitis A,B or C									
Cirrhosis of the Liver									
Other Liver Disease									
Ulcerative Colitis									
Crohns Disease									
Pyloric Stenosis									
Multiple Polyps of the Colon									
Rectal Disorder									
Inflammatory Bowel Disease									
Any other problem of the digestive system									
METABOLIC/ ENDOCRINE									
Diabetes requiring insulin therapy									
Diabetes not requiring insulin therapy									
Childhood Diabetes									
Thyroid disorder									
Goiter									
Hypoglycemia									
Adrenal Dysfunction or Disorder									
Phenyl Ketonuria (PKU) or inherited Metabolism Disorder									
Obesity									
Dwarfism									

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FAMILY HEALTH HISTORY (continued)
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	None	Self	Mother	Father	Sibling	Grand- parents	Aunt/ Uncle	Cousin	Explanation (which side of family, age of onset, etc.)
URINARY									
Kidney Problems									
Polycystic Kidney Disease									
Other disease/ defect of urinary tract (urethra, bladder, ureter)									
GENITAL/ REPRODUCTIVE									
Hermaphroditism/ Ambiguous Genitals									
Hypospadias or undescended testicle									
Uterine Fibroids									
Ovarian Cysts or Ruptured									
Lumps or Cysts in Breast or Discharge									
Polycystic Ovarian Syndrome (PCOS)									
Pelvic Inflammatory Disease (PID)									
Endometriosis									
REPRODUCTIVE OUTCOMES									
2 or more Miscarriages									
Stillborn									
Premature Menopause									
Death of a newborn infant									
Childhood death									
Birth defects									
Infertility									
Premature Birth									

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	None	Self	Mother	Father	Sibling	Grand- parents	Aunt/ Uncle	Cousin	Explanation (which side of family, age of onset, etc.)
NEUROLOGICAL									
Migraines									
Mental retardation									
Senility or Mental Deterioration before age 50									
Multiple Sclerosis									
Cerebral Palsy									
Neurofibromatosis									
Epilepsy / Seizures									
Attention Deficit Disorder/ Hyperactivity									
Autism / Asperger's									
Alzheimer's Disease/Dementia									
Hydrocephalus									
Tuberous Sclerosis									
Parkinson's Disease									
Creutzfeldt-Jakob Disease									
Scoliosis									
Myasthenia Gravis									
Huntington's or Wilson's Disease									
Tourette's syndrome									
Other diseases of the nervous system									
MENTAL HEALTH									
Anxiety / Panic Attacks									
Anorexia / Bulemia/other eating disorders									

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	None	Self	Mother	Father	Sibling	Grand- parents	Aunt/ Uncle	Cousin	Explanation (which side of family, age of onset, etc.)
Depression									
Schizophrenia									
Manic Depressive or Bipolar Disorder									
Other mental health disorder requiring hospitalization									
Suicide Attempts									
Other mental health problems that warranted counseling (please list)									
MUSCLE/BONE/ JOINTS									
Muscular Dystrophy									
Achondroplasia – form of dwarfism with abnormal bone growth									
Other Chronic Muscle Disease									
Osteogenesis imperfecta (brittle bone disease)									
Loss of Muscle Coordination									
Osteoporosis									
Marfan Syndrome									
Arthritis									
Rheumatoid or Juvenile Arthritis									
Spinal Muscular Atrophy									
Hereditary Low Back Disorder or Deformity of Spine									
Reiter's Disease									
Myasthenia Gravis									
Gout									

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	None	Self	Mother	Father	Sibling	Grand- parents	Aunt/ Uncle	Cousin	Explanation (which side of family, age of onset, etc.)
Metabolic Bone Disease (be more specific)									
Lupus (systemic lupus erythematosis – SLE)									
SIGHT/SOUND/SMELL									
Deafness before age 60									
Deformity of the ear									
Cataracts before age 50									
Blindness									
Color Blindness									
Severe Myopia									
Glaucoma									
Retinoblastoma									
Retinitis Pigmentosa									
Deviated Septum									
Any other Sensory Disorder									
SKIN									
Acne									
Albinism									
Eczema									
Excessive Facial Hair (Hirsutism)									
Pigmentation Disorders									
Psoriasis									
Neurofibromatosis									

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	None	Self	Mother	Father	Sibling	Grand- parents	Aunt/ Uncle	Cousin	Explanation (which side of family, age of onset, etc.)
Other disorders of the skin									
Infectious Skin Disease									
More than 5 purple- or coffee- colored spots on skin (size of quarter or larger)									
CONGENITAL ABNORMALITIES/ BIRTH DEFECTS									
Cleft Lip / Palate									
Congenital Hip Problems									
Club Feet									
Heart Defect									
Hearing Problems									
Spina Bifida -Neural Tube (open spine)									
Microcephaly									
Holoprosencehaly – a single-lobed brain structure and severe skull and facial defects									
Other									
CHROMOSOMAL ABNORMALITIES									
Down Syndrome									
Other (i.e. Turner, Fragile X, Klinefelter's etc.)									
OTHER									
Alcoholism									
Drug abuse, Misuse or Addiction									
Premature degeneration of any organ system									
Any other condition not mentioned above									

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More information about the above medical conditions are located at: <http://www.mazonet.com/genetics/index.htm>

Explain: _____

GENETIC HISTORY

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Ethnic origin (e.g., French, Irish)

Mother: _____ Father: _____

Race: Check all that apply for your ancestors:

African American	_____	_____	_____	_____	_____	_____	_____
Eastern European (Ashkenazi) Jewish	_____	_____	_____	_____	_____	_____	_____
Mediterranean (Greek, Italian)	_____	_____	_____	_____	_____	_____	_____
Hispanic	_____	_____	_____	_____	_____	_____	_____
Indian (from India)	_____	_____	_____	_____	_____	_____	_____
Southeast Asian (Laotian, Vietnamese, Cambodian)	_____	_____	_____	_____	_____	_____	_____
French Canadian	_____	_____	_____	_____	_____	_____	_____
Cajun	_____	_____	_____	_____	_____	_____	_____

(**MGM**=Maternal Grandmother, **MGF**=Maternal Grandfather; **PGM**=Paternal Grandmother, **PGF**=Paternal Grandfather)

Have you or anyone in your family ever been tested positive as a carrier or had any of any of the following diseases?

Blooms Syndrome	No	If yes:	_____	disease	_____	carrier	_____	negative	_____	unknown
Canavan	No	If yes:	_____	disease	_____	carrier	_____	negative	_____	unknown
Cystic Fibrosis	No	If yes:	_____	disease	_____	carrier	_____	negative	_____	unknown
Fabry Disease	No	If yes:	_____	disease	_____	carrier	_____	negative	_____	unknown
Familial Dysautonomia	No	If yes:	_____	disease	_____	carrier	_____	negative	_____	unknown
Familial Mediterranean Fever	No	If yes:	_____	disease	_____	carrier	_____	negative	_____	unknown
Fanconi Anemia Grp. C:	No	If yes:	_____	disease	_____	carrier	_____	negative	_____	unknown
Gaucher	No	If yes:	_____	disease	_____	carrier	_____	negative	_____	unknown
Niemann-Pick type A	No	If yes:	_____	disease	_____	carrier	_____	negative	_____	unknown
Mucopolipidosis type IV	No	If yes:	_____	disease	_____	carrier	_____	negative	_____	unknown
Sickle Cell	No	If yes:	_____	disease	_____	carrier	_____	negative	_____	unknown
Tay-Sachs	No	If yes:	_____	disease	_____	carrier	_____	negative	_____	unknown
Thalassemia	No	If yes:	_____	disease	_____	carrier	_____	negative	_____	unknown

Is there anything else we should know about your family?

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PERSONAL AND MOTIVATIONAL
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In your own words, describe your personality, temperament, and character: _____

What physical, artistic, intellectual or social abilities do you feel best about:

What are your present and future career goals: _____

What are your present and future personal goals: _____

List the 3 achievements you are most proud of:

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PERSONAL AND MOTIVATIONAL (continued)
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What is your favorite movie? _____

What is your favorite book? _____

What is your favorite color? _____

What is your favorite food? _____

What is one of your most memorable moments and why?

If you could change one thing about yourself, what would it be and why?

Is there a person alive or dead whom you admire and why?

What would you do on a "perfect" day if you could do anything you wanted?

Describe your personality and temperament as a child:

What was your favorite thing to do as a child?

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PERSONAL AND MOTIVATIONAL (continued)
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What did your parents teach you to value?

How were you in comparison to other children?

Describe your personality and temperament as a teenager:

Did you have any problems as a child and/ or as a teenager? Explain:

Who was the most important influence on you and why?

What were your ambitions/ goals as a teenager?

What were your best and worst subjects in school?

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PERSONAL AND MOTIVATIONAL (continued)
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Please provide the following information about your family:

	Intellectual/Academic Achievements	Artistic Achievements
Mother		
Father		
Sisters		
Brothers		

Reasons for wanting to donate eggs or sperm : _____

If you could pass on a message to the recipient(s) of your eggs or sperm, what would that message be?

If you could write a message to the child born through your participation as an egg or sperm donor for when he/she turns 18 years old, what would you tell him/her?

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GLOSSARY- INHERITED DISEASES

DEFINITIONS

Inherited – A disease or characteristic that is transmitted through genes from parents to offspring. Inheritance patterns include the following:

Autosomal Dominant – Disorders caused by one mutated copy of a gene. An affected person usually has one affected parent. Autosomal dominant disorders usually occur in every generation of an affected family. When a person carries an autosomal dominant gene mutation, each of his/her offspring has a 50% chance for inheriting the gene mutation.

Autosomal Recessive – Disorders caused by two mutated copies of a gene. An affected person usually has unaffected parents who each carry one copy of the mutated gene. Autosomal recessive disorders are not usually seen in every generation of a family. Carrier parents have a 25% chance for having an affected child.

X-linked dominant – Disorders caused by mutations in genes located on the X chromosome. Females are more frequently affected than males, and the chance to pass on an X-linked dominant disorder differs between men and women. Fathers cannot pass the X-linked traits or disorders to their sons. Females who have an X-linked dominant gene mutation have a 50% chance to have an affected child.

X-linked recessive – Disorders caused by mutations on genes on the X chromosomes. Males are more often affected than females, and the chance to pass on the disorder differs between men and women. Families with X-linked recessive disorders often have affected males, but rarely affected females, in each generation. Females who carry an X-linked recessive gene mutation have a 50% chance to pass it on to each of her children.

Multifactorial – Disorders caused by a combination of the effects of multiple genes or by interactions between genes and the environment.

Sources and additional information:

Talking Glossary of Genetic Terms <http://www.genome.gov/10002096>; <http://www.genome.gov/glossary.cfm#g>

Fact Sheets <http://www.genome.gov/10000202>

Cancer Dictionary <http://www.cancer.gov/dictionary/>

Genetics Home Reference National Library of Medicine <http://ghr.nlm.nih.gov/>

National Institutes of Health Genetic and Rare Diseases Information Center

<http://rarediseases.info.nih.gov/GARD/Default.aspx?PageID=4>

Gene Tests <http://www.genetests.org/>

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