Reset

File:

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DONOR NON-IDENTIFYING PERSONAL HISTORY - FEMALE

Date history was completed:_____
Blood type:_____

Physical Profile:

Month/year of birth:_____Place of birth:_____

Height:_____Weight:_____

Age when adult height was reached:_____Weight at age 21:_____

Eye color:_____Normal hair color:_____

Hair (check one)

- ☐ thin
- ☐ average
- ☐ thick

Hair (check one)

- ☐ curly
- ☐ straight
- ☐ wavy

Complexion: (check one) Light ☐ Medium ☐ Olive ☐ Rosy ☐ Freckled ☐

Any birthmarks:_____

Acne:_____Severity:_____At what age:_____

Race:_____Ethnicity: (e.g. German, Italian, etc.)_____

Body build:

Describe yourself (e.g. big or small boned, slight, strong, etc.)_____

Check one: ☐ Right handed ☐ Left handed ☐ Ambidextrous

Form: 319M

Embryo Donor History (cont)

Education (check the appropriate level):

- ☐ 12th grade completed
- ☐ Associate's Degree
- ☐ Trade School (Trade studied: e.g. LPN)
- ☐ Some College
- ☐ College Degree Major:
- ☐ Master's Degree Field:
- ☐ Doctorate Degree Field:

Talents: *(please explain)*_____

_____

Special interests/hobbies: *(please explain)*_____

_____

Personal Health History:

Vision: Do you wear glasses/contacts?_____Age first wore glasses?_____

Check one: ☐ Nearsighted ☐ Farsighted

Hearing: ☐ Normal Describe any problems_____

Teeth: (check one) ☐ Poor ☐ Fair ☐ Good ☐ Orthodontia

Form: 319M

Embryo Donor History (cont)

Do you smoke cigarettes now?_____How many per day?_____

Have you ever smoked cigarettes?_____How many packs per day?_____

For how many years?_____When did you quit smoking?_____

Do you drink alcoholic beverages?_____What kind?_____

How many drinks (beer, wine alcohol) do you consume:

Per day_____Per week_____

Do you currently have allergies? ☐ yes ☐ no
If yes, are they to: ☐ Food ☐ Drugs ☐ Environmental ☐ Other

Please list below the specific allergy (substances that produces it) and reactions:

Substances_____Reaction_____

_____ _____

Your diet (check one): Vegetarian ☐ Non-vegetarian ☐ Excellent diet ☐
(check one): Poor diet ☐ Average diet ☐

How much exercise do you get? (check one) none ☐ occasionally ☐ regularly ☐

Personal Medical History:

Have you ever had surgery? ☐ Yes ☐ No

Please explain:_____

_____

Have you ever been hospitalized? ☐ Yes ☐ No

Please explain:_____

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Embryo Donor History (cont)

Have you ever had any major illnesses such as amoebic dysentery, hepatitis, pneumonia, mononucleosis, etc?

☐ No ☐ Yes:_____

Personal Family History:

How many blood siblings are in your immediate family (including yourself)?
#of males:_____#of females:_____

Are you adopted? ☐ Yes ☐ No

Have twins or multiple births occurred in your family? ☐ Yes ☐ No

If yes, relationship to you:_____

Please describe your family members by the following characteristics:

Relation	**Eye Color**	**Hair Color**	**Height**	**Ethnic Origin**	**Age if living**	**Age at death**	**Cause of death**
Mother							
Father							
Maternal Grandmother							
Maternal Grandfather							
Paternal Grandmother							
Paternal Grandfather							

Form: 319M

Embryo Donor History (cont)

Do you have any brothers or sisters who died in infancy or childhood?

No ☐ Yes ☐ Please explain:_____

Are there any known genetic diseases or conditions that run in your family?

No ☐ Yes ☐ Please explain:_____

Please describe the medical history of your family below:

Write in: 1) The name of the specific condition; and
2) Age at onset in the appropriate box; and
3) Their relationship to you

Medical Condition	**Yourself**	**Parents, Brothers, Sisters, Grandparents, Uncles, Aunts & Cousins**
Physical, joint & bones: Club foot, cleft palate, chronic muscle disease, lupus, osteoporosis, dwarfism, gout, deformity of the spine		
Paralysis or crippling disorders: Muscular dystrophy, multiple sclerosis, cerebral palsy, spina bifida		
Seizure, convulsions, or epilepsy: Migraines, senility before age 50, Huntington's disease, Gaucher's disease, Wilson's disease, other diseases of the nervous systems		

Embryo Donor History (cont)

Medical Condition	Yourself	Parents, Brothers, Sisters, Grandparents, Uncles, Aunts, & Cousins
Slight hearing or speech impairment: Deformity of the ear, blindness before age 60, blindness, color blindness, glaucoma, deviated septum, deafness before age 60		
Learning disability		
Mental retardation: Down syndrome, etc.		
Hormonal disorder: Diabetes, thyroid disease, goiter, hyperactivity, adrenal disorder		
Arthritis: Rheumatoid, osteo, prosaic, etc.		
Allergic/Respiratory: Food, drugs, asthma, hay fever, eczema, emphysema, tuberculosis, lung disease		
Blood diseases: Hemophilia (bleeding), anemia, sickle cell anemia, hepatitis, leukemia, other blood disorders		
Ovarian/reproductive problems: Ovarian cysts or malignancies, infertility, uterine fibroids, cancer of cervix, ovaries or uterus, undescended testicle, hypospadias, endometriosis		
Memory loss, dementia, Alzheimer's disease		
Kidney disorder: Stones, failure, infection		
Cardiovascular: High blood pressure, stroke, heart attack		

Embryo Donor History (cont)

Medical Condition	Yourself	Parents, Brothers, Sisters, Grandparents, Uncles, Aunts, & Cousins
Psychiatric: Schizophrenia, severe depression, manic depression		
Anxiety, mild depression, or mental health problems		
Alcoholism		
Drug Abuse		
Cancer: Type and location		
Spontaneous abortions: Miscarriages, abortions, stillbirths, neonatal deaths (crib deaths)		
Gastrointestinal: Ulcers, gallstones, hepatitis A, hepatitis B, liver disease, colitis, Crohn's disease, digestive problem		
Migraines: Chronic headaches		
Skin problems: Chronic acne, eczema, skin cancer, pigmentation disorders		

Has anyone in your family, including yourself, experienced recurring and/or have physical symptoms that have *not* been evaluated by a physician? (Please include symptoms that you may not consider serious)

Do you presently have any health problems? If yes, please describe:

Additional writing space from above answers:

Submit