



DONOR/FAMILY MEDICAL AND GENETIC HISTORY

DONOR # 828

(INSTRUCTIONS FOR DONOR)

The attached medical/genetic history questionnaire form is very important to us in obtaining information about you and your family. This form will be reviewed and evaluated by the Medical Director of the Laboratory. Your acceptance into the Donor Sperm Program is based upon a satisfactory review. The following are guidelines to help you fill out this questionnaire.

1. Please fill in all blanks completely using a black pen. Write "NA" in blanks that are 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. Give ages to your best approximation. List exact relationships such as "first cousin through my mother's sister".
3. Please provide information on all relatives requested. Do not list names.
4. Please return completed medical/genetic history questionnaire and all consent forms in person to the Laboratory Director of Midwest Sperm Bank upon your next scheduled appointment at the Laboratory.



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DONOR FERTILITY HISTORY

Have you ever has a semen analysis done before: **No**

If yes, please list the dates and any pertinent information:

Date	Sperm Count	Motility	Other
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What were the reasons for obtaining the semen analysis?

Have you ever applied or been screened to be a sperm donor? **No**

If yes, name of sperm bank: _____ When? _____

Were you accepted as a sperm donor?

If yes, how long did you donate: _____ Months

How many successful live births resulted from your donations:

Have you ever donated blood or plasma? **Yes**

Have you ever been refused as a blood donor? **No**

If yes, When? _____ Reason: _____

Have you had a blood transfusion in the last 12 months? **No**

If yes, date of blood transfusion: ____/____/____

Have you ever been told that you were infertile? **No**

If yes, when? _____ Reason: _____

Is there any history of fertility problems in your family? (difficulty conceiving, history of recurrent miscarriage)? **No**

If yes, please explain: _____

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Did your parents have difficulty conceiving? *No*

Do you have any brothers who have fertility problems? *No*

Do you have any uncles who have fertility problems? *No*

Did your mother take diethylstilbestrol (DES) or any drugs while she was pregnant with you? *No*

If yes, please explain: _____

Are you exposed to excess heat (saunas, hot tubs, steam rooms) *No*

If yes, how frequent?

Do you wear Jockey-type underwear? *Yes*

DONOR HEALTH HISTORY

Do you currently have any allergies? *Yes*

If yes, are they related to: ____ Food ____ Drugs X Environmental (Pollen) ____ Other

Please list specific substances and reaction(s) produced:

<u>Substance</u>	<u>Reaction</u>
Pollen	Runny nose, sneezing

Please list any childhood allergies you have outgrown: *None*

Do you have your vision checked at regular intervals? *No*

How is your vision? (Without glasses): Poor ____ Fair ____ Good X Excellent

Do you wear glasses or contact lenses? *No*

Are you: ____ Nearsighted ____ Farsighted Other (specify): _____

Your vision is: Right eye: Left eye:

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Do you have your hearing checked at regular intervals? **No**

Do you have normal hearing? **Yes**

If no, please explain:

Do you have your teeth checked at regular intervals? **Yes**

Condition of your teeth (check one): _____ Poor _____ Fair X Good _____ Excellent

NUTRITION

Your diet is (check one): _____ Vegetarian **X** Non-Vegetarian

Your diet is (check one): _____ Fair X Good _____ Excellent

Please indicate **how often** per week you eat or drink the following food or beverages:

Eggs (with yolks)	3
Fried foods	1
Red meat (steak, hamburger, pork, lamb, etc.)	2
Cold cuts (sausage, salami, hot dogs, bacon, etc.)	1
Oil-based salad dressing, & mayonnaise	0
Soups, frozen entrees and processed (canned or frozen) <u>vegetable</u> prepared with seasonings or sauces	0
Fresh vegetable and fruits	4
Whole grain cereals and breads	6
Beverages containing sugar (include coffee or tea with added sugar)	3
How often do you add salt to your foods at the table	5
Whole milk, dairy products (milk, yogurt, cream, ice cream, cheese, butter or sour cream)	4
Skim milk and skim milk products	3
Cookies, pastries, cakes	1

Salty snack food – potato chips, nuts, corn ships, pretzels, etc.) **1**

Beverages and/or food products containing Aspartame, NutraSweet, etc. **2**

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EXERCISE

How much time do you spend per week participating in the following recreational, occupational or household activities:

very strenuous activities, for example: baseball, bicycling, cross country skiing, running, singles racquet sports, lap swimming, digging, shoveling.

strenuous activities, for example: leisure bicycling, doubles racquet sports, downhill skiing, jogging, leisure swimming, heavy gardening, construction work.

moderate activities, for example: softball, brisk walking, dancing, golf, hiking, volleyball, cleaning, mopping.

Very strenuous: **1** days per week

Strenuous: **3** days per week

Moderate: **3** days per week

How often do you exercise aerobically (20 minutes or more of continuous), rhythmic exercise at moderate to strenuous intensity)? **1 week**

Do you regularly exercise to increase your strength (for example: Nautilus, weight training, pull-ups, push-ups, sit-ups)? **Yes**

Do you regularly do stretching exercises? **Yes**

MEDICAL

Have you ever had surgery? **Yes**

OPERATIONS:

YEAR	TYPE OF OPERATION
2018	Root Canal

HOSPITALIZATION OTHER THAN SURGERY:

YEAR	TYPE OF ILLNESS
N/A	

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Have you ever had any broken bones? **No**

Have you ever had any major illnesses such as Dysentery, Hepatitis, Pneumonia, Mononucleosis, etc.? **No**

If yes, please describe: _____

Are you presently under a physician's care for any reason? **No**

If yes, please describe:

Have you ever had occupational exposure to radiation, x-ray exposure or chemicals? **No**

If yes, please describe: _____

Do you have any current medical problems/conditions? **No**

If yes, please describe:

Have you or any of your partners ever had:

	YES	NO	MYSELF/PARTNER	WHEN
Syphilis		X		
Gonorrhea		X		
NSU (non-specific urethritis)		X		
Chlamydia		X		
Venereal Disease		X		
Herpes		X		
Other sexually transmissible diseases		X		

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EXPOSURE

Have you ever served in the military? *No*

If yes, when? .

Have you ever been exposed to “agent orange” or any other herbicides in Vietnam or elsewhere (forest service, highway maintenance, etc.)? *No*

If yes, when? _____ Where? _____ What Substance(s)? _____

Please list all current medications you are taking (include vitamins, aspirin, antacids, laxatives, etc.):

MEDICATION	FREQUENCY	REASON
<i>Multivitamin</i>	<i>4</i>	<i>Nutrition</i>
<i>Benzoyl Peroxide</i>	<i>4</i>	<i>Acne</i>
Creatine	<i>4</i>	<i>Supplement</i>

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

Please check all that apply:

	FREQUENCY	WHEN (years)	HOW USED?
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Marijuana	<i>3x per week</i>	<i>2018-2022</i>	<i>Edible</i>
Cocaine	<i>Never</i>		
Barbiturates	<i>Never</i>		
Narcotics (Heroin, methadone, Opium, morphine, Codeine)	<i>Never</i>		
Amphetamines	<i>Never</i>		
Hallucinogens	<i>1x/year</i>	<i>2018-2021</i>	<i>Edible</i>
Tranquilizers	<i>Never</i>		
Anti-Depressants	<i>Never</i>		
PCP	<i>Never</i>		
Inhalants (Amly or butyl nitrate, aerosol propellants)	<i>Never</i>		
Over the Counter drugs			

How many days in the past 12 months could you not work because of all illness (colds, flu, accidents, surgery, etc.) **0**

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TOBACCO USE

Are you a:

Regular cigarette smoker **No**
ever regularly smoked cigarettes

Former cigarette smoker

At what age did you begin smoking cigarettes regularly?

When you smoke(d), how many packs per day do you smoke?

If you are a former cigarette smoker, how long has it been since you quit?

Are you a:

Regular pipe smoker **No** Former pipe smoker Never regularly smoked pipes

At what age did you begin smoking pipes regularly?

When you smoke(d), how many pipes per day do you smoke?

If you are a former pipe smoker, how long has it been since you quit?

Are you a:

Regular cigar smoker **No** Former cigar smoker Never regularly smoked cigars

At what age did you begin smoking cigars regularly?

How many cigars did you smoke regularly per day in the last two years or the last two years before quitting?

If you are a former cigar smoker, how long has it been since you quit?

Do you regularly use chewing tobacco or snuff?

ALCOHOL USE

Do you ever drink alcoholic beverages? **Yes**
(If no, then proceed to the next section)

How much alcohol do you drink during an average week?

- 2** Glasses of wine
- 2** Bottles of beer
- Cocktails or shots of hard liquor (1 ½ oz.)

During an average week, what is the maximum number of drinks (wine, beer and cocktails combined) you have in one day? **3**

Do you tend to drink alone, or with others? **Socially**

Within the past year, have you ever felt bad or guilty about drinking? **No**

Within the past year, have people annoyed you by criticizing your drinking? **No**

Within the past year, have you ever felt you should cut down on your drinking? **No**

Within the past year, have you ever taken a drink first thing in the morning to get rid of a hangover or to steady your nerves (eye opener)? **No**

At what point in the day do you feel you need a drink most? **Night.**

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CAFFEINE USE

Do you drink coffee? **Yes**

If yes, how many cups per day? **2**

Do you drink tea? **No**

If yes, how many cups per day?

Do you drink regular or diet beverages? **Neither**

If yes, how many cans per day? .

WORK HISTORY /EXPERIENCE

What is your current or most recent occupation? **Software Engineer**

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

JOBS/DUTIES	DATES OF EMPLOYMENT YEAR BEGAN	YEAR ENDED	NAMES OF DRUGS, CHEMICALS, AND GASSES EXPOSED TO
Software Engineer	2020	Current	None
Student	2016	2020	None

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In the past six months, have you been exposed to any of the following in your living environment, or while involved in hobbies? If yes, please check the appropriate item below and give dates and how often you have been exposed: ***None***

EXPOSED TO:	WHEN	HOW OFTEN?
Toxic Chemicals		
Sprays		
Fumes/Exhaust		
Radiation		
Flea Powders/Sprays		
Lead/Lead Products		
Asbestos/Asbestos Products		
Cleaning Solutions/Solvents		

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SEXUAL HISTORY AND RELATIONSHIPS

How many of your closest friends are men? ***4***

How many are women? ***1***

Have you ever or are you now engaged in a homosexual relationship? ***No***

Have you ever been involved in a sexual relationship with anyone who has told you they had a venereal infection or sexually transmitted disease, or AIDS? ***No***

Have you ever had any intravenous infusions of blood or have you given yourself or has anyone given you intravenous injections? ***No***

Do you take or have you ever taken any concentrated products derived from blood or blood substances? ***No***

Have you ever known or associated with anyone who has had a positive HIV test (AIDS virus)? ***No***

Have you ever had sex with a person engaged in sex in exchange for money or drugs? ***No***

Have you ever been treated or diagnosed as having any type of venereal infection, including Syphilis, Gonorrhea, Herpes (Type 1 or 2), Chlamydia, yeast infections or AIDS? ***No***

Have you ever been in a situation that would give you higher risk of coming in contact with sexually transmitted disease including AIDS? ***No***

Have you ever traveled outside the United States? ***Yes***

If yes, please list location and approximate date.

LOCATION	DATES
<i>Dominican Republic</i>	<i>March 2022</i>

Did you contact any disease from your foreign travel? *No*

If yes, please describe: _____

Have you ever had a tattoo? *Yes*

If yes, what year did you get the tattoo? *2016, 2020*

Have you ever had your body pierced? *No*

If yes, where and what year?

Have you ever had acupuncture done? *No*

If yes, where and what year? _____ Year

Have you had a blood transfusion in the last 12 months? *No*

If yes, what was the date of the transfusion? ____/____/____

Have you ever received pituitary-derived Human Growth Hormone? *No*

If yes, what year? _____ Year

Have you ever received non-viral inactivated factor VIII or factor IX concentrate? *No*

If yes, what year? _____ Year

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Have you ever engaged in anal intercourse? *No*

Are you currently sexually active? *Yes*

How many sexual partners do you currently have? *0*

Within the past six months, how many sexual partners have you had? *1*

Number of total past sexual partners? *5*

Have your partners been: *X* Female Male Both

Has any sexual partner had an episode of Trichomoniasis? *No*

If yes, please describe: _____

Have you ever been tested for HIV (AIDS)? *Yes*

If yes, when: *Every 6 months* Results: *Negative* Reason for Testing: *Donor Testing*

FAMILY HEALTH HISTORY (SUMMARY)

	EYE COLOR	HAIR COLOR	COMPLEXIO N	HEIGH T	BODY TYPE	VISION
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Mother	<i>Brown</i>	<i>Brown</i>	<i>Fair</i>	<i>5'6"</i>	<i>Average</i>	<i>Good</i>
Father	<i>Green</i>	<i>Brown</i>	<i>Fair</i>	<i>5'11"</i>	<i>Average</i>	<i>Poor</i>
Sister 1						
Sister 2						
Sister 3						
Brother 1	<i>Green</i>	<i>Brown/Blonde</i>	<i>Fair</i>	<i>5'9"</i>	<i>Slim</i>	<i>Poor</i>
Brother 2						
Brother 3						
Maternal Grandmother	<i>Green</i>	<i>Brown</i>	<i>Fair</i>	<i>5'6</i>	<i>Average</i>	<i>Poor</i>
Maternal Grandfather	<i>Green</i>	<i>Brown</i>	<i>Fair</i>	<i>5'10"</i>	<i>Average</i>	<i>Good</i>
Paternal Grandmother	<i>Blue</i>	<i>Brown</i>	<i>Fair</i>	<i>5'4"</i>	<i>Petite</i>	<i>Good</i>
Paternal Grandfather	<i>Green</i>	<i>Brown</i>	<i>Fair</i>	<i>6'0"</i>	<i>Slim</i>	<i>Good</i>

How many siblings are in your immediate family (including yourself)? **2**

How many males? **2** How many females? **0**

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Please list below the ages of all family members. If they have died, please list their age at death and the cause of death. Please be as specific as possible.

	AGE IF LIVING	AGE AT TIME OF DEATH	CAUSE OF DEATH
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Paternal Grandfather		75	<i>Liver Failure</i>
Paternal Grandmother		82	<i>Coronavirus</i>
Maternal Grandfather	75		
Maternal Grandmother	75		
Father	59		
Mother	53		
Brother 1	22		
Brother 2			
Brother 3			
Sister 1			
Sister 2			
Sister 3			

Has any member of your family, including yourself, had a problem or defect at birth of any of the following body systems. Please list the birth defect, the family member, when it occurred and any relevant information.

BODY SYSTEM	BIRTH DEFECT	WHO	WHEN	CIRCUMSTANCES
Bone, Muscles, Joints, Limbs				
Gastrointestinal System				
Nervous System				
Blood Circulatory System	<i>Heart Arrhythmia</i>	<i>Father/Uncle</i>	<i>45 y/o</i>	<i>Uncle passed in his 40's</i>
Respiratory System				
Organ (Heart, Lung, Kidney, etc.)				
Genital/Urinary				
Metabolic (hormones, enzymes, etc.)				
Eye/Ear				

Is there any member of your family who has had or currently has a learning disorder? **Yes**

If yes, Please explain:. ***I have mild Asperger's***

Do you have any brothers or sisters who died in infancy or childhood? **No**

If yes, who and what was the cause: _____

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

If yes, what are they? ***Heart Arrhythmia***

Has anyone in your family, including yourself, experienced recurring and/or chronic physical symptoms that have not been evaluated by a Physician? **No**

If yes, please describe: .

RELATIVES	YOU	MOTHER	FATHER	SIBLINGS		GRANDPARENTS				AUNT		UNCLE		MAT.	PAT
Please indicate the # of each in the blank boxes	1	1	1	0	1	1	1	1	1	1	2	2	2	6	9

Please indicate (by a checkmark) which of the following medical problems you or one of your family members have had. If neither you nor any of your family members are affected by any of the medical problems listed above, please be sure you put a checkmark in each box in the far right column, labeled “No one.” .

RELATIVES	YOU	MOTHER	FATHER	SIBLINGS		GRANDPARENTS				AUNT		UNCLE		MAT.	P A T	N o o n e
1. Heart			X							X		X				
a. Stroke			X													
b. Heart Attack																
c. Heart Disease												X				
i. From Birth																
ii. Other																
d. Hardening of Arteries																
e. High Blood Pressure																
2. Blood																
a. Anemia																
b. Sickle-cell Anemia																
c. Hemophilia or other Bleeding Problem																
d. Leukemia																
e. Immune Deficiency																
f. Other Blood Disorder																
3. Respiratory (lungs)																
a. Hay Fever	X		X		X											
b. Asthma					X											
c. Emphysema																
d. Tuberculosis																
e. Lung Cancer																
f. Pneumonia																
g. Other Lung Disease																
4. Gastro-intestinal																
a. Ulcer of stomach or Duodenum																
b. Gall Stones																
c. Hepatitis A (infectious)																
d. Hepatitis B (serum)																
e. Other Liver Disease								X								
f. Colon Cancer																
#785																
g. Ulcerative Colitis																
h. Crohn's Disease																
i. Cystic Fibrosis																
j. Intestinal Cancer																
k. Rectal Disorder																
l. Any other Cancer Problem of Digestive System																
5. Metabolic/Endocrine																

a. Diabetes Melitis																	
b. Hypoglycemia																	
c. Thyroid Cancer									X								
d. Thyroid Disease																	
e. Goiter																	
f. Adrenal Dysfunction or Disorder																	
g. Hyperactivity																	
h. Hormonal Dysfunction or Disorder																	
6. Urinary																	
a. Polycystic Kidney Disease																	
b. Other Kidney Disease																	
c. Other Disease of Urinary Tract (urethra, bladder, ureter)																	
d. Rectal Disorder																	
7. Genital / Reproductive																	
a. Undescended Testicle																	
b. Hypospadiasis																	
c. Prostate Cancer																	
d. Uterine Fibroids																	
e. Ovarian Cysts																	
f. Cancer of Cervix, Ovaries or Uterus																	
8. Neurological																	
a. Migraines	X						X										
b. Mental Retardation																	
c. Senility before age 50																	
d. Multiple Sclerosis																	
e. Cerebral Palsy																	
f. Epilepsy																	
g. Convulsive disorders																	
h. Hydrocephalus (water on the brain)																	
i. Disorders of the Spinal Cord																	
j. Huntington's Chorea																	
k. Gaucher's Disease																	
l. Wilson's Disease																	
m. Alzheimer's Disease											X						
n. Other Nervous System Disease																	
9. Mental Health																	
a. Schizophrenia																	
b. Manic Depressive Disorder																	
c. Other Mental Health Disorders requiring Hospitalization																	

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RELATIVES	YOU	MOTHER	FATHER	SIBLINGS	GRANDPARENTS				AUNT		UNCLE		MAT.	PAT	No One
10. Muscles / Bones / Joints															
a. Muscular Dystrophy															
b. Other Chronic Muscle Disease															
c. Lupus															
d. Deformity of Spine															
e. Osteoporosis															
f. Dwarfism															
g. Heredity Low Back Disease															
h. Arthritis															
i. Gout															
j. Congenital Dislocation of the Hip															
11. Sight / Sound / Smell															
a. Deafness before age 60															
b. Deformity of the Ear															
c. Cataracts before 50															
d. Blindness															
e. Color Blindness											X				
f. Glaucoma															
g. Deviated Septum															
h. Retinoblastoma															
i. Congenital Word Blindness															
j. Any other sight / sound or smell disorder															
12. Skin															
a. Acne	X														
b. Eczema															
c. Skin Cancer															
d. Pigmentaion Disorder															
e. Other Disorders of the Skin															
13. Other															
a. Alcoholism															
b. Drug Abuse or Addiction															
c. Breast Cancer															
d. Any other Cancer not mentioned above															
e. Any other condition not mentioned above															

Please explain: *The most serious family medical issue is the heart arrhythmias. My paternal uncle died from heart issues in his 40's and my father has had similar problems. My father and several of his siblings have pacemakers. I have carpal tunnel, as well as my mother..*

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ANCESTRY

Have you ever been tested as a carrier of Cystic Fibrosis (if white): *No* If yes, result: _____
Carrier _____ Non-Carrier

Are you Jewish ancestry? *No*

If yes, please check: _____ Ashkenazi, _____ Shephardi, _____ Other

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

Tay Sachs: – If yes, result: _____ Carrier _____ Not Carrier _____ Unknown

Gaucher: – If yes, result: _____ Carrier _____ Not Carrier _____ Unknown

Canavan: – If yes, result: _____ Carrier _____ Not Carrier _____ Unknown

Are you of Black Ancestry? *No*

If yes, have you been tested as a carrier of Sickel Cell Disease?

If yes, result: _____ Carrier _____ Not Carrier _____ Unknown

Are you of Mediterranean (Greek or Italian) ancestry? *No*

If yes, have you been tested as a carrier of Thalassemia?

If yes, result: _____ Carrier _____ Not Carrier _____ Unknown

CHILDRENS MEDICAL HISTORY

N/A

LIVING CHILDREN (GIRL, BOY)	AGE	DESCRIBE ANY HEALTH PROBLEMS	AGE DIAGNOSED

CHILDREN (DECEASED) (GIRL, BOY)	AGE	CAUSE OF DEATH	AGE DIAGNOSED	OTHER HEALTH PROBLEMS

Are you a twin? *No*

If yes, Identical

Are you a triplet?

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IN YOUR OWN WORDS

Why do you want to be a donor?

I wanted to donate to help prospective families trying to have children. I also take interest to the idea of there being young people genetically similar to me who get to experience life, impact the world, and persist after I'm gone.

In your own words, describe your personality and character.

In general I keep a quite and polite demeanor and am kind to others. I'm very curious and am always finding new things that interest and excite me. I can be lazy at times but am stubborn and indefatigable when I put my mind to something.

What are your hobbies, interests, and talents?

My primary interest is science and technology, especially computer programming. I work professionally as an engineer and like learning about new technologies in my free time. I also love the outdoors and enjoy hiking, camping, fishing, and gardening. I'm very curious and read books and articles on a wide range of topics including economics, politics, history, philosophy, and finance.

If we could pass on a message to the recipients) of your semen, what would that message be?

Hello! I hope all is well with you. If you were conceived using my donation I wish you the very best! I hope you're able to live a happy, productive, and fulfilling life. Life goes very fast, so do your best and enjoy every minute. Lots of love.

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Personal Characteristics

Math Skills/Ability:

I'm very good at math, engineering, and computer programming.

Mechanical Skills:

I'm handy and good at woodworking and DIY.

Athletic Skills: (type of sports, etc)

I'm heavily built and strong. I have done well with rowing and weightlifting.

What is your favorite sport:

Rowing.

Musical Skills:

Modest. I played piano and violin as a kid and currently play beginner guitar.

What is your favorite type of music:

Folk, Rock, Hip-Hop, Country.

What languages do you speak:

English, and some Spanish.

Special Hobbies/Talents:

My main hobbies are computer programming, gardening, and hiking.

Describe your artistic abilities:

I have very little talent in visual arts, but I can use photoshop well.

What are your favorite foods:

Cheeseburgers, Fruit, Cereal, and Potatoes.

What is your favorite color:

Blue.

Do you like pets? If so, which is your favorite:

Yes, Dogs and Fish.

To where would you most like to travel and why?

I'd like to visit India, it seems like a beautiful and unique place that is very different from America.

How would you describe your personality?

I'm a quiet and polite guy with an insatiable curiosity about the world.

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PSYCHOLOGICAL PROFILE

Have there been any positive or negative major occurrences in your life in the past three months?

— X — No Yes

What are three things you like about yourself? *Independently minded, honest, I'm good at building things.*

What are three things you like to change about yourself. *I'd like to be better at reaching out to friends out of the blue, less stubborn when appropriate, and work harder.*

Is there a history of psychiatric illness in your family? __X__ No ___ Yes

If yes, what type?

Are you now, or have you been in counseling or therapy during the last year?

X No Yes

What was the reason for the counseling or therapy? _____

Do you feel the counseling or therapy was helpful? _____ No _____ Yes

Indicate the amount of overall stress you feel in each of the following areas of your life.

	None	Little	Somewhat	A lot	Overwhelming
Work/Job			<i>X</i>		
Family		<i>X</i>			
Finance/bills			<i>X</i>		
Health		<i>X</i>			
Legal		<i>X</i>			
Social life/friends			<i>X</i>		
Environment (noise, neighbors, traffic, pollution, etc.				<i>X</i>	

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When in a stressful situation, how likely are you to do each of the following:

	Never or Seldom	Seldom	Some of the Time	Often	Almost Always
Try to find out more about the situation by talking to someone.			<i>X</i>		
Criticize or blame yourself.			<i>X</i>		
Try to come up with a couple of different solutions to the problem.				<i>X</i>	
Get angry or impatient at someone or something.			<i>X</i>		
Start to feel sick.			<i>X</i>		
Look for something to take your mind off the problem.			<i>X</i>		
What? <i>Walk outside.</i>					

	Almost Never	Infrequently	Sometimes	Frequently	Almost Always
Even after you have expressed anger, do you have trouble forgetting about it?		<i>X</i>			
Do you get upset when you have to wait in lines?					<i>X</i>
How often do you bring your work home with you or find yourself thinking about work problems after hours?				<i>X</i>	
Do you tend to get angry more frequently than others than others around you?	<i>X</i>				
When someone is talking and takes too long to come to the point, do you feel like speeding the person along or finishing their sentences for them?				<i>X</i>	

Do people find you to be competitive? Are you?				X	
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Donor ID #: 828

	Never	Infrequently	Sometimes	Frequently	Almost Always
When you were younger, was your temper hard to control?	X				
Do you finish eating before others?					X
Would people who know you well regard you as taking your job too seriously? Do you?		X			

Over the last month, how often have you felt:

	Rarely	Sometimes	Often	Most of the time
That life has been filled with things that interest and challenge you.				X
Down, blue or sad.	X			
Nervous or uptight.			X	
Pleased, satisfied or happy about your accomplishments.				X
Run-down and lacking in energy.	X			
Tense, restless and unable to relax.		X		
Needed and useful in helping others.			X	
That life isn't worth living.	X			
More scared or panicky than you think you should feel.		X		
Sick	X			

How many close friends do you have who you feel at ease with and can confide in about personal matters or call for help? **5**

How many close relatives do you have who you feel at ease with and can confide in about personal matters or call for help? **6**

How many of these friends do you see or talk to on the telephone at least once a month? **2**

How many of these relatives do you see or talk to on the telephone at least once a month? **2**

Donor ID #: 828

Overall, how happy, pleased or satisfied are you with your relationships with friends?

Quite happy, I enjoy spending time with my friends and have a positive relationship with them.

Overall, how happy, pleased or satisfied are you with your relationships with relatives?

Very satisfied, I'm lucky to have a large tight-knit family. I have a close relationship with grandparents, Aunts, Uncles, and cousins.

Donor ID #: 828

OCCUPATION: *Software Engineer*

PHYSICAL FEATURES & MEASUREMENTS:

Hands: *Right Handed*

Fingers: *Medium*

Sizes: Neck: 14

Chest: 39

Inseam: 34

Waist: 37

Sleeve: 35

Wrist: 6

Hat: 23

Shoe: 12

PHYSICAL AIDS

Vision: *Normal*

Glasses: *None*

Astigmatism: *No*

Age diagnosed:

Dental:

Device: *Braces*

Reason: *Cosmetic*

Age during use: *12-14 years old.*

OTHER:

List:

Reason:

FACIAL FEATURES:

EYES:

Set: *Average*

Size: *Average*
Shape: *Almond*
Color: *Blue*
Shade: *Light*

EYEBROWS:

Arc: *Medium*
Thickness: *Medium*
Set: *Average*

Donor ID: # 828

NOSE:

Size: *Medium*
Width: *Average*
Length: *Average*
Bridge: *Straight*
Nostril Flare: *Thick*
Septum: *Average*

CHEEKBONES:

Set: *Average*
Prominence: *Medium*

MOUTH:

Size: *Average*
Lips: *Average*
Turn: *Straight*

TEETH:

Size: *Medium*
Set: *Overbite*

CHIN:

Shape: *Oval*
Prominence: *Average*
Cleft: *Medium*

EARS:

Size: *Average*
Set: *Average*

Angle: *Average*
Lobe size: *Medium*
Attachment: *Attached*

HAIR:

Color @ birth: *Brown/Blonde*
Color presently: *Brown*
Shade: *Medium*
Type: *Straight*
Fullness: *Thick*
Texture: *Fine*

Donor ID #: 828

SKIN:

Tone: *Leight*
Tan Ability: *Medium*
Condition: *Medium*

HAIRLINE:

Forehead Set: *Average*
Contour: *Straight*

OTHER FACIAL FEATURES:

Moles: *None*
Freckles: *Several*
Dimples: *Medium*
Adam's Apple: *Slight*
Facial Hair:
Thickness: *Thin*
Shade: *Light*

**Midwest Sperm Bank
Donor Information**

PERSONAL INFORMATION:

Height: 6 FT 0 IN

Weight: 225 LBS

Race: Caucasian X Asian Black Hispanic Other

ETHNIC ORIGIN/ ANCESTRY:

Mother: *British / German*

Father: *Irish*

TALENTS:

Voice: Soprano Alto Tenor Baritone Bass

Instrument: *Guitar* Yrs Experience: 5

Other: Yrs Experience:

GOALS:

Academic: *I graduated from undergrad and want to continue adult learning.*

Professional: *Successful engineering career, start a company.*

Personal: *Fitness, Improve my Spanish*

RELIGION:

Faith: *Christian*

Denomination: *Quaker*

LANGUAGES:

Speak: *English*

Read: *English, Beginner Spanish*

Write: *English*

SPORTS:Play: **Rowing, Weight Lifting, Frisbee, Basketball**Watch: **American Football**SIBLINGS: # of Brothers: 1 # of Sisters Twin: **No**Family Twins: # Identical # Fraternal **MARITAL STATUS:**Single: X Married Divorced Separated **Family History – Donor # 828****Father of Donor**

Year of Birth: 1963

Racial Group

 X Caucasian Black Asian Other:
 If Jewish: Ashkenazi Sephardic Oriental

Height: **5'11** Weight: **240** Eye Color: **Green**

Hair Color: Brown Balding Curly
 Thin Wavy
 X Average X Straight

Vision: Excellent Good Fair X Poor
 Bone Structure: Small X Medium Large Very Large

Other distinguishing features (dimples, cleft chin, Roman nose, etc.): ***Dimples and cleft chin***

Skin Characteristics:

 Freckles X None Few Numerous
 X Very fair (little to no ability to tan on sun exposure)
 Fair (skin will tan lightly on sun exposure)
 Medium (light color but will tan moderate to dark)
 Olive (pigmentation of unexposed skin): Slight Moderate Dark
 Dark (unexposed skin): Light Tan Dark Tan Brown Black

Occupation: **Academic Advisor**

Education: **PhD in Political Science**

Special Skills or Characteristics: **Reading, Writing, Academics, Politics, Quiet and Funny, Kind**

Describe his health: _____ Excellent _____ Good X Fair _____ Poor
_____ Deceased (give cause):

What kind of person is/was he?

Optimistic	<u> 1 </u>	2	3	4	Pessimistic
Assertive	1	<u> 2 </u>	3	4	Passive
Leader	1	<u> 2 </u>	3	4	Follower
Easy Going	<u> 1 </u>	2	3	4	Controlling, rigid



Family History - # 828

Mother of Donor

Year of Birth: **1962**

Racial Group

 X Caucasian _____ Black _____ Asian _____ Other:
If Jewish: _____ Ashkenazi _____ Sephardic _____ Oriental _____

Height: 5'6 Weight: 160 Eye Color: Brown

Hair Color:

_____ Hair (Check One)	_____ Hair Type (Check One)
_____ Balding	_____ Curly
_____ Thin	_____ Wavy
<u> X </u> Average	<u> X </u> Straight

Vision: X Excellent _____ Good _____ Fair _____ Poor
Bone Structure: _____ Small X Medium _____ Large _____ Very Large

Other distinguishing features (dimples, cleft chin, Roman nose, etc.):

Skin Characteristics:

_____ Freckles _____ None _____ Few _____ Numerous
_____ Very fair (little to no ability to tan on sun exposure)
 X Fair (skin will tan lightly on sun exposure)
_____ Medium (light color but will tan moderate to dark)
_____ Olive (pigmentation of unexposed skin): _____ Slight _____ Moderate _____ Dark
_____ Dark (unexposed skin): _____ Light Tan _____ Dark Tan _____ Brown _____ Black

Occupation: **Lawyer**

Education: **Graduated Law School**

Special Skills or Characteristics: **Reading, Gardening, Academics**

Describe her health: X Excellent Good Fair Poor
 Deceased (give cause): _____

What kind of person is/was she?

Optimistic	1	2	<u>3</u>	4	Pessimistic
Assertive	1	<u>2</u>	3	4	Passive
Leader	1	2	<u>3</u>	4	Follower
Easy Going	1	2	<u>3</u>	4	Controlling, rigid