



# FERTILITY TREATMENT CENTER

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Uniform Donor Application Form for **Male Donor -M**

**THIS SECTION WILL BE SHARED AND VIEWED BY RECIPIENTS**

## PHYSICAL CHARACTERISTICS

Are you adopted? \_\_\_ Yes \_\_\_ No      Blood Type if known: \_\_\_\_\_      Height: \_\_\_\_\_      Weight: \_\_\_\_\_

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): \_\_\_\_\_

## PERSONAL HEALTH HISTORY

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: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**SOCIAL HISTORY AND HABITS**

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 \_\_\_\_\_

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? \_\_\_\_\_

**FAMILY HISTORY**

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 \_\_\_\_\_

**REPRODUCTIVE HISTORY**

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				

**GENETIC HISTORY**

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

Mother: \_\_\_\_\_ Father: \_\_\_\_\_

**Race:** Check all that apply for your ancestors:

- African American \_\_\_Mother\_\_\_ Father\_\_\_ MGM\_\_\_ MGF\_\_\_ PGM\_\_\_ PGF
- Eastern European (Ashkenazi) Jewish \_\_\_Mother\_\_\_ Father\_\_\_ MGM\_\_\_ MGF\_\_\_ PGM\_\_\_ PGF
- Mediterranean (Greek, Italian) \_\_\_Mother\_\_\_ Father\_\_\_ MGM\_\_\_ MGF\_\_\_ PGM\_\_\_ PGF
- Hispanic \_\_\_Mother\_\_\_ Father\_\_\_ MGM\_\_\_ MGF\_\_\_ PGM\_\_\_ PGF
- Indian (from India) \_\_\_Mother\_\_\_ Father\_\_\_ MGM\_\_\_ MGF\_\_\_ PGM\_\_\_ PGF
- Southeast Asian (Laotian, Vietnamese, Cambodian) \_\_\_Mother\_\_\_ Father\_\_\_ MGM\_\_\_ MGF\_\_\_ PGM\_\_\_ PGF
- French Canadian \_\_\_Mother\_\_\_ Father\_\_\_ MGM\_\_\_ MGF\_\_\_ PGM\_\_\_ PGF
- Cajun \_\_\_Mother\_\_\_ Father\_\_\_ MGM\_\_\_ MGF\_\_\_ PGM\_\_\_ PGF

**(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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***FAMILY HEALTH HISTORY***

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										

***PERSONAL AND MOTIVATIONAL***

In your own words, describe your personality, temperament, and character: \_\_\_\_\_

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

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What are your present and future career goals: \_\_\_\_\_

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What are your present and future personal goals: \_\_\_\_\_

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List the 3 achievements you are most proud of: \_\_\_\_\_

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?

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?

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What were your ambitions/ goals as a teenager?

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What were your best and worst subjects in school?

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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 embryo(s): \_\_\_\_\_

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

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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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**FAMILY HEALTH HISTORY**

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.

	None	Self	Mother	Father	Sibling	Grand- parents	Aunt/ Uncle	Cousin	Explanation (which side of family, age of onset, etc.)
<b>CANCER</b>									
Breast									
Colon or Intestinal									
Lung									
Ovarian or Uterine									
Prostate or Testicular									
Skin									
Stomach									
Thyroid									
Blood (e.g. leukemia)									
Other									
<b>HEART</b>									
Stroke									
Heart Attack									
Congenital Heart Disease									
Heart Disease or Defect									
Hardening of the Arteries									
High Blood Pressure									
High cholesterol level									
<b>BLOOD</b>									
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									
<b>RESPIRATORY</b>									
Asthma									
Hay Fever									
Emphysema									
Tuberculosis									
Pneumonia									
Alpha-1 antitrypsin Disorder									
Blood in Sputum									
Other Lung Disease									
<b>GASTRO-INTESTINAL</b>									
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									
<b>METABOLIC/ENDOCRINE</b>									
Diabetes requiring insulin therapy									

MALE DONOR -M (continued)  
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	None	Self	Mother	Father	Sibling	Grand- parents	Aunt/ Uncle	Cousin	Explanation (which side of family, age of onset, etc.)
Diabetes not requiring insulin therapy									
Childhood Diabetes									
Thyroid disorder									
Goiter									
Hypoglycemia									
Adrenal Dysfunction or Disorder									
Phenyl Ketonuria (PKU) or inherited Metabolism Disorder									
Obesity									
Dwarfism									
<b>URINARY</b>									
Kidney Problems									
Polycystic Kidney Disease									
Other disease/defect of urinary tract (urethra, bladder, ureter)									
<b>GENITAL/REPRODUCTIVE</b>									
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									
<b>REPRODUCTIVE OUTCOMES</b>									
2 or more Miscarriages									
Stillborn									
Premature Menopause									
Death of a newborn infant									
Childhood death									
Birth defects									
Infertility									
Premature Birth									
<b>NEUROLOGICAL</b>									
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									
<b>MENTAL HEALTH</b>									
Anxiety / Panic Attacks									
Anorexia / Bulemia/ other eating disorders									
Depression									



MALE DONOR -M (continued)  
THIS SECTION WILL BE SHARED AND VIEWED BY RECIPIENTS

	None	Self	Mother	Father	Sibling	Grand- parents	Aunt/ Uncle	Cousin	Explanation (which side of family, age of onset, etc.)
Schizophrenia									
Manic Depressive or Bipolar Disorder									
Other mental health disorder requiring hospitalization									
Suicide Attempts									
Other mental health problems that warranted counseling (please list)									
<b>MUSCLE/BONE/JOINTS</b>									
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									
Metabolic Bone Disease (be more specific)									
Lupus (systemic lupus erythematosus – SLE)									
<b>SIGHT/SOUND/SMELL</b>									
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									
<b>SKIN</b>									
Acne									
Albinism									
Eczema									
Excessive Facial Hair (Hirsutism)									
Pigmentation Disorders									
Psoriasis									
Neurofibromatosis									
Other disorders of the skin									
Infectious Skin Disease									
More than 5 purple- or coffee- colored spots on skin (size of quarter or larger)									
<b>CONGENITAL ABNORMALITIES/BIRTH DEFECTS</b>									
Cleft Lip / Palate									
Congenital Hip Problems									
Club Feet									
Heart Defect									
Hearing Problems									
Spina Bifida -Neural Tube (open spine)									
Microcephaly									

MALE DONOR -M (continued)  
**THIS SECTION WILL BE SHARED AND VIEWED BY RECIPIENTS**

	None	Self	Mother	Father	Sibling	Grand- parents	Aunt/ Uncle	Cousin	Explanation (which side of family, age of onset, etc.)
Holoprosencephaly-a single- lobed brain structure and severe skull and facial defects									
Other									
<b>CHROMOSOMAL ABNORMALITIES</b>									
Down Syndrome									
Other (i.e. Turner, Fragile X, Klinefelter's etc.)									
<b>OTHER</b>									
Alcoholism									
Drug abuse, Misuse or Addiction									
Premature degeneration of any organ system									
Any other condition not mentioned above									