Georgia Center for Reproductive Medicine
5354 Reynolds Street, Suite 510
Savannah, GA 31405
(912)352-8588

Egg Donor Questionnaire

Application #: _____

Donor ID: _____

Date: _____ Interviewed by: _____

1. Name: _____
2. How did you hear about us? _____
3. Address:

   Current: _____ How Long? _____

   _____

   Previous: _____ How Long? _____

   _____

   Email: Home: _____ Work: _____
4. Phone Contacts

   1st _____ 2nd _____ 3rd _____
5. Social Security #: _____

Physical Characteristics

6. DOB: _____ Age Today: _____ Place of Birth _____

   Height: _____ Weight: _____
7. Race: _____
8. Complexion: fair ☐ medium ☐ dark ☐ olive ☐ freckles ☐
9. Hair: balding☐ thin ☐ average ☐ curly ☐ wavy ☐ straight ☐
10. Natural Hair Color: _____ Natural Eye Color: _____
11. Acne: none ☐ mild ☐ moderate ☐ severe ☐
12. Bone type/Bone structure: small ☐ medium ☐ large ☐
13. Dexterity: Right handed ☐ Left handed ☐ Ambidextrous ☐
14. Blood type and RH (if known): _____

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Personal Information

15. Religion born into: _____ Current Religion: _____

    Marital Status: Single ☐ Married ☐ Divorced ☐ In a Relationship ☐

16. Sexual orientation: heterosexual ☐ homosexual ☐ bisexual ☐

17. Ethnic origin/ Ancestry (Irish, German, African, etc.): _____

18. Do you smoke? **No** **Yes:** *how many packs a day?*_____

19. Have you ever smoked? **No** **Yes:** *how long ago did you quit?* _____ (must be > 6 months)

20. How much alcohol do you drink? _____

21. How much caffeine do you drink? _____

22. What recreational drugs do you use? _____

23. How much do you exercise? _____

24. Current weight: _____ Recent changes: _____ Ideal weight: _____

25. Briefly describe your diet: _____

26. Number of children: _____

27. What kind of work do you do? _____

28. Are you currently under significant stress? _____

    _____

29. Are your family/friends supportive of your decision to donate your eggs? _____

    _____

30. Who is the most supportive person in your life? _____

31. Tell me everything you know in detail regarding the egg donation process:

    ☐ Self-injections

    ☐ Frequent blood testing

    ☐ Vaginal ultrasounds

    ☐ Early morning availability

    ☐ Use of condoms

    ☐ 2 Visits to center: 1st visit for screening (1-2 days.)

    ☐ 2nd visit for egg-retrieval (if long distance, anticipate 3 or more day stay.)

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☐ Committed time frame once in cycle

32. Prior egg donations: _____

_____

Education

33. Completed high school: Year: _____ GPA: _____
34. College entrance exam scores: SAT: _____ ACT: _____
35. Currently in college, pursuing degree in: _____
36. Completed college: Year: _____ Degree: _____ GPA: _____
37. Currently pursuing advanced degree in: _____
    Completed advanced degree: Year: _____ Degree: _____
    GPA: _____

Personality Information

38. List subjects you enjoyed most: _____
39. Did you like school? _____
40. What would you like to do in the future? _____
41. What do you like to do in your spare time? _____
42. Do you have any special talents (musical, artistic, sporting ability, creative skills)?

    _____

43. How would you describe yourself (outgoing, moody, passive, sensitive, humorous, quiet, extroverted, introverted, etc.)? _____
44. How do you get along with people (parents, friends, boss, etc.)? _____

    _____

45. How do you solve your personal problems and make decisions (quickly, after carefully exploring all points of view, with deliberations, etc.)? _____

    _____

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46. What is important to you? _____

_____

47. Why are you considering becoming a donor? _____

_____

_____

General Information

48. Do you have normal hearing? ☐Yes ☐No If no, explain: _____

49. Condition of teeth? ☐Poor ☐Fair ☐Good

50. Do you (or did you ever) need corrective lens for vision? ☐Yes ☐No
☐Farsighted ☐Nearsighted ☐Other (explain) _____
Do you were glasses/lenses all the time? ☐Yes ☐No
Do you need glasses/lenses only to read? ☐Yes ☐No

51. Does any member of your family require vision correction? ☐Yes ☐No
For what purpose? ☐To read only ☐Farsighted ☐Nearsighted
Other (explain): _____

52. Did you or any member of your family have to wear eyeglasses at an early age (from birth to pre-teen years)? ☐Yes ☐No Who? _____

53. Do you sleep well? ☐Yes ☐No If no, do you know why? _____

54. Your diet: ☐Vegetarian ☐Non-Vegetarian

55. Your diet: ☐Poor ☐Average ☐Excellent

56. How much exercise do you get? ☐None ☐Occasionally ☐Regularly
Please explain type and frequency of exercise: _____

57. Have you ever had surgery? ☐Yes ☐No If yes, please list and explain: _____

_____

58. Have you had any hospitalization not already mentioned? ☐Yes ☐No If yes, please explain: _____

59. Have you had any major radiation exposure or X-Ray exposure? ☐Yes ☐No If yes please explain: _____

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60. Have you had any vaccinations (shots) or immunizations in the last year? ☐Yes ☐No If yes, please list: _____

61. Have you ever taken street drugs by needle, even once? ☐Yes ☐No

62. Have you injected drugs for a non-medical reason in the last 5 yrs, including intravenous, intramuscular, or subcutaneous injection? ☐Yes ☐No

63. In the last twelve months, have you been a sex partner of anyone who has ever taken street drugs by needle? ☐Yes ☐No

64. In the last twelve months have you received blood transfusions, blood injections, tattoos, organ or tissue transplants? ☐Yes ☐No

65. In the last twelve months, have you been exposed to anyone with yellow jaundice or hepatitis? ☐Yes ☐No

66. Have you to your knowledge, had a positive test for HIV (any AIDS) tests? ☐Yes ☐No

67. In the past 12 months, have you given money or drugs to anyone to have sex with you? ☐Yes ☐No

68. Have you had sex for drugs or money in the past 5 years? ☐Yes ☐No

69. Have you ever taken clotting factor concentrates for a bleeding disorder such as hemophilia? ☐Yes ☐No

70. In the last twelve months, have you been exposed to or had sex with anyone with AIDS or with a positive test for HIV (the AIDS antibody)? ☐Yes ☐No

71. In the past twelve months, have you had sex with a person known or suspected to have active hepatitis B or C? ☐Yes ☐No

72. In the last twelve months, have you been exposed to known or suspected HIV, hepatitis B, and/or hepatitis C infected blood through pericutaneous inoculation, contact with an open wound, non-intact skin, or mucous membrane? ☐Yes ☐No

73. In the last twelve months, have you been in close contact (i.e. sharing kitchen and bathroom) with a person having active viral hepatitis? ☐Yes ☐No

74. In the last twelve months, have you had sex with someone who has taken clotting factor concentrates for a bleeding disorder such as hemophilia? ☐Yes ☐No

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75. In the last twelve months, have you had sex, even once, with a man who has had sex with another man since 1977? ☐Yes ☐No

76. In the last twelve months, have you had sex with a male or female prostitute? ☐Yes ☐No

77. In the last twelve months, have you been in jail for more than 72 consecutive hours, including juvenile detention? ☐Yes ☐No

78. Have you yourself received or had intimate contact (i.e. exchanged body fluids, including sharing toothbrushes and razors) with someone who has received organs or cells from non-human sources? ☐Yes ☐No

79. In the last twelve months, have you ever been raped? ☐Yes ☐No

80. Have you ever been treated for syphilis or gonorrhea? ☐Yes ☐No If yes, how many times and when? _____

81. In the last twelve months, have you ever had acupuncture, electrolysis, ear and/or body piercing, or tattooing in which sterile procedures may not have been used? ☐ Yes ☐No If yes, please describe: _____

82. In the last 12 months, have you had any accidental needle stick, sharp instrument injury, contact w/human blood serum or plasma in the eye, mucus membranes (lips, interior of nose) or sores. ☐Yes ☐No

83. After the age of 11, have you ever had viral hepatitis (Hepatitis A excluded: IgM anti-HAV test)? ☐Yes ☐No

84. Have you had more than one sexual partner in the last 6 months? ☐Yes ☐No

85. Have you ever been treated for Chlamydia? ☐Yes ☐No If yes, how many times and when? _____

86. Have you ever been treated for pelvic inflammatory disease (PID)? ☐Yes ☐No If yes, how many times and when? _____

87. Please check if you or any of your sexual partners have ever had:
(Please ask if any of these terms are unfamiliar to you)

_____ Nonspecific urethritis (NSU) When? _____
_____ Chlamydia When? _____
_____ Venereal Warts When? _____

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_____ Herpes When? _____
_____ Other sexually transmitted diseases When? _____

88. Have you ever had any major infectious illnesses, such as hepatitis, pneumonia, etc.? ☐Yes ☐No Please explain: _____

89. Have you ever served overseas in the military? ☐Yes ☐No If yes, please describe when and where: _____

90. From 1980 through 1996, were you a member of the US military, a civilian military employee or a dependent of a member of the US military? ☐Yes ☐No

91. Did you spend a total time of 6 months or more associated with a military base in any of the following countries: Belgium, The Netherlands, Germany, Spain, Portugal, Turkey, Italy, or Greece? ☐Yes ☐No

92. Since 1980, have you ever lived in or traveled to Europe? (Includes: England, Ireland, Scotland, Wales, the Isle of Man, the Channel Islands, Gibraltar, or the Falkland Islands) ☐Yes ☐No

93. Between 1980 and 1996 did you spend time that adds up to more than 3 months or more in the UK? ☐Yes ☐No

94. Since 1980 have you received a transfusion of blood, platelets, plasma, cryoprecipitate, or granulocytes in the U.K. or France? ☐Yes ☐No

95. Since 1980 have you spent time that adds up to 5 years or more in Europe (including time spent in the UK between 1980 and 1996)? ☐Yes ☐No

96. Have you been in a place affected by SARS or with an affected person with in the past 14 days? ☐Yes ☐No

97. Have you been treated for SARS in the last 28 days? ☐Yes ☐No

98. Were you born, lived in, or traveled to any African country since 1977? ☐Yes ☐No

99. When you traveled to _____, did you received a blood transfusion or any other medical treatment with a product made from blood? ☐Yes ☐No

100. Have you had sexual contact with anyone who was born in or lived in any African country since 1977? ☐Yes ☐No

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101. Have you ever been exposed to "agent orange" or any other herbicides or chemicals in Vietnam or elsewhere (forest service, highway maintenance, etc.)? ☐Yes ☐No If yes, what substances and where exposed? _____

_____

102. Have you been diagnosed with West Nile Virus? ☐Yes ☐No

103. Have you had a headache and fever within the last 7 days? ☐Yes ☐No

104. Have you had a blood transfusion of infusion within the past 48 hrs before your blood test for eligibility? ☐Yes ☐No

105. Have you ever received growth hormone made from human pituitary glands? ☐Yes ☐No

106. Have you ever received a dura mater (brain covering graft)? ☐Yes ☐No

107. Have any of your blood relatives ever had Creutzfeldt-Jakob disease? ☐Yes ☐No

108. In the past twelve months, have you had a positive syphilis test? ☐Yes ☐No

109. In the past 4 weeks have you had any shots or vaccinations?

Vaccines with no waiting period

- Allergy desensitization shots ☐Yes ☐No
- Cholera ☐Yes ☐No
- Diphtheria ☐Yes ☐No
- DPT-Diphtheria pertussis tetanus ☐Yes ☐No
- DT-Diphtheria tetanus ☐Yes ☐No
- Hepatitis A (HAVRIX) ☐Yes ☐No
- Influenza ☐Yes ☐No
- Lyme Disease ☐Yes ☐No
- Paratyphoid ☐Yes ☐No
- Pertussis (Whooping Cough) ☐Yes ☐No
- Plague ☐Yes ☐No
- Polio (injection) ☐Yes ☐No
- Rocky Mountain Spotted Fever ☐Yes ☐No
- Typhoid (injection) ☐Yes ☐No
- Typhus ☐Yes ☐No

Conditional Vaccines:

- Hepatitis B(Heptavax B, recombivax, or Engergix B): 12m deferral if for HBV exposure ☐Yes ☐No

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- Rabies: 12m deferral if animal bite broke the skin ☐Yes ☐No
- Tetanus: 3w deferral if for exposure ☐Yes ☐No
- TB: If a skin test (PPD test) was performed temporary deferral until results are negative. If positive, defer to a Medical Director Review. ☐Yes ☐No

Vaccines requiring 2w waiting period:

- Measles (rubeola) ☐Yes ☐No
- Mumps ☐Yes ☐No
- Typhoid ☐Yes ☐No
- Polio (oral) ☐Yes ☐No
- Yellow Fever ☐Yes ☐No

Vaccines requiring 4w waiting period:

- German Measles (rubella) ☐Yes ☐No
- MMR (measles, mumps, and rubella) ☐Yes ☐No
- Chicken Pox (varicella vaccine) ☐Yes ☐No

Personal Health History

110. Do you currently have any allergies? Yes ☐ No ☐

If yes, check applicable allergies: Food ☐ Drugs ☐ Environmental ☐ Animals ☐ Other

Please list the substances and reactions produced:

Substances	Reactions
_____	_____
_____	_____

111. Please describe any childhood allergies you may have outgrown: _____

_____

112. What medications are you currently taking (please include prescriptions, over the counter medications, and supplements)? _____

_____

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General Health

Please mark if you are <u>now</u> or have <u>recently</u> experienced any of the following:

Problem	Yes	No	Explain
Problems with your vision	☐	☐	
Double vision	☐	☐	
Blurred vision	☐	☐	
Loss of vision	☐	☐	
Problems with your hearing	☐	☐	
Ringing in your ears	☐	☐	
Earache	☐	☐	
Loss of balance	☐	☐	
Problems with your sense of smell	☐	☐	
Frequent sinus pain, congestion, or drainage	☐	☐	
Frequent or severe headaches	☐	☐	
Difficulty swallowing	☐	☐	
Sores in your mouth or gums	☐	☐	
Bleeding from your gums	☐	☐	
Pain in any of your teeth	☐	☐	
Lumps or bumps in your neck	☐	☐	
Chest pain	☐	☐	
Any pain with exertion	☐	☐	
Shortness of breath	☐	☐	
Difficulty sleeping at night	☐	☐	
A need to be propped up with pillows to sleep	☐	☐	
Waking up in the middle of night short of breath	☐	☐	
Fever or chills	☐	☐	
Waking up at night soaked in sweat	☐	☐	
Hot flashes	☐	☐	
Rapid heart beat	☐	☐	
Breast pain	☐	☐	
A persistent lump in your breast	☐	☐	
Discharge of any kind from your breast	☐	☐	
Heartburn	☐	☐	
Stomach pain	☐	☐	
Pelvic pain	☐	☐	
Bloating	☐	☐	
Back pain	☐	☐	
Joint pain	☐	☐	
Swelling of your feet	☐	☐	
Painful or enlarged veins in your legs	☐	☐	
Feel hot or cold when others are comfortable	☐	☐	

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Nervousness	☐	☐	_____
Irritability	☐	☐	_____
Persistent unexplained fatigue	☐	☐	_____
Are you depressed?	☐	☐	_____
Constipation or diarrhea	☐	☐	_____
Urinating more frequently than every two hours	☐	☐	_____
Waking up in the middle of the night to urinate	☐	☐	_____
Painful urination	☐	☐	_____
Change in the amount or distribution of hair	☐	☐	_____
Skin marking (moles, etc.) that concern you	☐	☐	_____
Change in your skin texture (more moist or dry)	☐	☐	_____

Physical Characteristics of the Family

113. Please describe your family members by the following characteristics:

Family Member	Age	Eye Color	Hair Color	Complexion	Height	Weight	Ethnic Origin
Children: 1. 2. 3.							
Father							
Mother							
Brothers: 1. 2. 3.							
Sisters: 1. 2. 3.							
Grandfathers: Paternal Maternal							

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Family Member	Age	Eye Color	Hair Color	Complexion	Height	Weight	Ethnic Origin
Grandmothers: Paternal Maternal							

Past Gynecologic History

114. What was the first day of your last menstrual cycle? _____

115. How old were you when you first noticed breast development? _____

116. How old were you when you first noticed pubic hair growth? _____

117. How old were you when you had your first period? _____

118. Do you have regular periods? _____ Length of cycle: _____ Always regular? _____ LMP: _____

119. How old were you when you began to have regular periods? _____

120. How many days are there from the first day of bleeding of one period to the first day of bleeding of the next period? _____

121. How many total days of menstrual flow do you have? _____

122. How many "heavy flow" days do you have during your period? _____

123. How many pads/tampons do you use for protection? _____

124. Describe any discomfort you have associated with your period: _____

_____

125. When does this discomfort start and how long does it last? _____

_____

126. Have you ever been on oral contraceptive pills? _____ How long? _____

Date Started	Date Stopped	Type	Reason for Stopping
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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127. Method of Birth Control: _____ Would you be willing to change or temporarily stop? _____

128. Describe any discomfort with intercourse? _____

129. Do you use any kind of lubrication during intercourse? _____

130. How many times a month do you have intercourse? _____

131. How long have you been in your current relationship? _____

132. How many partners have you had within the last 6 months? _____

133. What, if any, changes have you noticed in your sexual drive? _____

134. Have you ever been pregnant? _____ Number of pregnancies: _____

Number of spontaneous miscarriages: _____

Number of elective abortions: _____

Number of ectopic pregnancies: _____

135. List any PAP smear abnormalities you have had in the past: _____

_____

When was your last PAP smear? _____ Result: _____

When was your last mammogram? _____ Result: _____

136. List any past imperfections/irritations in your pelvic organs: _____

_____

137. How old was your mother when she went through menopause? _____

138. How many total times have you been pregnant? _____

139. If you have conceived, how many months of trying did it take? _____

140. If never pregnant, have you ever tried? _____ How long? _____

141. List each pregnancy in chronological order:

Date	Duration	Delivery Type	Problems
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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Ancestry

142. Do you have any Jewish ancestors? ☐Yes ☐No ☐Unknown
If yes, have you been tested as a carrier of Tay Sachs, Cystic Fibrosis, or Gaucher's disease? ☐Yes ☐No If yes, Result: _____

143. Do you have any African ancestors? ☐Yes ☐No ☐Unknown
If yes, have been tested as a carrier of sickle cell disease? ☐Yes ☐No
If yes, Result: _____

144. Do you have any Mediterranean (Greek or Italian) ancestors? ☐Yes ☐No ☐Unknown
If yes, have you been tested as a carrier of Thalassemia? ☐Yes ☐No
If yes, Result: _____

145. Do you have any Asian ancestors? ☐Yes ☐No ☐Unknown
If yes, have you been tested as a carrier of Thalassemia? ☐Yes ☐No
If yes, Result: _____

146. What level of schooling did your mother reach? _____
What is her occupation? _____

147. What level of schooling did your father reach? _____
What is his occupation? _____

148. Are you adopted? ☐Yes ☐No

149. Have twins or multiple births ever occurred in your family? ☐Yes ☐No
If yes, what relation to you? _____

Family Medical History

150. Has any member of your family, including yourself, had a **problem at birth** or **birth defect** of any of the following body systems? Please include first cousins and great grandparents.

Bones, muscles, joints, limbs	☐Yes	☐No
Gastrointestinal system	☐Yes	☐No
Nervous system, brain, spinal cord	☐Yes	☐No
Blood circulation	☐Yes	☐No
Respiratory system	☐Yes	☐No
Organ (heart, lung, kidney, etc.)	☐Yes	☐No
Genital/urinary	☐Yes	☐No

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Metabolic (hormones, enzymes, etc.) ☐Yes ☐No

If yes, please list below the specific defect in each case:

Birth Defect	Who	When did this occur	Seriousness

151. Do you have any brothers, sisters, or children that died in infancy or childhood?
☐Yes ☐No If yes, what was the cause? _____

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

153. Has anyone in your family, including yourself and your first cousins, 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

Please explain: _____
_____
_____
_____
_____
_____

154. Look very carefully through the following list of medical problems and place and "X" in the applicable boxes to indicate problems you or one of your relatives has had. Please consider each condition carefully for each family member. If you have any questions as to the definition of a condition please call our office to verify.

Medical Problems	Self	Children	Mother	Father	Siblings	Grand-parents	Aunts/ Uncles	First Cousins
1. Heart								
Stroke								
Heart attack								
From birth								
other								
Hardening of the arteries								
Congenital heart defects								
High Blood pressure								

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Medical Problems	Self	Children	Mother	Father	Siblings	Grand-parents	Aunts/ Uncles	First Cousins
Aneurysm								
2. Blood								
Anemia								
Sickle-cell anemia								
Hemophilia or other bleeding problem								
Leukemia								
Immune Deficiency								
Other blood disorder								
Clots								
3. Respiratory (lungs)								
Hay Fever								
Asthma								
Emphysema								
Tuberculosis								
Lung Cancer								
Pneumonia								
Other lung disease								
4. Gastro-intestinal								
Ulcer of the stomach/ duodenum								
Gallstones								
Hepatitis A (infectious)								
Hepatitis B (serum/blood)								
Other liver diseases								
Colon Cancer								
Ulcerative Colitis								
Crobn's disease								
Cystic Fibrosis								
Jaundice								
Intestinal Cancer								
Any other cancer/problem of the digestive system								
5. Metabolic/ Endocrine								
Diabetes mellitus (specify type 1 or 2)								

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Medical Problems	Self	Children	Mother	Father	Siblings	Grand-parents	Aunts/ Uncles	First Cousins
Low blood sugar								
Thyroid Cancer								
Goiter								
Other thyroid disease								
Adrenal dysfunction or disorders								
Hyperactivity								
6. Urinary								
Kidney disease								
Other diseases of the urinary tract (urethra, bladder, ureter)								
7. Genital/ Reproductive								
Undescended testicle(s)								
Malformed Penis								
Prostate Cancer								
Miscarriages (2 or more)								
Stillborns (2 or more)								
Unclear sex at birth								
Uterine Fibroids								
Ovarian Cysts								
Cancer of the cervix, ovaries, or uterus								
Other conditions								
8. Neurological								
Migraines								
Mental Retardation								
Senility before age 50								
Multiple sclerosis								
Cerebral Palsy								
Epilepsy/ Seizures								
Hydrocephalus (water on the brain)								
Disorders of the spinal cord								

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Medical Problems	Self	Children	Mother	Father	Siblings	Grand-parents	Aunts/ Uncles	First Cousins
Parkinson's disease								
Myasthenia gravis								
Spina Bifida (open spine)								
Paralysis/ paraplegia								
Huntington's disease								
Gaucher's disease								
Wilson's disease								
Other diseases of the nervous system								
9. Mental Health								
Schizophrenia								
Manic depression (Bipolar)								
Depression of any other kind								
Attention deficit disorder								
10. Muscles/ Bones/Joints								
Muscular Dystrophy								
Other chronic muscle disease								
Lupus								
Deformity of the spine								
Osteoporosis								
Dwarfism								
Heredity of low back disease								
Arthritis								
Congenital hip problems								
Gout								
Club Foot								
Tourette's Syndrome								
Other								
11. Sight/ Sound/ Smell								
Deafness before age 60								

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Medical Problems	Self	Children	Mother	Father	Siblings	Grand-parents	Aunts/ Uncles	First Cousins
Deformity of the ear								
Cataracts before age 60								
Blindness								
Color Blindness								
Glaucoma								
Deviated Septum								
Any other sight/sound/ smell disorder								
12. Skin								
Acne								
Eczema								
Edema (Swelling)								
Coffee-colored skin spots								
Skin cancer								
Pigmentation disorders								
Other disorders of the skin								
13. Other								
Early death (<50 years)								
Chromosome problems								
Inguinal Hernia								
Cystic Fibrosis								
Down's Syndrome								
Lymphedema								
Alcoholism/ cirrhosis								
Drug abuse, misuse, or addiction								
Breast cancer								
Other cancers not mentioned above								
Obesity								
Cleft lip and/or palate								
Any other condition not listed above								

155. **Carefully review the preceding tables and boxes selected. Use your answers to complete the table below and be sure to explain all the conditions that you**

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marked. If the relative indicated below is healthy and has not been treated for anything, please mark "healthy". Do not use phrases such as "not applicable" and "natural causes" or "old age". <u>(At the very least, please comment on yourself, children, parents, siblings, and grandparents.)</u>

Relationship	Current age or age of death	Health Problems	Age Diagnosed	Living	Deceased	Comments
Self						
Child						
Child						
Sister						
Sister						
Brother						
Brother						
Mother's side of family						
Mother						
Grandmother						
GG mother						
GG father						
Grandfather						
GG mother						
GG father						
Aunt						
Aunt						
Uncle						
Uncle						
First Cousin						
First Cousin						
Father's side of the family						
Father						
Grandmother						
GG mother						
GG father						
Grandfather						
GG mother						
GG father						
Aunt						
Aunt						
Uncle						
Uncle						
First Cousin						
First Cousin						

If you need additional space to explain any of the conditions, you may use the following space:

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Work Related Information

156. What is your current or most recent occupation? _____

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

Job/Duties	Year Employment Began	Year Employment Ended	Exposed to which drugs, chemicals, gases
1.			
2.			
3.			
4.			
5.			
6.			

157. In the past 6 months, have you been exposed to any of the following in your living environment or while involved in hobbies? If yes to any of these, please check the appropriate item below and give dates and how often you have been exposed. Please consider carefully.

Exposed to	When	How often
Toxic chemicals		
Sprays		
Fumes/Exhaust		
Radiation		
Flea powders/sprays		
Lead/Lead products		

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Exposed to	When	How often
Asbestos/Asbestos products		
Cleaning solutions/solvents		

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DONOR ACKNOWLEDGMENT:
HUMAN PITUITARY-DERIVED GROWTH HORMONE

The undersigned acknowledges that, to the best of her knowledge, she has not received injections of the human pituitary-derived growth hormone (pit-hGH) between 1963 and 1985. The undersigned further states that she has not used this drug non-therapeutically, that is, during rigorous physical training

The donor has been made aware of the commercial sources of pit-hGH available between 1978 and 1985, which were Asellacrinn (Serono) and Cresorman (KabiVitrum). She has been made aware of Creutzfeldt-Jakob disease (CJD) which is associated with pit-hGH.

Signature of Donor	Signature of Witness
Date	Date

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DONOR MEDICAL AND GENETIC HISTORY CERTIFICATION

I certify that the above information is, to the best of my knowledge, true and complete, and I have not intentionally omitted/withheld any information required to be given in this questionnaire. I also acknowledge that I have asked the meaning of any term that I was not familiar with.

_____	_____
Signature of Donor	Signature of Witness
_____	_____
Date	Date