

Dear prospective Donor:

Thank you for your interest in the New England Cryogenic Center, Inc. Sperm Donation Program. Our goal is to assist our client's with the gift of life. Our sperm donors can make a world of difference in the lives of many of our clients.

One of our criteria for donor selection is our confidence that each donor is honest, mature, and serious about his commitment to this program.

Please take the time to review this application. Answer all questions with a thorough understanding of the importance of their nature. If a question **does not apply** to you simply write in "N/A".

Please complete the application using **BLUE OR BLACK INK PEN**; do not use pencil.

After completion of the application, please mail back to:

New England Cryogenic Center, Inc  
153 Needham Street  
Building 1  
Newton, Ma 02464

Once we receive the application it will be reviewed. If the application is accepted we will contact you by phone and make arrangements for an appointment.

Thank you for your time and interest.

Sincerely,

John R. Rizza, Sr.  
Executive Director

## NECC Donor Orientation

Donor appointments are scheduled Monday through Friday between 8:00am and 4:00pm. There is the possibility that a scheduled donor appointment may be bumped for an emergency banker appointment at short notice.

Your eligibility for admission to the NECC Donor Program will be based on 3-5 qualifying specimens. Qualifying specimens are analyzed for sperm concentration & motility (Pre and Post Thaw) and are not compensated. Following this initial assessment, arrangements will be made for you to have an interview as well as a physical by our Medical Director.

As you move forward through the application process, you will be required to give both urine and blood specimens for genetic screening and to be tested for sexually transmitted diseases (STDs). Following admission to the program, donors are responsible for a minimum of forty (40) “*passing*” visits, and are required to give urine and blood specimens every (3-6) months. You will also be required to complete a “6 Month Health Assessment” every six months to allow NECC to update donor education, career and family health history status. A repeat physical is performed each year throughout your participation as well.

Donor compensation is based on the following schedule:

1. The first 3-5 specimens are for qualification only and are not compensated.
2. Only “*Passing*” specimens from “*Eligible*” donors are compensated.
  - “*Passing*” specimens are based on sperm concentration & motility.
  - “*Eligible*” donors meet regulatory requirements and NECC policies.
3. Accepted donors are compensated \$100 for each “*passing*” specimen.
4. For each of the first 24 “*passing*” specimens, NECC will withhold 50% (\$50) of the \$100 compensation in a reserve account (totaling \$1,200).
5. Six (6) months after completion of the program (reaching a minimum of 40 passing visits); we will require a blood and urine sample for final testing. Following the release of your remaining specimen inventory, you will receive the final payment of \$1,200. If you have relocated to another city; testing can be arranged at a local Quest Diagnostics Laboratory, and results can be submitted to NECC via mail or fax. You are responsible to NECC for up to \$3000.00 if you fail to have final testing performed. If at any time during your participation you are deemed ineligible, you will not receive the amount withheld in the reserve account.

### **NECC Donor Orientation Cont'd**

Donors are required to have 3 days (72 hours) of abstinence prior to each donation. If you do not have 3 days abstinence, we will not collect a specimen. If you know prior to a scheduled appointment that you will be unable to meet the three day abstinence requirement, you must call to reschedule. Time of abstinence directly affects specimen quality. Remember that you will not be compensated for “*failed*” specimens.

Donors are required to be on time for scheduled appointments. Donors are given a 15 minute grace period; if you arrive after that, we will not collect a specimen, and you will not be compensated. If you are going to be late, please call to let us know.

Donors are required to inform NECC staff of any planned extended periods of absence. It is recommended that donors make and keep regular appointments.

Applicant Printed Name \_\_\_\_\_

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

### **Please note the following prior to your appointment:**

1. You must abstain from ejaculating for 3 days (72 hours) prior to your appointments with NECC.
2. You must bring a state and college ID to your first appointment with NECC.
3. You should avoid wearing tight fitting brief style underwear for two days prior to producing your specimens.
4. You should avoid any strenuous exercise such as running, aerobics, cycling, etc. for two days prior to producing a specimen.
5. Please keep in mind that sperm production is reduced when the groin area is exposed to elevated temperatures (hot tub, sauna, steam room.... etc.)

**NEW ENGLAND CRYOGENIC CENTER, INC.  
DONOR QUESTIONNAIRE**

Name \_\_\_\_\_

Age \_\_\_\_\_ Date of birth \_\_\_\_\_ Place of Birth \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

College/University \_\_\_\_\_ Year Completed \_\_\_\_\_

Social Security Number \_\_\_\_\_

Phone # \_\_\_\_\_

Place of Business \_\_\_\_\_ Work Phone \_\_\_\_\_

Email address \_\_\_\_\_

Referred to by \_\_\_\_\_

Person to contact \_\_\_\_\_ Phone \_\_\_\_\_

**Current Address:**

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Country \_\_\_\_\_

**Former Address (if less than 5 years)**

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Country \_\_\_\_\_

*For office use only:*

Notes:

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

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**NEW ENGLAND CRYOGENIC CENTER, INC.  
DONOR QUESTIONNAIRE**

**Today's Date:** \_\_\_\_\_ **Initials:** \_\_\_\_\_

**Physical Characteristics**

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Race: \_\_\_\_\_  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Eye Color: \_\_\_\_\_ Hair Color: \_\_\_\_\_

| <b>Hair<br/>(check one)</b> |  | <b>Hair<br/>(check one)</b> |  | <b>Complexion<br/>(check one)</b> |  |
|-----------------------------|--|-----------------------------|--|-----------------------------------|--|
| Balding                     |  | Curly                       |  | Fair                              |  |
| Thin                        |  | Wavy                        |  | Medium                            |  |
| Average                     |  | Straight                    |  | Dark                              |  |
| Thick                       |  |                             |  |                                   |  |

Body type/bone structure: small \_\_\_\_\_ medium \_\_\_\_\_ large \_\_\_\_\_

Right handed: \_\_\_\_\_ Left Handed: \_\_\_\_\_

**Personal Characteristics**

Family Ethnic Origin

Ethnic origin/Ancestry: \_\_\_\_\_

Mother: \_\_\_\_\_ Father: \_\_\_\_\_  
Maternal Grandmother: \_\_\_\_\_ Paternal Grandmother: \_\_\_\_\_  
Maternal Grandfather: \_\_\_\_\_ Paternal Grandfather: \_\_\_\_\_

Religion born into: \_\_\_\_\_

Do you have any Jewish ancestry? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you have any French Canadian ancestry? \_\_\_\_\_ Yes \_\_\_\_\_ No

Education: (check all that apply)

- \_\_\_\_\_ Completed grade school
- \_\_\_\_\_ Completed high school Year: \_\_\_\_\_
- \_\_\_\_\_ Attending college, undergraduate study in: \_\_\_\_\_
- \_\_\_\_\_ Completed college, degree in: \_\_\_\_\_
- \_\_\_\_\_ Attending grad school, Med school graduate study in: \_\_\_\_\_
- \_\_\_\_\_ Completed graduate school, advanced degree in: \_\_\_\_\_

SAT Scores Math \_\_\_\_\_ Writing \_\_\_\_\_ Critical Reading \_\_\_\_\_ College GPA \_\_\_\_\_

LSAT, MCAT, GMAT, GRE Score(s) if applicable \_\_\_\_\_

Marital Status (check one): single \_\_\_\_\_ married \_\_\_\_\_ divorced \_\_\_\_\_ widowed \_\_\_\_\_

If you are single, do you want to marry someday? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you want to have children? \_\_\_\_\_ Yes \_\_\_\_\_ No

How many boys? \_\_\_\_\_ How many girls? \_\_\_\_\_

Today's Date: \_\_\_\_\_

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**Fertility History**

Do you have any children: \_\_\_\_\_ Yes \_\_\_\_\_ No  
 If yes, how many male children? \_\_\_\_\_ How many female children? \_\_\_\_\_

For each child please write below their ages and any special health problems they may have:

| Age | Special Health Problems |
|-----|-------------------------|
|     |                         |
|     |                         |
|     |                         |
|     |                         |

Has a women ever conceived with your sperm? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please list the years in which pregnancies occurred: \_\_\_\_\_

Have you ever donated sperm before? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, when? \_\_\_\_\_ Where? \_\_\_\_\_

For how long? \_\_\_\_\_

How many births resulted from your donations? \_\_\_\_\_

Have you ever been refused as a sperm donor? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, at which facility? \_\_\_\_\_

Please indicate the reason for refusal? \_\_\_\_\_

Have you ever had a semen analysis? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, Please explain the reason for the analysis and fill in the information below:

|    | Date | General result | Count | Motility | Other |
|----|------|----------------|-------|----------|-------|
| 1. |      |                |       |          |       |
| 2. |      |                |       |          |       |

Have you ever been told that you were infertile? \_\_\_\_\_ Yes \_\_\_\_\_ No

Has your mother ever had a miscarriage? \_\_\_\_\_ Yes \_\_\_\_\_ No

Is there any history of infertility problems in your family (difficulty conceiving or miscarriage)?

\_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please explain \_\_\_\_\_

Did your parents have difficulty conceiving? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do any of your brothers have fertility problems? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do any of your uncles have fertility problems? \_\_\_\_\_ Yes \_\_\_\_\_ No

Did your mother take diethylstilbestrol (DES) or any drugs while she was pregnant with you?

\_\_\_\_\_ Yes \_\_\_\_\_ No

Are you exposed to excess heat in the way of sauna, hot tubs, steam rooms etc.? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you wear Jockey/ brief type underwear? \_\_\_\_\_ Yes \_\_\_\_\_ No

Would you consider the following?

To be contacted by the child after age 18? \_\_\_\_\_ Yes \_\_\_\_\_ No

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**Personal Health History**

Have you ever donated blood or plasma? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, when \_\_\_\_\_

Have you ever been refused as a blood donor? \_\_\_\_\_ Yes \_\_\_\_\_ No  
 If yes, when? \_\_\_\_\_ On what basis? \_\_\_\_\_

Do you currently have any allergies? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, are they:  
 \_\_\_\_\_ Food \_\_\_\_\_ Drugs \_\_\_\_\_ Environmental \_\_\_\_\_ Other

Please list below specific substances and reaction(s) produced:

| Substance | Reaction |
|-----------|----------|
|           |          |
|           |          |
|           |          |

As per above, please describe any childhood allergies you have outgrown:

\_\_\_\_\_

\_\_\_\_\_

How is your vision without glasses? \_\_\_\_\_ Poor \_\_\_\_\_ Fair \_\_\_\_\_ Good \_\_\_\_\_ Excellent

Do you wear glasses? \_\_\_\_\_ Yes \_\_\_\_\_ No

Are you: \_\_\_\_\_ Nearsighted \_\_\_\_\_ Farsighted \_\_\_\_\_ Other (specify) \_\_\_\_\_

Your vision is: Right eye: 20/ \_\_\_\_\_ Left eye: 20/ \_\_\_\_\_

Your eyeglass Rx: (OD): Spherical \_\_\_\_\_ Cylinder \_\_\_\_\_ Axis \_\_\_\_\_

(OS): Spherical \_\_\_\_\_ Cylinder \_\_\_\_\_ Axis \_\_\_\_\_

Do you have normal hearing? \_\_\_\_\_ Yes \_\_\_\_\_ No

If no, please explain: \_\_\_\_\_

Condition of your teeth (check one) \_\_\_\_\_ Poor \_\_\_\_\_ Fair \_\_\_\_\_ Good \_\_\_\_\_ Excellent

Have you ever had braces? \_\_\_\_\_ Yes \_\_\_\_\_ No

Your diet is (check one) \_\_\_\_\_ Vegetarian \_\_\_\_\_ Non-vegetarian

Your diet is (check one) \_\_\_\_\_ Poor \_\_\_\_\_ Fair \_\_\_\_\_ Good \_\_\_\_\_ Excellent

How much exercise do you get? \_\_\_\_\_ None \_\_\_\_\_ Occasional \_\_\_\_\_ Regular

What type of exercise? \_\_\_\_\_

\_\_\_\_\_

Have you ever had surgery? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you had any hospitalization not already mentioned? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Have you ever had major radiation exposure or X-ray exposure? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Today's Date: \_\_\_\_\_

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**Health: Exposures**

**Sexual partners/ contacts** = persons with whom you have engaged in one or more of the following activities: Prolonged open mouth kissing, erotic massage and or mutual masturbation, oral sex (vaginal, anal, penile), anal sex, sexual intercourse.

Have you or any of your sexual partners ever had:

|   | Yes | No | Myself/Partner |
|---|-----|----|----------------|
| Syphilis  |     |    |                |
| Gonorrhea   |     |    |                |
| NSU (non-specific urethritis)                                 |     |    |                |
| Chlamydia   |     |    |                |
| Venereal warts  |     |    |                |
| Herpes  |     |    |                |
| Trichomoniasis  |     |    |                |
| Other sexually transmissible diseases<br>If yes, please list: |     |    |                |

Have you ever had a major illnesses such as amoebic dysentery, hepatitis, pneumonia, mono-nucleosis, etc? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please explain: \_\_\_\_\_

Do you have any current or chronic medical problems/conditions? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please explain: \_\_\_\_\_

Have you ever been in juvenile detention or been an inmate of a correctional facility for 72 consecutive hours or longer? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, explain: \_\_\_\_\_

Within the past 12 months? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, explain: \_\_\_\_\_

Have you been bitten by an animal suspected of rabies in the last six months? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please explain: \_\_\_\_\_

Have you ever served in the military? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, when and where? \_\_\_\_\_

Did your father serve in the military? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, when and where? \_\_\_\_\_

Today's Date: \_\_\_\_\_

Initials: \_\_\_\_\_

**Health: Exposures (continued)**

Are you currently taking any medications? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If yes, list all medications; include dosage, frequency and reason for use?  
\_\_\_\_\_

Have you ever taken Growth Hormone from Human Pituitary Glands? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If yes, when and why? \_\_\_\_\_

Have you ever taken Insulin from cows (bovine or beef insulin)? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If yes, when and why? \_\_\_\_\_

Have you ever taken Hepatitis B Immune Globulin given following an Exposure to Hepatitis B?  
Note\* This is different from the hepatitis B vaccine, which is a series of 3 injections given to prevent future infection from exposures to hepatitis B. \_\_\_\_\_ Yes \_\_\_\_\_ No  
If yes, when and why? \_\_\_\_\_

Have you ever taken an unlicensed vaccine? (usually associated with a research protocol.) \_\_\_\_\_ Yes \_\_\_\_\_ No  
If yes, when and why? \_\_\_\_\_

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IF YOU WOULD LIKE TO KNOW WHY THESE MEDICINES AFFECT YOU AS A DONOR, PLEASE KEEP READING:

- **Growth hormone from human pituitary glands was prescribed for children with delayed or impaired growth. The hormone was obtained from human pituitary glands, which are found in the brain. Some people who took this hormone developed a rare nervous system condition called Creutzfeldt-Jakob Disease (CJD, for short). Potential donors who have taken growth hormone from human pituitary glands should be evaluated by the Medical Director.**
- **Insulin from cows (bovine, or beef, insulin) is an injected material used to treat diabetes. If this insulin was imported into the US from countries in which "Mad Cow Disease" has been found, it could contain material from infected cattle. There is concern that "Mad Cow Disease" is transmitted by transfusions and transplants. Potential donors who have taken insulin from cows should be evaluated by the Medical Director.**
- **Hepatitis B Immune Globulin (HBIG) is an injected material used to prevent infection following an exposure to hepatitis B. HBIG does not prevent hepatitis B infection in every case, therefore potential donors who have taken hepatitis B Immune Globulin should be evaluated by the Medical Director to be sure they were not infected. Hepatitis B can be transmitted, through transfusions and transplants, to a patient.**
- **Unlicensed vaccine is usually associated with a research protocol and the effect with regard to stem cell recipients is unknown. Potential donors who have taken unlicensed vaccines should be evaluated by the Medical Director.**

Today's Date: \_\_\_\_\_

Initials: \_\_\_\_\_

Health: Exposures (continued)

Please indicate whether you have used any of the following:

|  | Never Used | Frequency/ when used<br>(years) | How used? |
|--|------------|---------------------------------|-----------|
| Marijuana  |            |                                 |           |
| Cocaine  |            |                                 |           |
| Barbiturates (acid)  |            |                                 |           |
| Narcotics/ Opiates<br>(Heroin, Methadone, Opium, Morphine,<br>Vicodin, Oxycontin, Percocet, Codeine, Etc.) |            |                                 |           |
| Amphetamines<br>(Adderall, Dexedrine, MDMA aka Ecstasy)  |            |                                 |           |
| Hallucinogens<br>(LSD, Mescaline, Mushrooms, Peyote)   |            |                                 |           |
| Tranquilizers<br>(Special K, Sleeping Pills, Xanax, Valium,<br>or other Benzo's)                           |            |                                 |           |
| Anti-depressants   |            |                                 |           |
| PCP  |            |                                 |           |
| Inhalants<br>(Amyl or butyl nitrate, aerosol propellants)  |            |                                 |           |
| Over-the-counter drugs   |            |                                 |           |
| Steroids   |            |                                 |           |
| Others   |            |                                 |           |

Do you know or do you have reason to believe that your parents ever used non-prescription recreational drugs now or in their past? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, what kind? \_\_\_\_\_

Do you drink alcoholic beverages? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, which types? \_\_\_\_\_ Beer \_\_\_\_\_ Wine \_\_\_\_\_ Liquor

Approximately how many drinks per week do you consume? \_\_\_\_\_

If you now drink less than 3 drinks per week, was there ever a time when you drank more?  
\_\_\_\_\_ Yes \_\_\_\_\_ No If yes, how much and when (given years) \_\_\_\_\_

Do you smoke cigarettes? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, how many a day? \_\_\_\_\_

How long have you been smoking regularly? \_\_\_\_\_

Do you drink coffee or other caffeinated beverages? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, how many cups per day do you drink? \_\_\_\_\_

Today's Date: \_\_\_\_\_

Initials: \_\_\_\_\_

**Travel outside of the United States**

The following lists of countries are subject to change due to updates by the Food and Drug Administration

**HIV Group O countries of risk – Africa**

|                          |         |        |
|--------------------------|---------|--------|
| Cameroon                 | Gabon   | Zambia |
| Central African Republic | Niger   | Benin  |
| Chad                     | Nigeria | Kenya  |
| Congo                    | Senegal |        |
| Equatorial Guinea        | Togo    |        |

Were you born in or have you lived in any of the countries listed above? Yes \_\_\_ No \_\_\_

If yes, check all that apply and use space provided to describe why, when, and amount of time spent in each country: \_\_\_\_\_

If you lived in or traveled to any of the above countries since 1977, did you receive a blood transfusion or any medical treatment with a product made from blood? Is so when? \_\_\_\_\_

Have you had sexual contact with anyone who was born in or lived in any of these countries since 1977? Yes \_\_\_ No \_\_\_ If so, When \_\_\_\_\_

**vCJD countries of risk – Europe**

|                    |               |                 |
|--------------------|---------------|-----------------|
| Albania            | Germany       | Poland          |
| Austria            | Greece        | Portugal        |
| Belgium            | Hungary       | Romania         |
| Bosnia-Herzegovina | Ireland       | Slovak Republic |
| Bulgaria           | Italy         | Slovenia        |
| Croatia            | Liechtenstein | Spain           |
| Czech Republic     | Luxembourg    | Sweden          |
| Denmark            | Macedonia     | Switzerland     |
| Finland            | Netherlands   | United Kingdom  |
| France             | Norway        | Yugoslavia      |

Have you traveled to or lived in any of the countries listed above? Yes \_\_\_ No \_\_\_

If yes, check all that apply and use space provided to describe why, when, and amount of time spent in each country: \_\_\_\_\_

**vCJD countries of risk – United Kingdom**

|                  |                  |          |
|------------------|------------------|----------|
| England          | Gibraltar        | Scotland |
| Channel Islands  | Isle of Man      | Wales    |
| Falkland Islands | Northern Ireland |          |

Have you traveled to or lived in any of the countries listed above? Yes \_\_\_ No \_\_\_

If yes, check all that apply and use space provided to describe why, when, and amount of time spent in each country: \_\_\_\_\_

Today's Date: \_\_\_\_\_

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**Personal Health: Work History/Experience**

What is your current or most recent occupation? \_\_\_\_\_

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: |            | Exposed to which drugs, chemicals, gases |
|-------------|----------------------|------------|--|
|             | Year Began           | Year Ended |  |
|             |                      |            |  |
|             |                      |            |  |
|             |                      |            |  |
|             |                      |            |  |
|             |                      |            |  |
|             |                      |            |  |

In the past six months have you been exposed to any of the following in your living environment, while at work 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 each carefully.

| Exposed to                          | No | Yes | If yes, when | If yes, how often |
|-------------------------------------|----|-----|--------------|-------------------|
| Toxic Chemicals                     |    |     |              |                   |
| Sprays                              |    |     |              |                   |
| Fumes/Exhaust                       |    |     |              |                   |
| Radiation                           |    |     |              |                   |
| Flea powders/sprays                 |    |     |              |                   |
| Lead/lead products                  |    |     |              |                   |
| Asbestos/asbestos products          |    |     |              |                   |
| Cleaning solutions/solvents         |    |     |              |                   |
| Pesticides, herbicides, fertilizers |    |     |              |                   |
| Petroleum products                  |    |     |              |                   |

Was your father exposed to any of the above in his living environment, while at work or while involved in hobbies? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please explain \_\_\_\_\_

Today's Date: \_\_\_\_\_

Initials: \_\_\_\_\_

**Family Health History**

Please describe your family members by the following physical characteristics:

|                      | Eye Color | Hair Color | Complexion | Height | Body Type | Vision |
|----------------------|-----------|------------|------------|--------|-----------|--------|
| Mother               |           |            |            |        |           |        |
| Father               |           |            |            |        |           |        |
| Sister 1             |           |            |            |        |           |        |
| Sister 2             |           |            |            |        |           |        |
| Sister 3             |           |            |            |        |           |        |
| Brother 1            |           |            |            |        |           |        |
| Brother 2            |           |            |            |        |           |        |
| Brother 3            |           |            |            |        |           |        |
| Maternal Grandmother |           |            |            |        |           |        |
| Maternal Grandfather |           |            |            |        |           |        |
| Paternal Grandmother |           |            |            |        |           |        |
| Paternal Grandfather |           |            |            |        |           |        |

How many blood siblings are in your immediate family (including yourself)? \_\_\_\_\_  
 How many males? \_\_\_\_\_ How many females? \_\_\_\_\_

Have twins or multiple births occurred in your family? \_\_\_\_\_ Yes \_\_\_\_\_ No  
 If yes, what relation were they to you? \_\_\_\_\_  
 \_\_\_\_\_

Do you have children? \_\_\_\_\_ Yes \_\_\_\_\_ No  
 If yes, complete the table below:

|         | Eye Color | Hair Color | Complexion | Height | Body Type | Vision |
|---------|-----------|------------|------------|--------|-----------|--------|
| Child 1 |           |            |            |        |           |        |
| Child 2 |           |            |            |        |           |        |
| Child 3 |           |            |            |        |           |        |

Today's Date: \_\_\_\_\_

Initials: \_\_\_\_\_

**Family Health History**

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.

| Relation             | Age if living | Health Status if living<br>(Poor, Fair, Good, Excellent) | Age at time of death | Cause of death<br>Cause of death required.<br>(Natural causes is acceptable only if > 85 at time of death) |
|----------------------|---------------|--|----------------------|--|
| Paternal Grandfather |               |  |                      |  |
| Paternal Grandmother |               |  |                      |  |
| Maternal Grandfather |               |  |                      |  |
| Maternal Grandmother |               |  |                      |  |
| Father               |               |  |                      |  |
| Mother               |               |  |                      |  |
| Brother 1            |               |  |                      |  |
| Brother 2            |               |  |                      |  |
| Brother 3            |               |  |                      |  |
| Sister 1             |               |  |                      |  |
| Sister 2             |               |  |                      |  |
| Sister 3             |               |  |                      |  |

Please use the space below to elaborate on any health status information, cause of death or to list additional sibling(s):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Complete the table below; if you or any of your blood siblings have children:

Check here if not applicable \_\_\_\_\_

| Relation | Age if living | Health Status if living<br>(Poor, Fair, Good, Excellent) | Age at time of death | Cause of death<br>Cause of death required.<br>(Natural causes is acceptable only if > 85 at time of death) |
|----------|---------------|--|----------------------|--|
| Child 1  |               |  |                      |  |
| Child 2  |               |  |                      |  |
| Child 3  |               |  |                      |  |
| Niece 1  |               |  |                      |  |
| Niece 2  |               |  |                      |  |
| Niece 3  |               |  |                      |  |
| Nephew 1 |               |  |                      |  |
| Nephew 2 |               |  |                      |  |
| Nephew 3 |               |  |                      |  |

Today's Date: \_\_\_\_\_

Initials: \_\_\_\_\_

To the best of your recollection, how many brothers and/or sisters did the following have:

|                      | Brothers | Sisters |
|----------------------|----------|---------|
| Paternal Grandfather |          |         |
| Paternal Grandmother |          |         |
| Maternal Grandfather |          |         |
| Maternal Grandmother |          |         |
| Father               |          |         |
| Mother               |          |         |

Has any member of your family, including yourself, had a problem or defect at birth of any of the following body systems? Please check all that apply.

| YES | NO |                                     |
|-----|----|-------------------------------------|
|     |    | Bones, muscles, joints, limbs       |
|     |    | Gastrointestinal system             |
|     |    | Nervous system, brain, spinal cord  |
|     |    | Blood/circulatory system            |
|     |    | Respiratory system                  |
|     |    | Organ (heart, lung, kidney, etc.)   |
|     |    | Genital/urinary                     |
|     |    | Metabolic (hormones, enzymes, etc.) |
|     |    | Eye, ear                            |

If yes to any of the above, please list below the specific defect in each case.

| Birth defect/ Problem | Who? | When did this happen? | Relevant circumstances |
|-----------------------|------|-----------------------|------------------------|
|                       |      |                       |                        |
|                       |      |                       |                        |
|                       |      |                       |                        |

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

\_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please explain \_\_\_\_\_  
 \_\_\_\_\_

Do you have any brothers or sisters who died in infancy or childhood? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, what was the cause? \_\_\_\_\_

Are there any known genetic diseases or conditions that run in your family? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, what are they? \_\_\_\_\_

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

If yes, please explain: \_\_\_\_\_  
 \_\_\_\_\_

Does your father have any brothers? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, do they have any children? \_\_\_\_\_ Yes \_\_\_\_\_ No

How many boys \_\_\_\_\_ Girls? \_\_\_\_\_

Do you know if they (your uncles) had any miscarriages or deaths at birth? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please explain: \_\_\_\_\_

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**Family Health History (continued)**

Look through the following list of medical problems and indicate which ones you or one of your blood relatives have had. Please consider each condition carefully for each family member. **You must check off N/A if the problem does not apply.**

| Medical Problem              | N/A | You | Mother | Father | Sibling | Grandparents | Aunt/Uncle | Cousins | Niece/<br>Nephew | Your<br>Children |
|------------------------------|-----|-----|--------|--------|---------|--------------|------------|---------|------------------|------------------|
| 1. HEART                     |     |     |        |        |         |              |            |         |                  |                  |
| A. stroke                    |     |     |        |        |         |              |            |         |                  |                  |
| B. heart attack              |     |     |        |        |         |              |            |         |                  |                  |
| C. heart disease             |     |     |        |        |         |              |            |         |                  |                  |
| i. from birth (explain)      |     |     |        |        |         |              |            |         |                  |                  |
| ii. other (explain)          |     |     |        |        |         |              |            |         |                  |                  |
| D. hardening of the arteries |     |     |        |        |         |              |            |         |                  |                  |
| E. high blood pressure       |     |     |        |        |         |              |            |         |                  |                  |

| Medical Problem                            | N/A | You | Mother | Father | Sibling | Grandparents | Aunt/Uncle | Cousins | Niece/<br>Nephew | Your<br>Children |
|--|-----|-----|--------|--------|---------|--------------|------------|---------|------------------|------------------|
| 2. BLOOD                                   |     |     |        |        |         |              |            |         |                  |                  |
| A. anemia                                  |     |     |        |        |         |              |            |         |                  |                  |
| B. sickle-cell anemia                      |     |     |        |        |         |              |            |         |                  |                  |
| C. hemophilia or other<br>bleeding problem |     |     |        |        |         |              |            |         |                  |                  |
| D. leukemia                                |     |     |        |        |         |              |            |         |                  |                  |
| E. immune deficiency                       |     |     |        |        |         |              |            |         |                  |                  |
| F. other blood disorder<br>(explain)       |     |     |        |        |         |              |            |         |                  |                  |

| Medical Problem                 | N/A | You | Mother | Father | Sibling | Grandparents | Aunt/Uncle | Cousins | Niece/<br>Nephew | Your<br>Children |
|---------------------------------|-----|-----|--------|--------|---------|--------------|------------|---------|------------------|------------------|
| 3. RESPIRATORY (LUNGS)          |     |     |        |        |         |              |            |         |                  |                  |
| A. hay fever                    |     |     |        |        |         |              |            |         |                  |                  |
| B. asthma                       |     |     |        |        |         |              |            |         |                  |                  |
| C. emphysema                    |     |     |        |        |         |              |            |         |                  |                  |
| D. tuberculosis                 |     |     |        |        |         |              |            |         |                  |                  |
| E. lung cancer                  |     |     |        |        |         |              |            |         |                  |                  |
| F. pneumonia                    |     |     |        |        |         |              |            |         |                  |                  |
| G. other lung disease (explain) |     |     |        |        |         |              |            |         |                  |                  |

| Medical Problem                                   | N/A | You | Mother | Father | Sibling | Grandparents | Aunt/Uncle | Cousins | Niece/<br>Nephew | Your<br>Children |
|---|-----|-----|--------|--------|---------|--------------|------------|---------|------------------|------------------|
| 4. GASTRO-INTESTINAL                              |     |     |        |        |         |              |            |         |                  |                  |
| A. ulcer of stomach or<br>duodenum                |     |     |        |        |         |              |            |         |                  |                  |
| B. gall stones                                    |     |     |        |        |         |              |            |         |                  |                  |
| C. hepatitis A (infectious)                       |     |     |        |        |         |              |            |         |                  |                  |
| D. hepatitis B (serum)                            |     |     |        |        |         |              |            |         |                  |                  |
| E. other liver disease                            |     |     |        |        |         |              |            |         |                  |                  |
| F. colon cancer                                   |     |     |        |        |         |              |            |         |                  |                  |
| G. ulcerative colitis                             |     |     |        |        |         |              |            |         |                  |                  |
| H. Crohn's disease                                |     |     |        |        |         |              |            |         |                  |                  |
| I. cystic fibrosis                                |     |     |        |        |         |              |            |         |                  |                  |
| J. intestinal cancer                              |     |     |        |        |         |              |            |         |                  |                  |
| K. rectal disorder                                |     |     |        |        |         |              |            |         |                  |                  |
| L. other cancer/problem of<br>GI system (explain) |     |     |        |        |         |              |            |         |                  |                  |

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**Family Health History (continued)**

| Medical Problem<br>5. METABOLIC/ENDOCRINE | N/A | You | Mother | Father | Sibling | Grandparents | Aunt/Uncle | Cousins | Niece/<br>Nephew | Your<br>Children |
|---|-----|-----|--------|--------|---------|--------------|------------|---------|------------------|------------------|
| A. diabetes mellitus                      |     |     |        |        |         |              |            |         |                  |                  |
| B. hypoglycemia                           |     |     |        |        |         |              |            |         |                  |                  |
| C. thyroid cancer                         |     |     |        |        |         |              |            |         |                  |                  |
| D. thyroid disease                        |     |     |        |        |         |              |            |         |                  |                  |
| E. goiter                                 |     |     |        |        |         |              |            |         |                  |                  |
| F. adrenal dysfunction or disorder        |     |     |        |        |         |              |            |         |                  |                  |
| G. hyperactivity                          |     |     |        |        |         |              |            |         |                  |                  |
| H. hormonal dysfunction or disorder       |     |     |        |        |         |              |            |         |                  |                  |

| Medical Problem<br>6. URINARY  | N/A | You | Mother | Father | Sibling | Grandparents | Aunt/Uncle | Cousins | Niece/<br>Nephew | Your<br>Children |
|--|-----|-----|--------|--------|---------|--------------|------------|---------|------------------|------------------|
| A. polycystic kidney disease   |     |     |        |        |         |              |            |         |                  |                  |
| B. other kidney disease  |     |     |        |        |         |              |            |         |                  |                  |
| C. other disease of urinary tract (urethra, bladder, ureter) (explain) |     |     |        |        |         |              |            |         |                  |                  |
| D. rectal disorder   |     |     |        |        |         |              |            |         |                  |                  |

| Medical Problem<br>7. GENITAL/REPRODUCTIVE | N/A | You | Mother | Father | Sibling | Grandparents | Aunt/Uncle | Cousins | Niece/<br>Nephew | Your<br>Children |
|--|-----|-----|--------|--------|---------|--------------|------------|---------|------------------|------------------|
| A. undescended testicle                    |     |     |        |        |         |              |            |         |                  |                  |
| B. hypospadiasis                           |     |     |        |        |         |              |            |         |                  |                  |
| C. prostate cancer                         |     |     |        |        |         |              |            |         |                  |                  |
| D. uterine fibroids                        |     |     |        |        |         |              |            |         |                  |                  |
| E. ovarian cysts                           |     |     |        |        |         |              |            |         |                  |                  |
| F. cancer of cervix, ovaries or uterus     |     |     |        |        |         |              |            |         |                  |                  |

| Medical Problem<br>8. NEUROLOGICAL        | N/A | You | Mother | Father | Sibling | Grandparents | Aunt/Uncle | Cousins | Niece/<br>Nephew | Your<br>Children |
|---|-----|-----|--------|--------|---------|--------------|------------|---------|------------------|------------------|
| A. migraines                              |     |     |        |        |         |              |            |         |                  |                  |
| 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                    |     |     |        |        |         |              |            |         |                  |                  |
| N. other nervous system disease (explain) |     |     |        |        |         |              |            |         |                  |                  |

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**Family Health History (continued)**

9. MENTAL HEALTH

|  | N/A | You | Mother | Father | Sibling | Grandparents | Aunt/Uncle | Cousins | Niece/<br>Nephew | Your<br>Children |
|--|-----|-----|--------|--------|---------|--------------|------------|---------|------------------|------------------|
| A. schizophrenia   |     |     |        |        |         |              |            |         |                  |                  |
| B. manic depressive disorder   |     |     |        |        |         |              |            |         |                  |                  |
| C. other mental health disorders requiring hospitalization (explain) |     |     |        |        |         |              |            |         |                  |                  |

10. MUSCLES/BONES/JOINTS

|                                      | N/A | You | Mother | Father | Sibling | Grandparents | Aunt/Uncle | Cousins | Niece/<br>Nephew | Your<br>Children |
|--------------------------------------|-----|-----|--------|--------|---------|--------------|------------|---------|------------------|------------------|
| A. muscular dystrophy                |     |     |        |        |         |              |            |         |                  |                  |
| B. other chronic muscle disease      |     |     |        |        |         |              |            |         |                  |                  |
| C. lupus                             |     |     |        |        |         |              |            |         |                  |                  |
| D. deformity of spine                |     |     |        |        |         |              |            |         |                  |                  |
| E. osteoporosis                      |     |     |        |        |         |              |            |         |                  |                  |
| F. dwarfism                          |     |     |        |        |         |              |            |         |                  |                  |
| G. hereditary low back disease       |     |     |        |        |         |              |            |         |                  |                  |
| H. arthritis                         |     |     |        |        |         |              |            |         |                  |                  |
| I. gout                              |     |     |        |        |         |              |            |         |                  |                  |
| J. congenital dislocation of the hip |     |     |        |        |         |              |            |         |                  |                  |

11. SIGHT/SOUND/SMELL

|  | N/A | You | Mother | Father | Sibling | Grandparents | Aunt/Uncle | Cousins | Niece/<br>Nephew | Your<br>Children |
|--|-----|-----|--------|--------|---------|--------------|------------|---------|------------------|------------------|
| A. deafness before age 60                        |     |     |        |        |         |              |            |         |                  |                  |
| B. deformity of the ear                          |     |     |        |        |         |              |            |         |                  |                  |
| C. cataracts before age 50                       |     |     |        |        |         |              |            |         |                  |                  |
| D. blindness                                     |     |     |        |        |         |              |            |         |                  |                  |
| E. color blindness                               |     |     |        |        |         |              |            |         |                  |                  |
| F. glaucoma                                      |     |     |        |        |         |              |            |         |                  |                  |
| G. deviated septum                               |     |     |        |        |         |              |            |         |                  |                  |
| H. retinoblastoma                                |     |     |        |        |         |              |            |         |                  |                  |
| I. congenital word blindness                     |     |     |        |        |         |              |            |         |                  |                  |
| J. other sight/sound or smell disorder (explain) |     |     |        |        |         |              |            |         |                  |                  |

12. SKIN

|  | N/A | You | Mother | Father | Sibling | Grandparents | Aunt/Uncle | Cousins | Niece/<br>Nephew | Your<br>Children |
|--|-----|-----|--------|--------|---------|--------------|------------|---------|------------------|------------------|
| A. acne                                  |     |     |        |        |         |              |            |         |                  |                  |
| B. eczema                                |     |     |        |        |         |              |            |         |                  |                  |
| C. skin cancer                           |     |     |        |        |         |              |            |         |                  |                  |
| D. pigmentation disorders                |     |     |        |        |         |              |            |         |                  |                  |
| E. other disorders of the skin (explain) |     |     |        |        |         |              |            |         |                  |                  |

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**Family Health History (continued)**

13. OTHER

|   | N/A | You | Mother | Father | Sibling | Grandparents | Aunt/Uncle | Cousins | Niece/<br>Nephew | Your<br>Children |
|---|-----|-----|--------|--------|---------|--------------|------------|---------|------------------|------------------|
| A. alcoholism                                 |     |     |        |        |         |              |            |         |                  |                  |
| B. drug abuse or addiction                    |     |     |        |        |         |              |            |         |                  |                  |
| C. breast cancer                              |     |     |        |        |         |              |            |         |                  |                  |
| D. other cancer not mentioned above (explain) |     |     |        |        |         |              |            |         |                  |                  |

Please use this area to expand on any of the health history listed on pages 15-18:

Looking at your entire extended family, how would you rate the family's overall health?

|           | <b>Medical</b> |           | <b>Mental</b> |
|-----------|----------------|-----------|---------------|
| Excellent |                | Excellent |               |
| Very good |                | Very good |               |
| Average   |                | Average   |               |
| Poor      |                | Poor      |               |

**Personal Features**

Please describe the following about your features (check one).

In proportion, would you say that:

Your ears are: \_\_\_\_\_ average \_\_\_\_\_ small \_\_\_\_\_ large

Your ear lobes \_\_\_\_\_ attached \_\_\_\_\_ detached

Your chin is: \_\_\_\_\_ average \_\_\_\_\_ Small \_\_\_\_\_ large

Your cheek bones are: \_\_\_\_\_ average \_\_\_\_\_ high \_\_\_\_\_ very high

Your eyes are spaced: \_\_\_\_\_ evenly \_\_\_\_\_ close \_\_\_\_\_ wide

Your friends would consider your looks to be: \_\_\_\_\_ average \_\_\_\_\_ good \_\_\_\_\_ very good

Your mother would consider your looks to be: \_\_\_\_\_ average \_\_\_\_\_ good \_\_\_\_\_ very good

Your friends would consider your overall appearance: \_\_\_\_\_ average \_\_\_\_\_ good \_\_\_\_\_ very good

You would consider your appearance to be: \_\_\_\_\_ average \_\_\_\_\_ good \_\_\_\_\_ very good

Your father would consider your appearance to be: \_\_\_\_\_ average \_\_\_\_\_ good \_\_\_\_\_ very good

Your nose is: \_\_\_\_\_ large \_\_\_\_\_ small \_\_\_\_\_ average

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**Sexual partners/ contacts** = persons with whom you have engaged in one or more of the following activities:  
Prolonged open mouth kissing, erotic massage and or mutual masturbation, oral sex (vaginal, anal, penile), anal sex, sexual intercourse.

**ADDITIONAL QUESTIONS**

|   | YES | NO |
|---|-----|----|
| Do you have any autoimmune or malignant disease?  |     |    |
| Do you or have you had a degenerative or infectious neurological disease such as Creutzfeldt-Jacob disease, multiple sclerosis, dementia or Alzheimer's disease?                                |     |    |
| Have any of your relatives had Creutzfeldt-Jacob disease?   |     |    |
| Have you had or do you now have any systemic disease?   |     |    |
| Do you currently have any infectious skin disease that might risk contamination of the semen?   |     |    |
| Have you had a tattoo, ear/ body piercing or received acupuncture in the past year?   |     |    |
| Have you received a tattoo or body piercing within the past year in which needles were re-used, shared, or non-sterile?   |     |    |
| Are you a user (past or present) of non-prescription injected drugs? (including steroids or other intravenous, intramuscular or subcutaneous injections)  |     |    |
| Have you had sexual contact with anyone who has ever used needles to take drugs, steroids or anything <u>not</u> prescribed by a physician?   |     |    |
| Have you ever been infected by or tested positive for hepatitis B or C or hepatitis of unknown etiology?  |     |    |
| Have you ever had sexual relations with a person who has Hepatitis?   |     |    |
| Have you ever lived with a person who has Hepatitis?  |     |    |
| Have you ever been infected by or tested positive for HIV?  |     |    |
| Have you ever had sexual contact with anyone who has HIV/AIDS or has tested positive for the HIV/AIDS virus?  |     |    |
| Have you been the sexual partner of a homosexual or bisexual man?   |     |    |
| Have you had sexual contact with another male, even once?   |     |    |
| Are you a native of sub-Saharan African countries who arrived in the United States after 1977?  |     |    |
| Have you ever had sexual contact with anyone who was born in or lived in Africa?  |     |    |
| Have you engaged in prostitution (sex for exchange of money, drugs etc.) at any time since 1977?  |     |    |
| Have you been excluded from blood donation for reasons of infectious disease?   |     |    |
| How many sexual partners have you had within the past 6 months? (#) _____   |     |    |
| How many sexual partners have you had within the past 5 years? (#) _____  |     |    |
| Are you currently sexually active with a man?   |     |    |
| Does your partner have frequent vaginal infections, including trichomoniasis, syphilis, gonorrhea, Chlamydia, genital warts, genital herpes, or any history of sexually transmitted infections? |     |    |

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| <b>ADDITIONAL QUESTIONS</b>   | <b>YES</b> | <b>NO</b> |
|---|------------|-----------|
| Have you had a recent smallpox vaccination (vaccinia virus) in the last 60 days?<br>If less than 60 days did the scab separate by some other means than spontaneously?  |            |           |
| Do you have a clinically recognizable vaccinia virus infection contracted by close contact with someone who received the smallpox vaccine?  |            |           |
| Have you had contact with someone who had a smallpox vaccination?   |            |           |
| Have you had any vaccinations or other shots in the past 8 weeks? If yes, please describe:  |            |           |
| Have you ever had Malaria, Chagas' disease or babesiosis?   |            |           |
| Have you come into contact with someone else's blood in the past year?<br>If yes, please describe:  |            |           |
| Have you had any accidental needle sticks in the past year?   |            |           |
| Have you had a medical diagnosis of West Nile Virus (WNV) infection? If yes, defer donation for 120 days from onset of symptoms, or 14 days after condition has resolved whichever is the later date.   |            |           |
| Have you had both a fever and a headache (simultaneously) during the 7 days prior to donation? If yes, defer donation for 120 days.   |            |           |
| Are you or any close contacts a xenotransplantation (animal) product recipient?<br>Have you, your sexual partner, or any member of his/her household ever had a transplant or other medical procedure that involved being exposed to live cells, tissues, or organs from an animal? |            |           |

| <b>ADDITIONAL QUESTIONS</b>  | <b>YES</b> | <b>NO</b> |
|--|------------|-----------|
| Have you ever had a diagnosis of dementia or any degenerative or demyelinating disease of the central nervous system (CNS) or other neurological disease of unknown etiology?  |            |           |
| Have you ever received a Dura mater transplant?  |            |           |
| Have you ever had a transplant such as organ or bone marrow?   |            |           |
| Have you spent three months or more cumulatively in the UK from the beginning of 1980 through the end of 1996?   |            |           |
| Are you a current or former U.S. military member, civilian military employee, or dependent of a military member or civilian employee who resided at U.S. military bases in Northern Europe (Germany, U.K., Belgium, and the Netherlands) for 6 months or more from 1980 through 1990, or elsewhere in Europe (Greece, Turkey, Spain, Portugal, and Italy) for 6 months or more from 1980 through 1996? |            |           |
| Have you lived cumulatively for 5 years or more in Europe from 1980 until the present (note this criterion includes time spent in the U.K. from 1980 through 1996)?  |            |           |
| Have you received any transfusion of blood or blood components in the U.K. between 1980 and the present?   |            |           |
| Have you injected bovine insulin since 1980, unless you can confirm that the product was not manufactured after 1980 from cattle in the U.K.?  |            |           |

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| ADDITIONAL QUESTIONS  | YES | NO                    |
|---|-----|-----------------------|
| Have you ever had sex with any person described in the previous items of this section or with any person known or suspected to have HIV infection, clinically active hepatitis B infection or hepatitis C infection?                        |     |                       |
| Have you been exposed in the preceding 12 months to known or suspected HIV, HBV and/or HCV – infected blood through percutaneous inoculation (e.g. needle stick) or through contact with an open wound, non-intact skin or mucous membrane? |     |                       |
| Have you had close contact within the past 12 months with another person having clinically active viral hepatitis (e.g., living in the same household, where sharing of kitchen and bathroom facilities occurs regularly)?                  |     |                       |
| Were you diagnosed with viral hepatitis after the age of 11? Unless evidence from the time of illness documents that the hepatitis was identified as hepatitis A (e.g., a reactive IgM anti-HAV test)?                                      |     |                       |
| Have you had a transfusion of blood or blood products in the last 6 months?   |     |                       |
| Have you had any shots or vaccinations in the last 12 months?<br>If yes, please describe:   |     |                       |
| Do you have hemophilia? Do you use human-derived clotting factor?   |     |                       |
| Have you had sexual contact with anyone who has hemophilia or has used clotting factor concentrates?  |     |                       |
| Have you ever injected (been the recipient of) human derived pituitary growth hormone?  |     |                       |
| I am ( <b>or, am now</b> ) aware that I <b>must</b> notify NECC if I have had a transfusion with blood or blood components within 48 hours of any sperm donation?   |     | Must<br>Answer<br>Yes |

| ADDITIONAL QUESTIONS  | YES | NO |
|---|-----|----|
| Have you had any persistent or unexplained increase in fatigue?   |     |    |
| Have you had a fever, chills and/or night sweats not accompanied by a known illness?  |     |    |
| Have you had unexplained weight loss > than 10lbs. in less than two months?   |     |    |
| Have you had pink or purple flat or raised blotches or bumps (not bruises) usually painless, on or under the skin, inside mouth, nose, eyelids or rectum? |     |    |
| Have you had persistent white spots or unusual blemishes in the mouth?  |     |    |
| Have you had persistent diarrhea?   |     |    |
| Have you had a persistent dry cough, not from smoking or respiratory infection?   |     |    |
| Have you had shortness of breath or difficulty in breathing?  |     |    |
| Have you had any signs or symptoms of a cold sore in the past two weeks?  |     |    |

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**If there is an outbreak of SARS answer the following questions, otherwise note N/A.**

SARS: Severe Acute Respiratory Syndrome

|  | YES | NO |
|--|-----|----|
| Have you traveled to or resided in SARS affected areas in the last 14 days?  |     |    |
| Have you had close contact with someone who has traveled to or resided in SARS affected areas in the last 14 days? |     |    |
| Have you been treated for SARS or suspected you had SARS in the last 28 days?                                      |     |    |
| Have you had close contact with persons with or suspected of having SARS in the last 14 days?                      |     |    |

Contact the CDC website (<http://www.cdc.gov/ncidod/sats/index.htm>) or call CDC (888-246-2675) to obtain the latest information concerning areas affected by SARS.

**Today's Date:** \_\_\_\_\_

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**In your own words...** Use additional paper if needed.  
(You must respond to all questions, indicate N/A if an answer is not available)

Could you indicate some outstanding achievements by members of your family?

Describe your Personality and Character:

What are your hobbies, interest and talents?

If we could pass on a message to the recipient(s) of your semen, what would that message be? (Be serious, put a little thought into this one ☺)

What made you decide to be a donor?

If you had a choice to do anything in your life, what would it be?

Do you have the personal characteristics, mannerism etc. of any famous person or fictional TV character? (ie. Do you act like Homer from the Simpson's or do you sound like Ben Stein)

Do you resemble anyone famous (Actor, Politician, Professional Athlete)?

Today's Date: \_\_\_\_\_

Initials: \_\_\_\_\_

**THINGS ABOUT YOURSELF**

PLEASE PRINT/WRITE CLEARLY

(You must respond to all questions, indicate N/A if an answer is not available)

|  |
|--|
| <b>What TV shows did you watch as a kid?</b>         |
|  |
|  |
| <b>What TV shows do you watch now?</b>               |
|  |
|  |
| <b>What is your favorite movie(s)?</b>               |
|  |
|  |
| <b>What were your favorite books as a kid?</b>       |
|  |
|  |
| <b>What are your favorite books now?</b>             |
|  |
|  |
| <b>What are your favorite sports to watch?</b>       |
|  |
|  |
| <b>What are your favorite sports to play?</b>        |
|  |
|  |
| <b>What is your favorite flavor(s) of ice cream?</b> |
|  |
|  |
| <b>Where is your favorite place to vacation?</b>     |
|  |
|  |
| <b>What is your favorite season?</b>                 |
|  |
|  |
| <b>What is your favorite food(s)?</b>                |
|  |
|  |
| <b>What is your favorite color?</b>                  |

Today's Date: \_\_\_\_\_

Initials: \_\_\_\_\_

**THINGS ABOUT YOURSELF- continued**

|   |
|---|
| <b>What is your favorite holiday(s)?</b>                |
|   |
| <b>What makes you feel sad?</b>                         |
|   |
| <b>What makes you feel happy?</b>                       |
|   |
|   |
| <b>How important is money to you?</b>                   |
|   |
|   |
| <b>Do you believe that there is a God?</b>              |
|   |
|   |
| <b>Did you have a best friend growing up?</b>           |
| <b>What was he/she like?</b>                            |
|   |
|   |
| <b>Did you have pets growing up? What kind?</b>         |
|   |
|   |
| <b>Who do you trust the most in the world?</b>          |
|   |
| <b>Do you have any regrets so far in life?</b>          |
|   |
|   |
| <b>What is your favorite childhood memory?</b>          |
|   |
|   |
| <b>Who is your favorite musician?</b>                   |
|   |
|   |
| <b>Who is your favorite group?</b>                      |
|   |
|   |
| <b>Can you play a musical instrument(s)? What kind?</b> |
|   |
|   |

Today's Date: \_\_\_\_\_

Initials: \_\_\_\_\_

**THINGS ABOUT YOURSELF-** continued

|   |
|---|
| <b>If you could spend a week with any woman in the world, who would it be? (non-sexual)</b> |
|   |
|   |
|   |
| <b>Any man in the world? (non-sexual)</b>   |
|   |
|   |
|   |
|   |

Please use the space below to document any additional information you feel is important for NECC to know about yourself or any member of your family. Thank you for taking the time to complete this questionnaire.

|  |
|--|
|  |
|--|

The information that I have provided on this application is accurate and true to the best of my knowledge. I understand that any misrepresentation or omission of a fact on my application may result in termination from the donor program and may result in non-payment for donated specimens.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date



