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. The health history information sections of this application should include information pertaining only to your blood/ biological relatives.

After completion of the application, please mail back to:

New England Cryogenic Center, Inc.
500 Donald J. Lynch Boulevard
Marlborough, MA 01752

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,

Joseph Rizza
CEO

# Donor Orientation

Donor appointments are scheduled Monday through Friday between 8:00am and 3:30pm. 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 New England Cryogenic Center (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 examination.

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 or producing 100 "*passing*" vials, 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 every 6 months 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 $125 for each "*passing*" specimen.

4. For each of the first 12 "*passing*" specimens, NECC will withhold 50% ($62.50) of the $125 compensation in a reserve account (totaling $750.00).

5. Six (6) months after completion of the program (reaching a minimum of 40 passing visits or producing 100 passing vials); we will require a blood and urine sample for final testing as well as an updated health assessment. Following the release of your remaining specimen inventory, you will receive the final payment of $750.00. If you have relocated to another city; testing can be arranged at a local testing laboratory or draw site, 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.

# 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_____

Place of Birth_____

College/University/ School _____ Year Completed_____

Social Security Number_____

Phone # _____

Place of Business_____ Work Phone_____

Email address_____

Referred by: Craigslist ____ MBTA ____ Friend _____ Other _____

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 of Reviewer:* _____ *Date:* _____

**Today's Date:** _____ **Initials:** _____

# NEW ENGLAND CRYOGENIC CENTER, INC.
# DONOR QUESTIONNAIRE

## Personal Characteristics

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Natural Hair Color:

_____ Black _____ Light Brown _____ Blond
_____ Dark Brown _____ Red Brown _____ Dark Blond
_____ Brown _____ Red _____ Strawberry Blond

Eye Color:

_____ Black _____ Blue
_____ Brown _____ Green
_____ Gray _____ Hazel

What was your natural hair color as a child? (use the same options given above) _____
Do you have premature graying? _____ Yes _____ No If yes, at what age? _____

| Hair Fullness (check one) | | Hair Type (check one) | | Hair Texture (check one) | | Complexion (check one) Relative to ethnic origin | |
|---|---|---|---|---|---|---|---|
| Balding | | Curly | | Fine | | Very Fair | |
| Thin | | Wavy | | Medium | | Fair | |
| Average/ Medium | | Straight | | Coarse | | Medium | |
| Thick | | Kinky | | | | Dark | |
| | | Wiry | | | | Very Dark | |

Body type/bone structure: small _____ medium _____ large _____ very large _____

Right handed: _____ Left handed: _____ Ambidextrous: _____

Race: (check all that apply)

_____ Caucasian _____ Asian _____ Middle Eastern/Arabic
_____ Black/African American _____ Southeast Asian _____ Pacific Islander/Native Hawaiian
_____ Native American/Alaska Native _____ East Indian _____ Mixed/Multi Ethnic(explain below)
_____ Hispanic/Latino
_____ Other: (explain) _____

## Family Ethnic Origin

Mother: _____ Father: _____
Maternal Grandmother: _____ Paternal Grandmother: _____
Maternal Grandfather: _____ Paternal Grandfather: _____

Examples of Ethnic Origin: Albanian, African, Arabic, Argentinean, Armenian, Assyrian, Austrian, Australian, Azerbaijani, Baltic, Belgian, Bengali, Bolivian, Bosnian, Brazilian, Bulgarian, Canadian, Caribbean, Cambodian, Chilean, Chinese, Croatian, Czech, Danish, Dutch, Dominican, Ecuadorean, Egyptian, English, Eskimo (Inuit/ Yupik), Finnish, French, French Canadian, Georgian, German, Greek, Guatemalan, Guyanese, Haitian, Han Chinese, Hawaiian, Hindustani, Hungarian, Icelandic, Indian, Indonesian, Iranian, Irish, Israeli, Italian, Japanese, Jewish, Korean, Laz, Lebanese, Malays, Mexican, Mongolian, Native American, Northern European, Norwegian, Pacific Islander, Pakistani, Persian, Peruvian, Philippine, Polish, Portuguese, Puerto Rican, Punjabi, Romanian, Russian, Serbian, Sri Lankan, Slovakian, South American, Scottish, Spanish, Swedish, Swiss, Thai, Tibetan, Trinidadian, Turkish, Turkmens, Ukrainian, Uzbekistanian, Vietnamese, Venezuelan, Welsh, Zhuang, and others. (We apologize if your ethnicity was not listed, please include it above).

**Today's Date:** _____ **Initials:** _____

# Ethnic Origin/ Religion

Religion born into: _____ Religion practiced: _____

Your Mother's Religion: _____ Your Father's Religion: _____

Do you have any Jewish ancestry? ____ Yes ____ No
If yes, please indicate which ethnic group? ____ Ashkenazi ____ Sephardic ____ Other
Do you have any French Canadian ancestry? ____ Yes ____ No

# Education-(Indicate all that apply)

**High School**

Completed high school: Year: _____ GPA: _____

**Standardized Testing**

SAT Scores: Math _____ Writing _____ Critical Reading _____
ACT Scores: Math _____ Reading _____

_____ I did not take SAT or ACT examinations _____ I do not recall my test scores

LSAT, MCAT, GMAT, GRE Score(s) if applicable : _____
_____ I did not take grad school examinations _____ I do not recall my test scores

**College/ Trade/ Tech School**

A. College/ university name: _____ GPA _____
Major/ area of study: _____
Year (check one): ____ 1 yr. ____ 2 yr. ____ 3 yr. ____ 4 yr. ____ Grad.

B. Trade/ technical school name: _____
Major/ area of study: _____
Year (check one): ____ 1 yr. ____ 2 yr. ____ 3 yr. ____ 4 yr. ____ Grad.

C. Graduate school name: _____ GPA: _____
Major/ area of study: _____
Year (check one): ____ 1 yr. ____ 2 yr. ____ 3 yr. ____ 4 yr. ____ Grad

Degree Level: ____ M.A. ____ M.D. ____ O.D. ____ D.D.S.
____ M.S. ____ Ph.D. ____ D.O. ____ J.D.

**Other degrees/certificates/awards** _____

# Parent's education, occupation, and notable talents/ interests:

Indicate their highest completed degree of education, their occupation, and any notable talents / interests.

| | Occupation | Education | Notable Talents/Interests |
|---|---|---|---|
| Mother | | | |
| Father | | | |

**Today's Date:** _____ **Initials:** _____

# Abilities and Talents

Rate your abilities in each of the following subjects using a scale of 1-5
(1= poor, 2=fair, 3=avg., 4=good, 5= excellent)

| | | |
|---|---|---|
| ____ Math | ____ History | ____ Art |
| ____ Science | ____ Geography | ____ Music |
| ____ English | ____ Computers | ____ Athletics |

Which of these subjects was your favorite in school? _____ Why? _____
Which of these subjects was your least favorite? _____ Why? _____

Are you fluent in any language(s) other than English? _____ Yes _____ No
If yes, list languages here: _____

Are you a good test taker? _____Yes _____No Comments: _____

Do you recall (from childhood) what you wanted to be when you grew up? _____ Yes _____ No
If yes, what did you want to be and why? _____

Rate your abilities in each of the following areas using a scale of 1-5
(1= poor, 2=fair, 3=avg., 4=good, 5= excellent)

| | | |
|---|---|---|
| ____ Auto Repair/ Maintenance | ____ Electrical | ____ Culinary Arts |
| ____ Carpentry | ____ Engineering/ Electronics | ____ General Repairs |
| ____ Plumbing | ____ Computers | ____ Home Maintenance |
| ____ Gardening/Landscaping | ____ Leadership/Management | ____ Volunteering |
| ____ Organizing/Planning | ____ Finance/Accounting | ____ Outdoor/Nature Activities |
| ____ Teaching/Coaching | ____ Critical Thinking | ____ Fitness/Health |
| ____ Public Speaking | ____ Photography | ____ Networking |

Do you have any specific skills involving the items listed above? _____ Yes _____ No
If yes, describe here: _____

Indicate any sports you play regularly, or did play regularly in school: (check all that apply)

| | | |
|---|---|---|
| ____ Baseball | ____ Running | ____ Volleyball |
| ____ Basketball | ____ Weightlifting | ____ Skateboarding |
| ____ Football | ____ Cycling | ____ Skiing/Snowboarding |
| ____ Hockey | ____ Swimming | ____ Bowling |
| ____ Soccer | ____ Golf | ____ Other: _____ |
| ____ Wrestling | ____ Tennis | ____ None |

Which of these sports was/ is your favorite? _____ Why? _____

What are your favorite sports to watch? _____ Why? _____

**Today's Date:** _____ **Initials:** _____

# Personal and Fertility History

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? _____

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

Has a women ever conceived with your sperm? _____ Yes _____ No
If yes, please list the years in which pregnancies occurred: _____ _____ _____

Do you have any nieces or nephews: _____ Yes _____ No
If yes, how many nieces? _____ How many nephews? _____

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? _____ Yes _____ No
*(Difficulty conceiving or miscarriage)? If yes, please explain _____

Did your parents have difficulty conceiving? _____ Yes _____ No

Do any of your brothers/ sisters have fertility problems? _____ Yes _____ No

Do any of your uncles/ aunts 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

**Today's Date:** _____ **Initials:** _____

# Personal and Fertility 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 allergen/ substance, reaction(s) produced, and severity of reaction:

| Allergen/ Substance | Reaction | Severity: (mild, moderate, seasonal) |
|---|---|---|
| | | |
| | | |
| | | |

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

_____
_____

How is your vision without contacts/eyeglasses? _____ Poor _____ Fair _____ Good _____ Excellent
Do you wear contacts? _____ Yes _____ No If yes, at what age? _____
Do you wear glasses? _____ Yes _____ No If yes, at what age? _____

Are you? _____ Nearsighted _____ Farsighted _____ Other (specify) _____

Your eyeglass Rx: (OD): Spherical _____ Cylinder _____ Axis _____

(OS): Spherical _____ Cylinder _____ Axis _____

Do you have normal hearing without corrective aides? _____ Yes _____ No
If no, please explain: _____

Condition of your teeth (check one) __ Poor _____ Fair _____ Good _____ Excellent
Have you ever had braces? __ Yes _____ No
Do you have false teeth or implants? __ Yes _____ No

Your diet is (check one) _____ Vegetarian _____ Vegan _____ 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 (include years): _____
_____

Have you had any hospitalization not already mentioned? _____ Yes _____ No
If yes, please explain (include years): _____
_____

Have you ever had major radiation exposure or X-ray exposure? _____ Yes _____ No
If yes, please explain (include years): _____

**Today's Date:** _____ **Initials:** _____

# Health History

**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: (Indicate whether the condition was in yourself, your partner, both)

| | Yes | No | Myself/Partner/Both |
|---|---|---|---|
| Syphilis | | | |
| Gonorrhea | | | |
| NSU (non-specific urethritis) | | | |
| Chlamydia | | | |
| Venereal/ Genital warts | | | |
| Pelvic Inflammatory Disease (PID) | | | |
| Herpes | | | |
| Trichomoniasis | | | |
| Other sexually transmissible diseases (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, please explain: _____
If yes, was it within the past 12 months? _____ Yes _____ No
If yes, please explain: _____

Have you or your spouse/ partner ever been arrested? _____ Yes _____ No
If yes, please explain: _____

Have you or your spouse/ partner ever been in bankruptcy? _____ Yes _____ No
If yes, please 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, where, and what years did you serve: _____

Did your mother/ father ever serve in the military? _____ Yes _____ No
If yes, which parent, when, where, and what years did they serve: _____

**Today's Date:** _____ **Initials:** _____

# Health History

Are you currently taking any medications? _____ Yes _____ No
If yes, list all medications; include duration of use, 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 been given Hepatitis B Immune Globulin* following an exposure to Hepatitis B?
_____ Yes _____ No If yes, when and why? _____
* 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.

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

---

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 History

Please indicate whether you have used any of the following:

| Drug/ Medication | Never Used | Frequency & duration of use (Example: 2x/day for 3 months) | How taken & reason for use? (Example: orally for pain) |
|---|---|---|---|
| Marijuana | | | |
| Cocaine | | | |
| Barbiturates (acid) | | | |
| Narcotics/ Opiates (Heroin, Methadone, Opium, Morphine, Vicodin, Oxycontin, Percocet, Codeine, Etc.) | | | |
| Amphetamines (Adderall, Dexedrine, MDMA aka Ecstasy) | | | |
| Hallucinogens (LSD, Mescaline, Mushrooms, Peyote) | | | |
| Tranquilizers (Special K, Sleeping Pills, Xanax, Valium, or other Benzo's) | | | |
| Anti-depressants | | | |
| PCP | | | |
| Inhalants (Amyl or butyl nitrate, aerosol propellants) | | | |
| Antibiotics | | | |
| 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? _____

Have you ever been in counseling? _____ Yes _____ No
If yes, explain (dates, reason, etc) _____

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 | | |

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? _____

Were you born in, or have you lived in, or traveled to any country 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:
(Example: family trip to Kenya in 2010 for 3 weeks) _____

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? 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:
(Example: family trip to Italy in 2010 for 3 weeks) _____

## 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:
(Example: family trip to Wales in 2010 for 3 weeks) _____

**Today's Date:** _____ **Initials:** _____

# Health History/Work 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- Name of employers not required | Dates of Employment: Year Began | Year Ended | Exposed to which drugs, chemicals, gases |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

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 | | | | |
| Hazardous waste | | | | |
| Mercury | | | | |

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 (blood relatives only) by the following physical characteristics:

| | Eye Color | Hair Color | Complexion Relative to ethnic origin | 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 | | | | | | |

Were you adopted? _____ Yes _____ No

How many full blood siblings do you have? _____
How many males? _____ How many females? _____

Do you have any half siblings? (1/2 siblings share only one parent) _____ Yes _____ No
How many males? _____ How many females? _____
If yes, please describe relation to you? _____

_____

Have twins or multiple births occurred in your family? _____ Yes _____ No
If yes, please describe relation to you? _____

---

Do you have children, nieces or nephews? (blood relatives only) _____ Yes _____ No
If yes, complete the table below:

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

**Today's Date:** _____ **Initials:** _____

# Personal Features

Please describe the following about your features (check one). In proportion, would you say that:

| | | | | | |
|---|---|---|---|---|---|
| Your nose is: | _____ | large | _____ | small | _____ average |
| Your ear size is: | _____ | average | _____ | small | _____ large |
| Your ear lobes are: | _____ | attached | _____ | detached | |
| Your chin is: | _____ | average | _____ | small | _____ large |
| Your eyes are spaced: | _____ | evenly | _____ | close | _____ wide |

| | | | | | |
|---|---|---|---|---|---|
| Your mother would consider your looks to be: | _____ | average | _____ | good | _____ very good |
| Your father would consider your looks to be: | _____ | average | _____ | good | _____ very good |
| Your friends would consider your looks to be: | _____ | average | _____ | good | _____ very good |
| You would consider your overall appearance: | _____ | average | _____ | good | _____ very good |

Indicate if you have any of the following notable/ features: (check all that apply)

| | | | |
|---|---|---|---|
| _____ Full lips | _____ Dimples | _____ Large eyes | _____ Round face shape |
| _____ Thin lips | _____ High cheekbones | _____ Small eyes | _____ Square face shape |
| _____ Cleft Chin | _____ Strong jaw line | _____ Thick brow | _____ Oval face shape |
| _____ Freckles | _____ Long eyelashes | _____ Thin brow | _____ Heart face shape |

_____ Other features: _____

# Parental Features

## Mother's Features:

Indicate if your Mother has any of the following notable/ features: (check all that apply)

| | | | |
|---|---|---|---|
| _____ Full lips | _____ Dimples | _____ Large eyes | _____ Round face shape |
| _____ Thin lips | _____ High cheekbones | _____ Small eyes | _____ Square face shape |
| _____ Cleft Chin | _____ Strong jaw line | _____ Thick brow | _____ Oval face shape |
| _____ Freckles | _____ Long eyelashes | _____ Thin brow | _____ Heart face shape |
| | | _____ Large nose | |
| | | _____ Small nose | |

_____ Other features: _____

## Father's Features:

Indicate if your Father has any of the following notable/ features: (check all that apply)

| | | | |
|---|---|---|---|
| _____ Full lips | _____ Dimples | _____ Large eyes | _____ Round face shape |
| _____ Thin lips | _____ High cheekbones | _____ Small eyes | _____ Square face shape |
| _____ Cleft Chin | _____ Strong jaw line | _____ Thick brow | _____ Oval face shape |
| _____ Freckles | _____ Long eyelashes | _____ Thin brow | _____ Heart face shape |
| | | _____ Large nose | |
| | | _____ Small nose | |

_____ Other features: _____

**Today's Date:** _____ **Initials:** _____

# Family Personality Traits

Indicate **at least** one personality trait per blood relative listed below.
Check all that apply. **Indicate (N/A) if unknown.**

| **Personality Traits** | You | Mother | Father | Siblings | | Grandparents* | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | F | M | MGM | MGF | PGM | PGF |
| N/A (not applicable) | | | | | | | | | |
| Adventurous | | | | | | | | | |
| Cautious | | | | | | | | | |
| Organized | | | | | | | | | |
| Easy-Going | | | | | | | | | |
| Spontaneous | | | | | | | | | |
| Reserved | | | | | | | | | |
| Compassionate | | | | | | | | | |
| Sensitive | | | | | | | | | |
| Confident | | | | | | | | | |
| Perfectionist | | | | | | | | | |
| Driven | | | | | | | | | |
| Patient | | | | | | | | | |
| Courageous | | | | | | | | | |
| Optimistic | | | | | | | | | |
| Charming | | | | | | | | | |
| Encouraging | | | | | | | | | |
| Sentimental | | | | | | | | | |
| Unsure of personality traits | | | | | | | | | |

***MGM** (maternal grandmother), **MGF** (maternal grandfather), **PGM** (paternal grandmother), **PGF** (paternal grandfather)
**Maternal** (related through the mother's side of the family), **Paternal** (related through the father's side of the family)

Use the space below to elaborate on any specific personality traits or special memories you would like to share about any members of your family: (note: you may also include stories about family members not listed above)

**Today's Date:** _____ **Initials:** _____

# Family Health History

Please be as specific as possible when completing the table(s) below; include blood relatives only.

**Maternal** (related through the mother's side of the family), **Paternal** (related through the father's side of the family)

| Relation | Age if living | Health Status if living *(Poor, Fair, Good, Excellent) | Age at time of death | Cause of death Cause of death required. (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 | | | | |

***Excellent** (minor health problems typical for age), **Good** (average health problems for age), **Fair** (several serious medical problems), **Poor** (needs constant nursing care)

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 (Poor, Fair, Good, Excellent) | Age at time of death | Cause of death Cause of death required. (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:** _____

# Family Health History

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

Are there any members of your family who have had, or who currently have, 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 males? _____ How many females? _____

Do you know if they (your uncles) had any miscarriages or deaths at birth? ____ Yes ____ No
If yes, please explain: _____

**Today's Date:** _____ **Initials:** _____

# Family Health History (continued)

**Is there any reason why you cannot provide a complete family history** (including grandparents)? _____ **Yes** _____ **No**
**If yes, explain:** (i.e. you were adopted, or you do not know one side of your family) _____

☐ I agree to review the following list of medical conditions, and indicate which ones pertain to me or any of my blood relatives listed below.
☐ I agree to indicate N/A if the medical condition does not apply to me or any of my blood relatives listed below.
☐ I agree to include the age of onset for each item indicated below, and to use the comment section for additional details etc.
☐ I agree to contact New England Cryogenic Center if I require the definition of any conditions listed below.
☐ I have read and understand the following definitions: **F** (female), **M** (male), **Maternal/ Mat** (related through mother), **Paternal/ Pat** (related through father), **MGM** (maternal grandmother), **MGF** (maternal grandfather), **PGM** (paternal grandmother), **PGF** (paternal grandfather)

| Medical Condition | N/A | You | Mother | Father | Siblings | | Grandparents | | | | Aunts | | Uncles | | Cousins | | Children | Niece | Nephew | Age of onset/ comments |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | F | M | MGM | MGF | PGM | PGF | Mat | Pat | Mat | Pat | Mat | Pat | | | | |
| **1. HEART** | | | | | | | | | | | | | | | | | | | | |
| A. stroke | | | | | | | | | | | | | | | | | | | | |
| B. vascular stroke | | | | | | | | | | | | | | | | | | | | |
| C. heart attack | | | | | | | | | | | | | | | | | | | | |
| D. heart disease | | | | | | | | | | | | | | | | | | | | |
| E. congenital heart defect | | | | | | | | | | | | | | | | | | | | |
| F. aneurysm | | | | | | | | | | | | | | | | | | | | |
| G. angina | | | | | | | | | | | | | | | | | | | | |
| H. cardiomyopathy | | | | | | | | | | | | | | | | | | | | |
| I. circulatory disorder | | | | | | | | | | | | | | | | | | | | |
| J. congestive heart failure | | | | | | | | | | | | | | | | | | | | |
| K. heart arrhythmia | | | | | | | | | | | | | | | | | | | | |
| L. hardening of the arteries | | | | | | | | | | | | | | | | | | | | |
| M. high blood pressure | | | | | | | | | | | | | | | | | | | | |
| N. high cholesterol | | | | | | | | | | | | | | | | | | | | |
| O. other (explain) | | | | | | | | | | | | | | | | | | | | |

**Today's Date:** _____ **Initials:** _____

| Medical Condition | N/A | You | Mother | Father | Siblings | | Grandparents | | | | Aunts | | Uncles | | Cousins | | Children | Niece | Nephew | Age of onset/ comments |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | F | M | MGM | MGF | PGM | PGF | Mat | Pat | Mat | Pat | Mat | Pat | | | | |
| **2. BLOOD** | | | | | | | | | | | | | | | | | | | | |
| A. anemia | | | | | | | | | | | | | | | | | | | | |
| B. sickle-cell anemia | | | | | | | | | | | | | | | | | | | | |
| C. fanconi anemia | | | | | | | | | | | | | | | | | | | | |
| D. thalassemia | | | | | | | | | | | | | | | | | | | | |
| E. hemophilia or other bleeding problem | | | | | | | | | | | | | | | | | | | | |
| F. hemochromatosis | | | | | | | | | | | | | | | | | | | | |
| G. hereditary spherocytosis | | | | | | | | | | | | | | | | | | | | |
| H. hemoglobin disorder | | | | | | | | | | | | | | | | | | | | |
| I. HIV virus | | | | | | | | | | | | | | | | | | | | |
| J. immune deficiency | | | | | | | | | | | | | | | | | | | | |
| K. leukemia | | | | | | | | | | | | | | | | | | | | |
| L. lymphoma | | | | | | | | | | | | | | | | | | | | |
| M. other blood disorder | | | | | | | | | | | | | | | | | | | | |
| **3. RESPIRATORY (LUNGS)** | | | | | | | | | | | | | | | | | | | | |
| A. hay fever | | | | | | | | | | | | | | | | | | | | |
| B. asthma | | | | | | | | | | | | | | | | | | | | |
| C. emphysema | | | | | | | | | | | | | | | | | | | | |
| D. tuberculosis | | | | | | | | | | | | | | | | | | | | |
| E. lung cancer | | | | | | | | | | | | | | | | | | | | |
| F. pneumonia | | | | | | | | | | | | | | | | | | | | |
| G. cystic fibrosis | | | | | | | | | | | | | | | | | | | | |
| H. chronic obstructive pulmonary disease (COPD) | | | | | | | | | | | | | | | | | | | | |
| I. other lung disease | | | | | | | | | | | | | | | | | | | | |

**Today's Date:** _____ **Initials:** _____

| Medical Condition | N/A | You | Mother | Father | Siblings | | Grandparents | | | | Aunts | | Uncles | | Cousins | | Children | Niece | Nephew | Age of onset/ comments |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | F | M | MGM | MGF | PGM | PGF | Mat | Pat | Mat | Pat | Mat | Pat | | | | |
| **3. RESPIRATORY (LUNGS)- cont'd** | | | | | | | | | | | | | | | | | | | | |
| J. birth defect of respiratory system | | | | | | | | | | | | | | | | | | | | |
| **4. GASTRO-INTESTINAL** | | | | | | | | | | | | | | | | | | | | |
| A. ulcer of stomach or duodenum | | | | | | | | | | | | | | | | | | | | |
| B. gall stones | | | | | | | | | | | | | | | | | | | | |
| C. hepatitis A- infectious | | | | | | | | | | | | | | | | | | | | |
| D. hepatitis B (serum) | | | | | | | | | | | | | | | | | | | | |
| E. cirrhosis of the liver | | | | | | | | | | | | | | | | | | | | |
| F. other liver disease | | | | | | | | | | | | | | | | | | | | |
| G. colon cancer | | | | | | | | | | | | | | | | | | | | |
| H. ulcerative colitis | | | | | | | | | | | | | | | | | | | | |
| I. crohn's disease | | | | | | | | | | | | | | | | | | | | |
| J. intestinal cancer | | | | | | | | | | | | | | | | | | | | |
| K. rectal disorder | | | | | | | | | | | | | | | | | | | | |
| L. hernia | | | | | | | | | | | | | | | | | | | | |
| M. pyloric stenosis | | | | | | | | | | | | | | | | | | | | |
| N. birth defect of gastro-intestinal system | | | | | | | | | | | | | | | | | | | | |
| O. celiac disease | | | | | | | | | | | | | | | | | | | | |
| P. stomach cancer | | | | | | | | | | | | | | | | | | | | |
| Q. liver cancer | | | | | | | | | | | | | | | | | | | | |
| R. pancreatic cancer | | | | | | | | | | | | | | | | | | | | |
| S. pancreatitis | | | | | | | | | | | | | | | | | | | | |
| T. any other cancer/ problem of GI system | | | | | | | | | | | | | | | | | | | | |

**Today's Date:** _____ **Initials:** _____

| Medical Condition | N/A | You | Mother | Father | Siblings | | Grandparents | | | | Aunts | | Uncles | | Cousins | | Children | Niece | Nephew | Age of onset/ comments |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | F | M | MGM | MGF | PGM | PGF | Mat | Pat | Mat | Pat | Mat | Pat | | | | |
| **5. METABOLIC/ENDOCRINE** | | | | | | | | | | | | | | | | | | | | |
| 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 | | | | | | | | | | | | | | | | | | | | |
| I. metabolic/ endocrine dysfunction or disorder | | | | | | | | | | | | | | | | | | | | |
| J. G6PD deficiency | | | | | | | | | | | | | | | | | | | | |
| K. parathyroid disease | | | | | | | | | | | | | | | | | | | | |
| L. pituitary disease | | | | | | | | | | | | | | | | | | | | |
| M. other | | | | | | | | | | | | | | | | | | | | |
| **6. URINARY** | | | | | | | | | | | | | | | | | | | | |
| A. kidney stones | | | | | | | | | | | | | | | | | | | | |
| B. polycystic kidney disease | | | | | | | | | | | | | | | | | | | | |
| C. other kidney disease | | | | | | | | | | | | | | | | | | | | |
| D. cancer of the urinary tract (urethra, bladder, ureter) | | | | | | | | | | | | | | | | | | | | |
| E. other disease of the urinary tract (urethra, bladder, ureter) | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |

**Today's Date:** _____ **Initials:** _____

| Medical Condition | N/A | You | Mother | Father | Siblings | | Grandparents | | | | Aunts | | Uncles | | Cousins | | Children | Niece | Nephew | Age of onset/ comments |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | F | M | MGM | MGF | PGM | PGF | Mat | Pat | Mat | Pat | Mat | Pat | | | | |
| **7. GENITAL/REPRODUCTIVE** | | | | | | | | | | | | | | | | | | | | |
| A. undescended testicle | | | | | | | | | | | | | | | | | | | | |
| B. hypospadias | | | | | | | | | | | | | | | | | | | | |
| C. testicular cancer | | | | | | | | | | | | | | | | | | | | |
| D. prostate cancer | | | | | | | | | | | | | | | | | | | | |
| E. infertility | | | | | | | | | | | | | | | | | | | | |
| F. birth defect of the reproductive system | | | | | | | | | | | | | | | | | | | | |
| G. uterine fibroids | | | | | | | | | | | | | | | | | | | | |
| H. ovarian cysts | | | | | | | | | | | | | | | | | | | | |
| I. cervical cancer | | | | | | | | | | | | | | | | | | | | |
| J. ovarian cancer | | | | | | | | | | | | | | | | | | | | |
| K. uterine cancer | | | | | | | | | | | | | | | | | | | | |
| L. hermaphroditism | | | | | | | | | | | | | | | | | | | | |
| M. other | | | | | | | | | | | | | | | | | | | | |
| **8. REPRODUCTIVE OUTCOMES** | | | | | | | | | | | | | | | | | | | | |
| A. 2 or more miscarriages | | | | | | | | | | | | | | | | | | | | |
| B. stillborn | | | | | | | | | | | | | | | | | | | | |
| C. death of a newborn | | | | | | | | | | | | | | | | | | | | |
| D. neonatal jaundice | | | | | | | | | | | | | | | | | | | | |
| E. early childhood/ infancy death | | | | | | | | | | | | | | | | | | | | |
| **9. NEUROLOGICAL** | | | | | | | | | | | | | | | | | | | | |
| A. migraines | | | | | | | | | | | | | | | | | | | | |
| B. mental retardation | | | | | | | | | | | | | | | | | | | | |
| C. senility before age 50 | | | | | | | | | | | | | | | | | | | | |

**Today's Date:** _____ **Initials:** _____

| Medical Condition | N/A | You | Mother | Father | Siblings | | Grandparents | | | | Aunts | | Uncles | | Cousins | | Children | Niece | Nephew | Age of onset/ comments |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | F | M | MGM | MGF | PGM | PGF | Mat | Pat | Mat | Pat | Mat | Pat | | | | |
| **9. NEUROLOGICAL- cont'd** | | | | | | | | | | | | | | | | | | | | |
| D. multiple sclerosis | | | | | | | | | | | | | | | | | | | | |
| E. cerebral palsy | | | | | | | | | | | | | | | | | | | | |
| F. scoliosis | | | | | | | | | | | | | | | | | | | | |
| G. epilepsy | | | | | | | | | | | | | | | | | | | | |
| H. convulsive disorders | | | | | | | | | | | | | | | | | | | | |
| I. hydrocephalus (water on the brain) | | | | | | | | | | | | | | | | | | | | |
| J. disorders of the spinal cord | | | | | | | | | | | | | | | | | | | | |
| K. Huntington's chorea | | | | | | | | | | | | | | | | | | | | |
| L. Gaucher's disease | | | | | | | | | | | | | | | | | | | | |
| M. Wilson's disease | | | | | | | | | | | | | | | | | | | | |
| N. Alzheimer's disease | | | | | | | | | | | | | | | | | | | | |
| O. other nervous system disease | | | | | | | | | | | | | | | | | | | | |
| P. birth defect of the brain or spinal cord | | | | | | | | | | | | | | | | | | | | |
| Q. attention deficit disorder | | | | | | | | | | | | | | | | | | | | |
| R. autism | | | | | | | | | | | | | | | | | | | | |
| S. brain or spinal cancer | | | | | | | | | | | | | | | | | | | | |
| T. Canavan disease | | | | | | | | | | | | | | | | | | | | |
| U. developmental delay | | | | | | | | | | | | | | | | | | | | |
| V. familial dysautonomia | | | | | | | | | | | | | | | | | | | | |
| W. learning disorder | | | | | | | | | | | | | | | | | | | | |
| X. movement disorder | | | | | | | | | | | | | | | | | | | | |
| Y. neurofibromatosis | | | | | | | | | | | | | | | | | | | | |

**Today's Date:** _____ **Initials:** _____

| Medical Condition | N/A | You | Mother | Father | Siblings | | Grandparents | | | | Aunts | | Uncles | | Cousins | | Children | Niece | Nephew | Age of onset/ comments |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | F | M | MGM | MGF | PGM | PGF | Mat | Pat | Mat | Pat | Mat | Pat | | | | |
| **9. NEUROLOGICAL- cont'd** | | | | | | | | | | | | | | | | | | | | |
| Z. Niemann-Pick disease | | | | | | | | | | | | | | | | | | | | |
| AA. Parkinson's disease | | | | | | | | | | | | | | | | | | | | |
| BB. Speech delay / speech disorder | | | | | | | | | | | | | | | | | | | | |
| CC. Tourette Syndrome | | | | | | | | | | | | | | | | | | | | |
| DD. paraplegia | | | | | | | | | | | | | | | | | | | | |
| EE. Down's syndrome | | | | | | | | | | | | | | | | | | | | |
| FF. Spina Bifida/ NTD | | | | | | | | | | | | | | | | | | | | |
| GG. Amyotrophic Lateral Sclerisis (ALS) | | | | | | | | | | | | | | | | | | | | |
| **10. MENTAL HEALTH** | | | | | | | | | | | | | | | | | | | | |
| A. schizophrenia | | | | | | | | | | | | | | | | | | | | |
| B. manic depressive/ bipolar disorder | | | | | | | | | | | | | | | | | | | | |
| C. obsessive compulsive disorder | | | | | | | | | | | | | | | | | | | | |
| D. panic/anxiety disorder | | | | | | | | | | | | | | | | | | | | |
| E. depression | | | | | | | | | | | | | | | | | | | | |
| F. suicide/suicide attempt | | | | | | | | | | | | | | | | | | | | |
| G. other mental health disorder requiring hospitalization | | | | | | | | | | | | | | | | | | | | |
| **11. MUSCLES/BONES/JOINTS** | | | | | | | | | | | | | | | | | | | | |
| A. muscular dystrophy | | | | | | | | | | | | | | | | | | | | |
| B. loss of muscle control/ coordination | | | | | | | | | | | | | | | | | | | | |
| C. other chronic muscle disease | | | | | | | | | | | | | | | | | | | | |
| D. Myasthenia gravis | | | | | | | | | | | | | | | | | | | | |

**Today's Date:** _____ **Initials:** _____

| Medical Condition | N/A | You | Mother | Father | Siblings | | Grandparents | | | | Aunts | | Uncles | | Cousins | | Children | Niece | Nephew | Age of onset/ comments |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | F | M | MGM | MGF | PGM | PGF | Mat | Pat | Mat | Pat | Mat | Pat | | | | |
| **11. MUSCLES/BONES/JOINTS-- cont'd** | | | | | | | | | | | | | | | | | | | | |
| E. lupus | | | | | | | | | | | | | | | | | | | | |
| F. deformity of spine | | | | | | | | | | | | | | | | | | | | |
| G. scoliosis | | | | | | | | | | | | | | | | | | | | |
| H. osteoporosis | | | | | | | | | | | | | | | | | | | | |
| I. dwarfism | | | | | | | | | | | | | | | | | | | | |
| J. hereditary low back disease | | | | | | | | | | | | | | | | | | | | |
| K. arthritis | | | | | | | | | | | | | | | | | | | | |
| L. gout | | | | | | | | | | | | | | | | | | | | |
| M. congenital dislocation of the hip | | | | | | | | | | | | | | | | | | | | |
| N. birth defect- skeletal system | | | | | | | | | | | | | | | | | | | | |
| O. cleft lip/or cleft palate | | | | | | | | | | | | | | | | | | | | |
| P. club foot | | | | | | | | | | | | | | | | | | | | |
| Q. growth delay | | | | | | | | | | | | | | | | | | | | |
| **12. SIGHT/SOUND/SMELL** | | | | | | | | | | | | | | | | | | | | |
| A. deafness before age 60 | | | | | | | | | | | | | | | | | | | | |
| B. deformity of the ear | | | | | | | | | | | | | | | | | | | | |
| C. significant hearing loss | | | | | | | | | | | | | | | | | | | | |
| D. cataracts before age 50 | | | | | | | | | | | | | | | | | | | | |
| E. blindness | | | | | | | | | | | | | | | | | | | | |
| F. color blindness | | | | | | | | | | | | | | | | | | | | |
| G. congenital word blindness | | | | | | | | | | | | | | | | | | | | |
| H. glaucoma | | | | | | | | | | | | | | | | | | | | |
| I. retinoblastoma | | | | | | | | | | | | | | | | | | | | |

**Today's Date:** _____ **Initials:** _____

| Medical Condition | N/A | You | Mother | Father | Siblings | | Grandparents | | | | Aunts | | Uncles | | Cousins | | Children | Niece | Nephew | Age of onset/ comments |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | F | M | MGM | MGF | PGM | PGF | Mat | Pat | Mat | Pat | Mat | Pat | | | | |
| **12. SIGHT/SOUND/SMELL- cont'd** | | | | | | | | | | | | | | | | | | | | |
| J. retinitis pigmentosa | | | | | | | | | | | | | | | | | | | | |
| K. severe refractive disorder | | | | | | | | | | | | | | | | | | | | |
| L. deviated septum | | | | | | | | | | | | | | | | | | | | |
| M. any other sight, sound, or smell disorder | | | | | | | | | | | | | | | | | | | | |
| N. birth defect of sensory system(s) | | | | | | | | | | | | | | | | | | | | |
| **13. SKIN** | | | | | | | | | | | | | | | | | | | | |
| A. acne | | | | | | | | | | | | | | | | | | | | |
| B. eczema | | | | | | | | | | | | | | | | | | | | |
| C. psoriasis | | | | | | | | | | | | | | | | | | | | |
| D. pigmentation disorders | | | | | | | | | | | | | | | | | | | | |
| E. skin cancer | | | | | | | | | | | | | | | | | | | | |
| F. other skin disorders | | | | | | | | | | | | | | | | | | | | |
| **14. OTHER** | | | | | | | | | | | | | | | | | | | | |
| A. alcoholism | | | | | | | | | | | | | | | | | | | | |
| B. drug abuse/ addiction | | | | | | | | | | | | | | | | | | | | |
| C. eating disorder | | | | | | | | | | | | | | | | | | | | |
| D. breast cancer | | | | | | | | | | | | | | | | | | | | |
| E. non-cancerous growths or tumors | | | | | | | | | | | | | | | | | | | | |
| F. any other cancer not mentioned above | | | | | | | | | | | | | | | | | | | | |
| G. recurring or chronic physical symptoms | | | | | | | | | | | | | | | | | | | | |
| H. genetic disorders not mentioned above | | | | | | | | | | | | | | | | | | | | |

**Today's Date:** _____ **Initials:** _____

| Medical Condition | N/A | You | Mother | Father | Siblings | | Grandparents | | | | Aunts | | Uncles | | Cousins | | Children | Niece | Nephew | Age of onset/ comments |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | F | M | MGM | MGF | PGM | PGF | Mat | Pat | Mat | Pat | Mat | Pat | | | | |
| **15. GENETIC ABNORMALITIES** | | | | | | | | | | | | | | | | | | | | |
| A. Turner's syndrome | | | | | | | | | | | | | | | | | | | | |
| B. Klinefelter's syndrome | | | | | | | | | | | | | | | | | | | | |
| C. Cri du chat syndrome | | | | | | | | | | | | | | | | | | | | |
| D. Trisomy 18 | | | | | | | | | | | | | | | | | | | | |
| E. Trisomy 13 | | | | | | | | | | | | | | | | | | | | |
| F. Albinism | | | | | | | | | | | | | | | | | | | | |
| G. Alport's disease | | | | | | | | | | | | | | | | | | | | |
| H. Marfan syndrome | | | | | | | | | | | | | | | | | | | | |
| I. Tay Sachs disease | | | | | | | | | | | | | | | | | | | | |
| J. Fragile X Syndrome | | | | | | | | | | | | | | | | | | | | |
| K. Balanced translocation | | | | | | | | | | | | | | | | | | | | |
| L. other genetic defects | | | | | | | | | | | | | | | | | | | | |

Have you ever had any genetic testing/ screening? Yes ____ No ____

If yes, please list the testing conducted, results obtained, and when & why tests were performed:

_____

_____

How would you rate your family's overall health?

| | Medical | | Mental |
|---|---|---|---|
| Excellent | | Excellent | |
| Very good | | Very good | |
| Average | | Average | |
| Poor | | Poor | |

Please use this area to expand on any of the health history above:

**Today's Date:** _____ **Initials:** _____

**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 not 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? | | |

**Today's Date:** _____ **Initials:** _____

| ADDITIONAL QUESTIONS | YES | NO |
|---|---|---|
| Have you had a recent smallpox vaccination (vaccinia virus) in the last 60 days? 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? 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? 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? | | |
| 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 cumulatively from 1980 through 1990, or elsewhere in Europe (Greece, Turkey, Spain, Portugal, and Italy) for 6 months or more cumulatively 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. or France 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.? | | |

**Today's Date:** _____ **Initials:** _____

| 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 **(or, am now)** aware that I **must** notify NECC if I have had a transfusion with blood or blood components within 48 hours of any sperm donation? | | **Must Answer Yes** |
| 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? | | |

**Today's Date:** _____ **Initials:** _____

**If there is an outbreak of SARS answer the following questions, otherwise note N/A.**
SARS: Severe Acute Respiratory Syndrome

Check here if not applicable: _____

| | 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:** _____ **Initials:** _____

## THINGS ABOUT YOURSELF

PLEASE PRINT/WRITE CLEARLY & IN YOUR OWN WORDS
Use additional paper if needed.
(You must respond to all questions, indicate N/A if an answer is not available)

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)

If you were to have children of your own, what advice would you give to them?

What made you decide to be a donor?

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

**Today's Date:** _____ **Initials:** _____

## THINGS ABOUT YOURSELF- continued

PLEASE PRINT/WRITE CLEARLY

If a movie was made about your life, what actor would play your role and why?

Do you have the personal characteristics, mannerism, etc. of any famous person or fictional TV character? (I.e. Do you act like Homer from the Simpsons, or are you a jokester like Adam Sandler?)

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

What is the one item you never leave home without?

What is your most treasured possession and why?

Are you more productive in the morning, afternoon, or evening?

What is one thing you wish you were better at and why?

What was/ is your plan after completion of your studies?

Which member of your family do you consider yourself most like and why?

If all jobs paid the same salary, what would you do for a living?

Do you have any pet peeves?

**Today's Date:** _____ **Initials:** _____

## THINGS ABOUT YOURSELF- continued

PLEASE PRINT/WRITE CLEARLY

What TV shows did you watch as a kid?

What TV shows do you watch now?

What is your favorite movie(s)?

What is your favorite movie genre (comedy/action/thriller) and why?

What were your favorite books as a kid?

What are your favorite books now?

What is your favorite flavor(s) of ice cream?

Where is your favorite place to vacation?

What is your favorite season?

What is your favorite food(s)?

**Today's Date:** _____ **Initials:** _____

## THINGS ABOUT YOURSELF- continued

PLEASE PRINT/WRITE CLEARLY

What is your favorite color?

What is your favorite holiday(s)?

What makes you feel sad?

What makes you feel happy?

How important is money to you?

Do you believe that there is a God?

Did you have a best friend growing up?
What was he/she like?

Did you have pets growing up? What kind?

Who do you trust the most in the world?

Do you have any regrets in life so far?

What is your favorite childhood memory?

**Today's Date:** _____ **Initials:** _____

## THINGS ABOUT YOURSELF- continued

PLEASE PRINT/WRITE CLEARLY

Who is your favorite musician?

Who is your favorite group?

Can you play a musical instrument(s)? What kind?

If you could spend a week with any woman in the world, who would it be & why? (non-sexual)

If you could spend a week with any man in the world, who would it be & why? (non-sexual)

Please use the space below to document any additional information you feel is important for New England Cryogenic Center 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 my donations.

_____ _____

Applicant Signature Date

*For office use only*

Donor Name: _____ Date _____

| Items for Medical Director Review | | (list more info needed. (Response req. if checked) | | Med. Director Accept / Not Accept | |
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Medical Director Signature: Date

Laboratory Director / Designee Signature: Date

*For office use only*

Donor Name: _____ Date _____

| Items for Medical Director Review | | (list more info needed. (Response req. if checked) | | Med. Director Accept / Not Accept | |
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Medical Director Signature: Date

Laboratory Director / Designee Signature: Date