

The Muasher Center For Fertility and IVF
8501 Arlington Blvd Suite #500
Fairfax, VA 22031

Date: _____

DONOR NON-IDENTIFYING INFORMATION

I. PHYSICAL CHARACTERISTICS

Date of Birth: _____ Place of Birth: _____

Race: _____ Height: _____ Weight: _____

Eye Color: _____ Hair Color: _____

(Check One) Hair Texture: _____ Thick _____ Thin _____ Average
(Check One) Hair Body: _____ Curly _____ Wavy _____ Straight
(Check One) Complexion: _____ Fair _____ Medium _____ Dark
(Check One) Bone Structure: _____ Small _____ Medium _____ Large
(Check One) Body Shape: _____ Apple _____ Pear _____ Slender
(Check One) Handiness: _____ Right _____ Left _____ Ambidextrous

II. PERSONAL INFORMATION

Ethnic Origin / Ancestry: _____

Are you adopted? Yes No If yes, do you know about your birth parents and family history? Yes No

Religion at Birth: _____

Current Religion: _____

Marital Status: Single Married Divorced Separated

Sexual Orientation: Heterosexual Homosexual Bisexual

Number of Pregnancies: _____ Miscarriages: _____ Abortions: _____ Tubal (ectopic): _____

Number of Children: _____ Stillbirths: _____ # of Girls: _____ # of Boys: _____

Ages of Children: _____

Health of Children: _____

Education

High School: Completed GED GPA: _____

College: Some College Currently enrolled Completed Major: _____ Minor: _____ GPA: _____

Advanced Degree(s) Currently pursuing Completed

Did you like school? Yes No Favorite subject(s): _____

Extra curricular activities / clubs / sports: _____

Achievements or Awards: _____

Tell us a little bit about yourself:

1. What would you like to do in the future, goals, ambitions etc?

III. PHYSICAL CHARACTERISTICS OF THE FAMILY

Please describe your family members by the following characteristics:

	Age	Eye color	Hair color	Complexion	Height	Body Type	Ethnic Origin
Mother:							
Father:							
Brother(s) 1.							
2.							
3.							
Sister(s) 1.							
2.							
3.							
Maternal Grandmother:							
Maternal Grandfather:							
Paternal Grandmother:							
Paternal Grandfather:							

Highest level of education completed by your mother: _____

What is her occupation? _____

Highest level of education completed by your father: _____

What is his occupation? _____

Have twins or multiple births occurred in your family? _____ If yes, how many and what relation are they to you?

IV. PERSONAL HEALTH HISTORY

Do you currently have any allergies? Yes No

If yes, please check Food Drugs Environmental Other

Please list substances and reactions produced:

Substances

Reactions

Describe any childhood allergies that you have outgrown:

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Condition of your teeth (check one): Poor Fair Good
Did you wear braces as a child? Yes No
Have you had any dental work in the last 6mos? Yes No

Do you have normal hearing? Yes No
If no, describe problem and at what age were you diagnosed?

Do you wear glasses / contacts? Yes No
If yes, Farsighted Nearsighted Other (specify)
Did any member of your family have to wear glasses at an early age (infancy to pre-teen)? Yes No
If yes, relationship and reason:

Do you sleep well? Yes No
If No, do you know why?

Your diet (check one) Vegetarian Non-Vegetarian
Your eating habits (check one) Poor Average Excellent
How much caffeine do you drink per day? _____
Do you take vitamins or dietary supplements? Yes No
If yes, please list substance and daily dosage:

How much exercise do you get? None Occasionally Regularly
What type of exercise do you do? How many hours/ day and how many days / week?

Have you ever had surgery? Yes No
Please explain:

Have you ever been hospitalized? Yes No
Please explain:

Have you had major radiation exposure or x-ray exposure? Yes No
Please explain:

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Have you ever been treated for syphilis?	Yes <input type="radio"/> No <input type="radio"/>	When?
Have you ever been treated for Chlamydia?	Yes <input type="radio"/> No <input type="radio"/>	When?
Have you ever been treated for Pelvic Inflammatory Disease (PID)?	Yes <input type="radio"/> No <input type="radio"/>	When?
Have you ever been treated for gonorrhea?	Yes <input type="radio"/> No <input type="radio"/>	When?
Have you been diagnosed with herpes?	Yes <input type="radio"/> No <input type="radio"/>	Last outbreak?
Have you ever had an abnormal pap smear?	Yes <input type="radio"/> No <input type="radio"/>	Last pap?
Have you had any vaccinations or immunizations in the last year? If yes, what type?	Yes <input type="radio"/> No <input type="radio"/>	When?
Have you ever taken any street drugs by needle, even once? Explain:	Yes <input type="radio"/> No <input type="radio"/>	
Have you in the last year been a sex partner of someone who has taken street drugs by needle?	Yes <input type="radio"/> No <input type="radio"/>	
In the last year have you received a blood transfusion, clotting factors for bleeding disorders, organ or tissue transplant? Explain:	Yes <input type="radio"/> No <input type="radio"/>	
Have you been exposed to someone with yellow jaundice or hepatitis? Explain:	Yes <input type="radio"/> No <input type="radio"/>	
To your knowledge, have you had a positive test for HIV?	Yes <input type="radio"/> No <input type="radio"/>	
Have you had acupuncture, ear/ body piercing or a tattoo in the last year? Explain:	Yes <input type="radio"/> No <input type="radio"/>	
Please check any of the following if ANY of your sexual partners have ever had any of the following: (please ask if any terms are unfamiliar to you)		
<input type="radio"/> Nonspecific urethritis (NSU)	When?	
<input type="radio"/> Chlamydia	When?	
<input type="radio"/> Venereal warts	When?	
<input type="radio"/> Gonorrhea	When?	
<input type="radio"/> Syphilis	When?	
<input type="radio"/> Herpes	When?	
Have you ever had any major illnesses? Explain:	Yes <input type="radio"/> No <input type="radio"/>	

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Please list any medications you are currently taking or have taken in the last 6 months. Include over the counter medications and give the daily dosages.

Have you ever used (even once) or do you currently use any of the following drugs? (include prescription drugs)

	Frequency/day?	Years used?	How used?	Date last used?
<input type="checkbox"/> Marijuana	_____	_____	_____	_____
<input type="checkbox"/> Cocaine	_____	_____	_____	_____
<input type="checkbox"/> Barbiturates	_____	_____	_____	_____
<input type="checkbox"/> Narcotics/Opiates	_____	_____	_____	_____
<input type="checkbox"/> Heroin	_____	_____	_____	_____
<input type="checkbox"/> Methadone	_____	_____	_____	_____
<input type="checkbox"/> Morphine	_____	_____	_____	_____
<input type="checkbox"/> Codeine	_____	_____	_____	_____
<input type="checkbox"/> Opium	_____	_____	_____	_____
<input type="checkbox"/> Amphetamines	_____	_____	_____	_____
<input type="checkbox"/> Hallucinogens (LSD)	_____	_____	_____	_____
<input type="checkbox"/> PCP	_____	_____	_____	_____
<input type="checkbox"/> Tranquilizers	_____	_____	_____	_____
<input type="checkbox"/> Inhalants (amyl or Butyl Nitrate, aerosol propellants)	_____	_____	_____	_____
<input type="checkbox"/> Steroids	_____	_____	_____	_____

Do you drink alcoholic beverages? Yes No
 (Check all that apply)

Beer How much per day/week? _____
 Wine How much per day/week? _____
 Liquor How much per day/week? _____

Was there ever a time when you drank more that 3 drinks/day on a daily or regular basis? Yes No
 Explain: _____

Do you drink to get drunk? Yes No
 Explain: _____

Do you smoke cigarettes? Yes No
 How many packs per day? _____ How long have you been smoking? _____
 Are you a former smoker? Yes No
 How much did you smoke? _____ packs/day How long did you smoke? _____ years
 When did you quit? _____

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V. ANCESTRY

Do you have any African ancestors? Yes No Unknown
 If yes, have you been tested for sickle cell disease? Yes No
 If yes, what are the results? _____

Do you have any Mediterranean (Greek or Italian) ancestors? Yes No Unknown
 If yes, have you been tested for Thalassemia? Yes No Unknown
 If yes, what are the results? _____

Do you have any Asian ancestors? Yes No Unknown
 If yes, have you been tested for Thalassemia? Yes No Unknown
 If yes, what are the results? _____

Do you have any Jewish ancestors? Yes No Unknown
 If yes, have you been tested for any of the following? Yes No Unknown
 (Check which ones you have been tested for)
 Tay Sachs
 Cystic Fibrosis
 Gauchers
 Familial Dysautonomia
 Fanconi Anemia
 Neimann-pick
 Canavan disease
 Results of any testing? _____

VI. FAMILY MEDICAL HISTORY

Has any member of your family, including yourself, had a problem or defect at birth of any of the following body systems? (please include first cousins, aunts, uncles, grandparents and great-grandparents)

- Musculoskeletal – bones, muscles, joints, limbs Yes No
- Gastrointestinal – digestive system Yes No
- Nervous system – Brain, spinal cord Yes No
- Circulatory system – Blood, circulation, arteries, veins Yes No
- Organs – heart, lungs, liver, kidneys, etc. Yes No
- Genital-urinary – ovaries, testies, bladder, urethra, etc. Yes No
- Metabolic – Hormones, enzymes, etc. Yes No

If you answered “yes” to any of the above please list the specific defect in each case.

Birth Defect	Who	Age Diagnosed	Seriousness

Do you have any siblings who died in infancy or childhood? Yes No
 Explain:

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Are there any known genetic diseases or conditions that run in your family?
Explain:

Yes No

Has anyone in your family, including yourself experienced recurring and/or chronic physical symptoms that have not been evaluated by a physician?
Please include those symptoms that you may not consider serious.
Explain:

Yes No

Please list below at what age your family members died and the cause of their death. Be as specific as possible.

Relation	Cause of Death	Age Diagnosed	Age at time of death
Paternal Grandfather			
Paternal Grandmother			
Maternal Grandfather			
Maternal Grandmother			
Father			
Mother			
Brothers 1.			
2.			
3.			
Sisters 1.			
2.			
3.			
First Cousins			
Paternal Great-grandfather Paternal Great-grandmother			
Maternal Great-grandfather Maternal Great-grandmother			

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Please check all that apply to both Maternal and Paternal sides of your family

Medical Problems	You	Mother	Father	Siblings	Grandparents	Aunts/Uncles	First Cousins
Heart/Circulatory							
Stroke							
Heart Attack							
Heart Disease							
Birth defects							
Hardening of Arteries							
High blood pressure							
High Cholesterol							
"Poor circulation"							
Varicose Veins							
Blood/Circulation							
Anemia							
Sickle Cell Anemia							
Hemophilia							
Bleeding problems							
Leukemia							
Immune deficiency							
HIV/AIDS							
Blood Clots							
Bruises easily							
Other							
Respiratory/Lungs							
Hayfever							
Asthma							
Emphysema							
Tuberculosis							
Lung Cancer							
Pneumonia							
Chronic Bronchitis							
Other Lung disease							
Gastrointestinal/Digestion							
Stomach ulcers							
Duodenum ulcers							
Gallstones							
Hepatitis A (infectious)							
Hepatitis B (serum)							
Cirrhosis of liver							
Other liver disease							
Colon Cancer							
Ulcerative Colitis							
Crohn's disease							
Irritable bowel syndrome							
Cystic Fibrosis							
Jaundice							
Rectal Disorders							

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Medical Problems	You	Mother	Father	Siblings	Grandparents	Aunts/Uncles	First Cousins
Metabolic/Endocrine							
Diabetes (Type 1)							
Diabetes (Type 2)							
Hypoglycemia							
Hypothyroidism							
Hyperthyroidism							
Thyroid cancer							
Pancreatitis							
Pancreatic cancer							
Goiter							
Adrenal disorders							
Cushing's Disease							
Other							
Urinary/Kidneys							
Kidney Cancer							
Kidney stones							
Kidney Failure (dialysis)							
Bladder Cancer							
Bladder disease							
Urinary tract disease							
Other							
Genital/Reproductive							
Undescended Testicle(s)							
Hypospadias							
Hyperspadias							
Prostate Cancer							
Prostate disease							
Hermaphroditism							
Endometriosis							
Uterine Cancer							
Cervical Cancer							
Ovarian Cancer							
Breast Cancer							
Testicular Cancer							
Ovarian Cysts							
Miscarriages (2 or more)							
Stillbirths							
Other							
Neurological							
Migraines							
Mental retardation							
Down's Syndrome							
Alzheimer's							
Senility							
Multiple Sclerosis							
Cerebral Palsy							
Epilepsy/seizures							
Hydrocephalus (water on brain)							
Parkinson's Disease							

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Medical Problems	You	Mother	Father	Siblings	Grandparents	Aunts/Uncles	First Cousins
Spinal Cord injuries							
Myasthenia Gravis							
Spina Bifida (open spine)							
Paralysis/paraplegia							
Huntington's Chores							
Gaucher's Disease							
Wilson's Disease							
Other							
Mental Health							
Depression							
Post traumatic stress							
Bipolar disorder							
Schizophrenia							
ADHD							
Muscles/Bones/Joints							
Muscular Dystrophy							
Lupus							
Chronic muscle disorders							
Deformity of the spine							
Scoliosis							
Osteoporosis							
Dwarfism							
Arthritis							
Congenital hip problems							
Gout							
Club Foot							
Sight/Sound/Smell							
Deafness							
Deformities of the ear							
Blindness							
Color blindness							
Cataracts							
Glaucoma							
Deviated Septum							
Other							
Skin							
Acne							
Eczema							
Psoriasis							
Edema (swelling)							
Skin Cancer							
Melanoma							
Pigmentation disorders							
Other Skin diseases							
Other							
Early Death (< 50 yrs old)							
Chromosome Problems							
Inguinal hernia							
Cleft lip and/or palate							
Alcoholism							
Drug Abuse/Addiction							
Obesity							

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

Exposed to:	When	How Often
Toxic Chemicals		
Toxic Sprays		
Fumes/Exhaust		
Radiation		
Flea Powders/sprays/Bombs		
Lead/Lead products		
Asbestos/Asbestos products		
Cleaning Solvents		

Please use the following space to tell us anything more about your lifestyle or family history you feel we should know.