THE CENTER FOR ADVANCED REPRODUCTIVE SERVICES' LAB

THERAPEUTIC DONOR INSEMINATION (TDI) PROGRAM

Recipient History Screening Form

Before you can become a recipient at The Center for Advanced Reproductive Services, we need to learn some important information about your personal and medical history. Your responses to these questions will help us to make sure that your health and genetic make-up are compatible with any potential sperm donor that you may be choosing.

Please provide complete and accurate information to these questions.

INSTRUCTIONS:

This screening form is very important to obtain information about you, the recipient, and your family. This is a listing of the recipient's relatives.

1. Please fill in all blanks completely. Write "NA" in blanks that are not applicable. Write "UNK" in blanks where you do not know the answer.

2. Please be specific. Avoid expressions such as "natural" or "old age" (for causes of death). List any health problems as specifically as possible. Give ages to your best approximation. List exact relationships such as "first cousin through my mother's sister".

3. Please provide information on all the relatives requested. You do not need to list names.

If you have any questions, please note them and ask them at the time of your physician's consultation.

RECIPIENT HISTORY SCREENING FORM

Date: _____

NAME: _____

UCHC Patient #: TO _____

Last 4 digits of SS#: _____

Birth Date: _____

Address: _____

_____

_____

Your Occupation: _____

Name of The Center's Physician and Date of consult:

_____

Date of Dr. Mary Casey Jacob's consult:

_____

Your Husband's or Partner's Name, if applicable:

_____

If applicable, your Husband's BLOOD TYPE & RH: _____

Your BLOOD TYPE & RH, if known: _____

Preferable means of contact:

- Home#: _____
- Cell#: _____
- Work#: _____

Possibility of wanting a sibling with the same donor?

YES _____ NO _____ MAYBE _____

Messages may be left? Home _____ Cell _____ Work _____

PHYSICIAN'S COMMENTS: (To be completed by screening physician)

Genetic restrictions: _____

REVIEW #1: Approved – Any donor or Must be reviewed with specific donor profile

Screening physician: _____ Date of screening: _____

Patient notified of above: _____ Date: _____

REVIEW #2: Donor Profile Reviewed and Approved for match to Donor# _____

Screening physician: _____ Date of screening: _____

RECIPIENT HISTORY : Female Information

1. Are you allergic to Penicillin or Penicillin-derivatives, such as Amoxicillin, Ampicillin, …etc?

   ___ Yes ___ No If yes, please explain reaction: _____

2. Were you born with any genetic conditions, such as PKU (phenylketonuria), Gaucher disease or any other?

   ___ Yes ___ No If yes, please explain and give age when diagnosed: _____

   _____

3. Are there any known genetic conditions or birth defects in your family? ___ Yes ___ No

   If yes, please explain: _____

   _____

4. Have you ever been tested for :

   a**. Tay-Sachs** disease (if Jewish or French Canadian ancestry): ___ Carrier ___ Non-carrier ___ Unknown

   b. Sickle cell disease (if Black or Hispanic): ___ Carrier ___ Non-carrier ___ Unknown

   c. Thalassemia (if African, Asian, Indian, Yugoslavian, Bulgarian, Hungarian, Turkish, Middle Eastern or Afghanistani, Mediterranean, Spanish, Portuguese, French, Italian, Greek):

   ___ Carrier ___ Non-carrier ___ Unknown

   d. Cystic Fibrosis: ___ Carrier ___ Non-carrier ___ Unknown

5. Do you have any health problems? ___ Yes ___ No (ie: high blood pressure, asthma, allergies, etc.)

   If yes, please explain and give age when diagnosed: _____

   _____

6. Were you born with any birth defects or differences? (e.g. heart defect, cleft of the lip or palate, hearing problems, seizures, open spine, club feet) ___ Yes ___ No

   If yes, please explain and give age when diagnosed: _____

   _____

RECIPIENT'S FATHER'S FAMILY

1. **Grandfather** (*your father's father*): ___ living ___ deceased
   Current Age (*or Age at death*) _____ If deceased, cause of death _____

   Health Problems and Age Diagnosed

   _____

   _____

   _____

2. **Grandmother** (*your father's mother*): ___ living ___ deceased
   Current Age (*or Age at death*) _____ If deceased, cause of death _____

   Health Problems and Age Diagnosed

   _____

   _____

   _____

3. **Aunts and uncles** (*your father's brothers and sisters*), **LIVING**:

   Sex Age Health Problems Age Diagnosed

   1. _____
   2. _____
   3. _____
   4. _____
   5. _____
   6. _____

4. **Aunts and uncles** (*your father's brothers and sisters*), **DECEASED** (*including stillborns, infant deaths and child-hood deaths*):

   1. _____
   2. _____
   3. _____
   4. _____

RECIPIENT'S FATHER'S FAMILY

5. **Father**: ___ living ___ deceased

Current Age (*or Age at death*) _____ If deceased, cause of death _____

Health Problems and Age Diagnosed

_____

_____

_____

Is there anything else you think we should know about your father's family?

_____

_____

_____

_____

_____

_____

RECIPIENT'S MOTHER'S FAMILY

1. **Grandfather** (*your mother's father*): ___ living ___ deceased

Current Age (*or Age of death*) _____ If deceased, cause of death _____

Health Problems and Age Diagnosed

_____

_____

_____

2. **Grandmother** (*your mother's mother*): ___ living ___ deceased

Current Age (*or Age at death*) _____ If deceased, cause of death _____

Health Problems and Age Diagnosed

_____

_____

_____

3. **Aunts and uncles** (*your mother's brothers and sisters*), **LIVING**:

	Sex	Age	Health Problems	Age Diagnosed
1.				
2.				
3.				
4.				
5.				
6.				

4. **Aunts and uncles** (*your mother's brothers and sisters*), **DECEASED** (*including stillborns, infant deaths and childhood deaths*):

1. _____
2. _____
3. _____
4. _____

RECIPIENT'S MOTHER'S FAMILY

5. **Mother:** ___ living ___ deceased

Current Age (*or Age at death*) _____ If deceased, cause of death _____

Health Problems and Age Diagnosed

_____

_____

_____

Is there anything else you think we should know about your mother's family?

_____

_____

_____

_____

_____

_____

SIBLINGS

1. Your brothers and sisters, **LIVING:**

	Sex	Age	Health Problems	Age Diagnosed
1.				
2.				
3.				
4.				
5.				
6.				

2. Your brothers and sisters, **DECEASED**:

	Sex	Age	Cause of Death	Age Diagnosed	Other Health Problems
1.					
2.					

CHILDREN

1. Your children, **LIVING**:

	Sex	Age	Health Problems	Age Diagnosed
1.				
2.				
3.				
4.				

2. Your children, **DECEASED**:

	Sex	Age	Cause of Death	Age Diagnosed	Other Health Problems
1.					
2.					

FAMILY HISTORY

	Yourself		Blood Relative		This person's relationship to you
	Yes	*No*	*Yes*	*No*	
1. BLINDNESS or other visual problems	___	___	___	___	_____
2. DEAFNESS, HEARING DIFFICULTIES Unusual shape or missing ear	___	___	___	___	_____
3. SPEECH PROBLEMS	___	___	___	___	_____
4. DENTAL PROBLEMS (such as missing or extra teeth)	___	___	___	___	_____
5. CLEFT LIP (harelip)	___	___	___	___	_____
6. CLEFT PALATE	___	___	___	___	_____
7. LEARNING DISABILITY or slow learner	___	___	___	___	_____
8. MENTAL RETARDATION or developmental delay	___	___	___	___	_____
9. ATTENTION DEFICIT DISORDER and/or HYPERACTIVITY	___	___	___	___	_____
10. DOWN'S SYNDROME (also called mongolism)	___	___	___	___	_____
11. MENTAL ILLNESS (e.g. anxiety, depression, manic depression, schizophrenia, nervous breakdown)	___	___	___	___	_____
12. HYDROCEPHALUS	___	___	___	___	_____
13. MICROCEPHALUS (small head)	___	___	___	___	_____
14. PATCHES OF HAIR OF DIFFERENT COLOR	___	___	___	___	_____
15. PATCHES OF SKIN OF DIFFERENT COLOR (example: white or brown spots)	___	___	___	___	_____
16. BIRTHMARKS	___	___	___	___	_____
17. SKIN PROBLEMS (Severe eczema, acne or other)	___	___	___	___	_____
18. BLEEDING PROBLEMS OR HEMOPHILIA	___	___	___	___	_____
19. SICKLE CELL ANEMIA	___	___	___	___	_____
20. THALASSEMIA	___	___	___	___	_____
21. HYPERTENSION or HIGH BLOOD PRESSURE	___	___	___	___	_____
22. STROKE	___	___	___	___	_____
23. HEART ATTACK (Coronary) before age 50	___	___	___	___	_____

IF YES TO ANY OF THE ABOVE, PLEASE ANSWER THE FOLLOWING:

NUMBER (from above)	AGE when first AFFECTED	COMMENTS (name of disorder if known)

_____

_____

_____

_____

	Yourself		Blood Relative		This person's relationship to you
	Yes	*No*	*Yes*	*No*	
24. Born with HEART DEFECT (example: hole in heart)	___	___	___	___	_____
25. Born with OPEN SPINE (SPINA BIFIDA)	___	___	___	___	_____
26. Born with MISSING BRAIN	___	___	___	___	_____
27. Born with HIP PROBLEMS	___	___	___	___	_____
28. DWARFISM OR SHORT STATURE	___	___	___	___	_____
29. SPINAL CURVATURE (Scoliosis)	___	___	___	___	_____
30. MALFORMED BONES OR MANY BROKEN BONES	___	___	___	___	_____
31. MALFORMED HANDS (extra/missing/webbed/fingers)	___	___	___	___	_____
32. MALFORMED FEET (extra/missing/webbed/fingers)	___	___	___	___	_____
33. CLUB FOOT	___	___	___	___	_____
34. ARTHRITIS, JOINT PROBLEMS	___	___	___	___	_____
35. MUSCULAR DYSTROPHY	___	___	___	___	_____
36. MUSCLE WEAKNESS	___	___	___	___	_____
37. LOSS OF MUSCLE CONTROL	___	___	___	___	_____
38. PYLORIC STENOSIS (projective vomiting)	___	___	___	___	_____
39. BREAST CANCER	___	___	___	___	_____
40. COLON CANCER	___	___	___	___	_____
41. OVARIAN CANCER	___	___	___	___	_____
42. OTHER CANCERS (type, site)	___	___	___	___	_____
43. CYSTIC FIBROSIS	___	___	___	___	_____
44. ALZHEIMER'S DISEASE	___	___	___	___	_____
45. HUNTINGTON'S DISEASE (chorea)	___	___	___	___	_____
46. NEUROFIBROMATOSIS	___	___	___	___	_____
47. MULTIPLE SCLEROSIS	___	___	___	___	_____
48. TAY SACHS DISEASE	___	___	___	___	_____
49. CERBRAL PALSY	___	___	___	___	_____

IF YES TO ANY OF THE ABOVE, PLEASE ANSWER THE FOLLOWING:

NUMBER (from above)	AGE when first AFFECTED	COMMENTS (name of disorder if known)

_____

_____

_____

_____

	Yourself		Blood Relative		This person's relationship to you
	Yes	*No*	*Yes*	*No*	
50. SEIZURES, CONVULSIONS, EPILEPSY	___	___	___	___	_____
51. CHILDHOOD DIABETES	___	___	___	___	_____
52. ADULT DIABETES	___	___	___	___	_____
53. THYROID DISORDER (under active or over active)	___	___	___	___	_____
54. KIDNEY PROBLEMS	___	___	___	___	_____
55. RESPIRATORY OR BREATHING PROBLEMS (example: emphysema)	___	___	___	___	_____
56. ASTHMA, HAY FEVER	___	___	___	___	_____
57. ALLERGIES – FOOD (specify)	___	___	___	___	_____
58. ALLERGIES – MEDICINE (specify)	___	___	___	___	_____
59. ALCOHOL DEPENDENCY OR ABUSE	___	___	___	___	_____
60. DRUG DEPENDENCY OR ABUSE (specify the drug)	___	___	___	___	_____
61. WEIGHT PROBLEMS (obesity or anorexia)	___	___	___	___	_____
62. INFERTILITY	___	___	___	___	_____
63. MISCARRIAGES If "yes" HOW MANY?	___	___	___	___	_____
64. STILLBIRTHS If "yes" HOW MANY?	___	___	___	___	_____
65. INFANT DEATHS (deceased before one month)	___	___	___	___	_____
66. CHILDHOOD DEATHS	___	___	___	___	_____
67. HIV POSITIVE (Human Immunodeficiency Virus)	___	___	___	___	_____
68. AIDS (Acquired Immunodeficiency Syndrome)	___	___	___	___	_____

IF YES TO ANY OF THE ABOVE, PLEASE ANSWER THE FOLLOWING:

NUMBER (from above)	AGE when first AFFECTED	COMMENTS (name of disorder if known)

_____

_____

_____

_____

Is there anything else you think we should know about your family? _____

_____

_____

_____