

Known Donor Questionnaire

Your donor's answers to these questions will provide you with a wealth of information about his health. You'll probably need assistance from a health care provider to interpret how some of these questions may affect the health of you or your future child. If your donor is planning to undergo a physical exam, which we recommend, ask him to bring this completed form with him so that his health care provider can review it; it's probably more specifically fertility-related than the list of questions his care provider would normally ask. During the exam, his health care provider will also do something called a "Review of Systems," which includes many questions about current symptoms your donor may have that he might otherwise forget to mention. We haven't included basic questions of this nature here.

Environmental Exposure

- In your work are you exposed to any health hazards such as asbestos, radiation, toxic chemicals, etc.?
- Have you been exposed to any of these in any of your hobbies or pastimes?
- Have you been exposed to any toxic agents in the military or anywhere else?
- What kind of regular, everyday use of chemicals do you have at home or in your hobbies?

Sexual Activity

- Do you have sex with men, women, or both?
- Please mark the activities you engage in sexually, even if not frequently. Note how often you use condoms or other barriers: always, mostly, sometimes, never.

- 1) put someone's penis in your rectum
- 2) put someone's penis in your mouth
- 3) put your penis in someone's rectum
- 4) put your penis in someone's mouth
- 5) put your penis in someone's vagina
- 6) put your mouth on someone's rectum
- 7) put your mouth on someone's vagina

- 8) only engage in mutual masturbation
9. put ungloved hand in someone's rectum
10. put ungloved hands in someone's vagina
11. share sex toys
12. participate in BDSM activities

of what nature and with what forms of protection

- Have you recently had an HIV test? If so, how long ago and what were the results? Have you recently been tested for other sexually transmitted infections?
- Do you have a regular partner?
- Do you have sex with people other than your partner?
- Does your partner have sex with people other than you?
- Has your partner had an HIV test? When was the most recent? Was it negative or positive? How about tests for other sexually transmitted infections?
- How many people have you had sex with in the past year?
- If you have used condoms, have any broken in the past year?
- In the past year have you experienced a change in the type or safety of your sexual activities on occasions when you have drunk alcohol, used drugs, or partied?

Drug and Alcohol Use

- How often do you drink alcohol:
 - ___ not at all
 - ___ once a week or less
 - ___ 2-3 times a week
 - ___ daily or almost daily
- Which of these applies to your alcohol consumption:
 - ___ When I drink it's usually one or two.
 - ___ When I drink it's usually three or more.
 - ___ When I drink I never get drunk.
 - ___ When I drink I rarely have gotten drunk.
 - ___ When I drink I occasionally get drunk.
 - ___ When I drink I usually get drunk.

___ I get drunk most weekends.

- Do you smoke cigarettes? If so, how many per day?
- Are you exposed to secondhand smoke at work, home, with friends, or when you're out socially?
- Do you smoke marijuana? If so, how often?
- Do you use other recreational drugs? If so, which ones and how often?
- Are you in recovery from alcohol or substance abuse? If yes, from which substances and how long have you been clean and sober?
- Do you use needles with any of your drug use?

Medical History

- Has a woman conceived with your sperm in the past? If so, how many times?
How many children have you helped conceive?
- Are you adopted?
- Do you have access to the medical history of both of your biological parents?
- If no, which do you not have access to?
- Do you have any inherited disorder, such as hemophilia or sickle-cell anemia?
- Do you carry a gene for any inherited disorder, such as anemias caused by thalassemia, sickle-cell anemia, or Tay-Sachs disease? Cystic fibrosis?
- Have you ever had a serious illness or accident? If so, explain.
- Have you ever had surgery?
- Have you ever been hospitalized for anything other than surgery?
- Have you ever had a blood transfusion? If so, when and where?
- Do you currently take any medications? If so, for what?
- Check and describe if you've had any of the following diseases or conditions:

___ allergies

___ anemia

___ arthritis

___ asthma

- blood diseases
- cancer
- coronary artery disease
- depression
- diabetes
- dyslexia
- epilepsy
- gallbladder problems
- glaucoma
- heart attack
- heart malformation
- high cholesterol
- hypertension
- liver disease
- migraine headaches
- polycystic renal disease
- nervous or mental disorders
- phlebitis/blood clots
- respiratory illness
- shingles
- spina bifida
- stroke
- thyroid disease
- tuberculosis
- ulcers

Sexually Transmitted Infections:

- chlamydia
- genital herpes
- genital warts
- gonorrhea

___ syphilis

hepatitis

___ other sexually transmitted infections

Family History

- Do twins or multiple births run in your family?
- Does any member of your family have a serious birth defect?
- Are there known genetic diseases in your family?
- Did your mother take the drug DES when she was pregnant with you?
- Did any of your siblings die in infancy or childhood?
- Do you or any member of your family have any diseases or conditions that you haven't already mentioned in the questionnaire?
- Have any of your blood relatives had any of the following problems? (include your parents, your children, your siblings, grandparents, first cousins, aunts and uncles)

___ alcoholism/drug addiction

___ any medical problem with a possible genetic cause

___ blindness

___ colon cancer

___ congenital anomalies (birth defects)

___ congenital heart disease

___ congenital hip dysplasia

___ convulsive disorders

___ deafness

___ diabetes before age 50 controlled by diet

___ diabetes before age 50 not controlled by diet (type 1 or 2)

___ heart disease before age 50

___ intestinal cancer

___ manic depression/bipolar disorder

___ mental retardation

___ muscular dystrophy

___ neural tube anomalies (anencephaly, hydrocephaly, spina bifida)

___ neurological disorders

___ polycystic renal disease

___ schizophrenia

___ severe high blood pressure before age 50

___ thyroid disorders

• List the age of your relatives, or if they have died, the age they were when they died and the cause of death:

mother's mother _____

mother's father _____

father's mother _____

father's father _____

mother _____

father _____

brothers _____

sisters _____

children _____