

**MEN'S PROFILE FOR DESIGNATED DONORS**

**NAME:** \_\_\_\_\_

Date \_\_\_\_\_  
 Name \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City/State/Zip \_\_\_\_\_  
 E-mail \_\_\_\_\_  
 Home phone \_\_\_\_\_ Other phone \_\_\_\_\_  
 Birth Date \_\_\_\_\_ Age \_\_\_\_\_ SS# \_\_\_\_\_  
 City, State & Country of Birth: \_\_\_\_\_  
 Height \_\_\_\_\_ Weight \_\_\_\_\_ Eye Color \_\_\_\_\_ Hair color \_\_\_\_\_  
 Do you wear Glasses/Contacts  Yes  No  
 If yes what strength \_\_\_\_\_

**RACE / ETHNICITY**

Race (check all that apply), include Known Countries and/or Tribes of Ancestry:

- Caucasian \_\_\_\_\_
- Hispanic/Latino \_\_\_\_\_
- African-American/African/Black \_\_\_\_\_
- Asian-American/Asian \_\_\_\_\_
- Native American \_\_\_\_\_
- Other \_\_\_\_\_

The race or ethnicity you consider your major identity: \_\_\_\_\_

Ethnicity of Mother \_\_\_\_\_ Father \_\_\_\_\_

Religion Born into:

You \_\_\_\_\_ Mother \_\_\_\_\_ Father \_\_\_\_\_

Religion you presently practice \_\_\_\_\_

Are you adopted?  Yes  No

Do you have access to both parents medical history?  Yes  No

If no, which parent(s) do you not have access to? \_\_\_\_\_

**EDUCATIONAL BACKGROUND** (circle highest level attained)

High School	1	2	3	4	
College/University	1	2	3	4	Degree/Field _____
Post Graduate	1	2	3	4+	Degree/Field _____

**WORK**

Are you working?  Yes  No

If yes, what is your job? \_\_\_\_\_

If this is not your usual work, what is? \_\_\_\_\_

Does your work expose you to any health hazards like asbestos, radiation, toxic chemicals?

Yes  No

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

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**PERSONAL**

Do you live: alone \_\_\_\_\_ with a partner \_\_\_\_\_ roommate(s) \_\_\_\_\_ children \_\_\_\_\_

Are you a: renter \_\_\_\_\_ homeowner \_\_\_\_\_ other \_\_\_\_\_

How do you feel about your living situation \_\_\_\_\_

**REPRODUCTIVE HISTORY**

Number of times you have caused a woman to become pregnant: \_\_\_\_\_

Number of children you have fathered (children born alive): \_\_\_\_\_

**RELATIONSHIPS AND SEX**

Do you have sex with: Men \_\_\_\_\_ Women \_\_\_\_\_

Do you identify as: Homosexual \_\_\_\_\_ Bisexual \_\_\_\_\_ Heterosexual \_\_\_\_\_

When you engage in sex do you:		When you engage in these sexual acts, do you use condoms or plastic protectors:			
		Always	Mostly	Sometimes	Never
Put someone's penis in your rectum?	<input type="radio"/> Yes <input type="radio"/> No				
Put someone's penis in your mouth?	<input type="radio"/> Yes <input type="radio"/> No				
Put your penis in someone's rectum?	<input type="radio"/> Yes <input type="radio"/> No				
Put your penis in someone's mouth?	<input type="radio"/> Yes <input type="radio"/> No				
Put your penis in someone's vagina?	<input type="radio"/> Yes <input type="radio"/> No				
Put your mouth on someone's rectum?	<input type="radio"/> Yes <input type="radio"/> No				
Put your mouth on someone's vagina?	<input type="radio"/> Yes <input type="radio"/> No				
Only engage in mutual masturbation?	<input type="radio"/> Yes <input type="radio"/> No				

Do you have a regular partner?  Yes  No

Do you live together?  Yes  No

How long \_\_\_\_\_

Do you have sex with other people?  Yes  No

Does your partner have sex with other people?  Yes  No

Has your partner tested negative for HIV?  Yes  No

How many people have you had sex with during the last year? \_\_\_\_\_

Are you aware that HIV can be transmitted by putting someone's penis in your mouth, even if they do not ejaculate?  Yes  No

Do you have any questions about safe sex?  Yes  No

**SAFETY**

Do you wear seat belts in the car?  Yes  No

Do you have a smoke detector in your home?  Yes  No

Do you have a fire extinguisher in your home?  Yes  No

Do you have health insurance?  Yes  No

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Do you have any inherited disorders (ex: hemophilia, sickle cell, thalassemia, sickle cell, Tay-Sachs diseases)?  Yes  No

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

Have you ever had a serious illness or accidents?  Yes  No

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

Have you ever had surgery?  Yes  No

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

Have you ever been hospitalized except for surgery?  Yes  No

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

Medications you are taking and why? \_\_\_\_\_

How much alcohol do you drink?

Not at all \_\_\_\_\_ once a week or less \_\_\_\_\_ 2-3 times/week \_\_\_\_\_ daily or almost \_\_\_\_\_

Which applies to your alcohol consumption: Please include comments

- when I drink it is usually one or two \_\_\_\_\_
- when I drink it is 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?  Yes  No

If yes, how much? \_\_\_\_\_

Do you use other recreational drugs?  Yes  No

If yes, what and how much? \_\_\_\_\_

Do you consider yourself an wet alcoholic or active drug abuser?  Yes  No

Are you in recovery from substance abuse?  Yes  No

If yes, what substances? \_\_\_\_\_

How long have you been clean and sober? \_\_\_\_\_

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## HEALTH SUMMARY

My general health status is:                     Excellent     Good     Fair     Poor  
I have tested negative for HIV:                 Yes             No            Date of last test \_\_\_\_\_

## CHECK ONLY IF YOU HAVE ANY OF THESE SYMPTOMS:

### General

- unexplained appetite changes
- unexplained weight loss
- fatigue
- fevers
- chills
- unexplained night sweats

### Skin

- rashes
- growths
- sun sensitivity
- itching
- change in texture, or pigment
- excessive dryness or sweating

### Head

- headaches

### Eyes

- double vision
- blurring
- spots
- floaters
- pain
- itching
- light sensitivity
- discharge

### Ears

- earaches
- ringing
- vertigo/room spinning

### Nose

- sinus problems
- bloody noses

### Mouth/Throat

- bleeding or sore gums
- sore throats
- hoarseness

### Neck

- pain
- stiffness
- swollen lymph nodes

### Cardiopulmonary

- chest pain
- shortness of breath
- sleeping on 2 or more pillows in order to breath comfortably
- cough
- coughing blood
- wheezing
- night sweats
- heart murmur
- swelling in ankles
- varicose veins
- heart palpitations
- fainting

### Gastrointestinal

- nausea
- vomiting
- constipation
- diarrhea
- blood in stool
- hemorrhoids
- jaundice

### Genitourinary

- pain or discomfort when urinating
- urinating frequently

### Musculoskeletal

- muscle pain
- cramps
- joint stiffness
- deformities
- back pain
- hand or feet discoloration or coldness

### Neuropsychiatric

- balance problems
- numbness
- paralysis
- tremor
- nervousness
- extreme depression
- hallucinations
- therapy
- suicidal thoughts
- severe anxiety

### Hematopoetic

- easy bruising
- bleeding

### Endocrine

- feeling too hot or too cold most of the time
- thirsty all the time
- hungry all the time

Allergies (including medications) \_\_\_\_\_

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**NAME:** \_\_\_\_\_

**CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING DISEASES OR CONDITIONS:**

- |   |   |  |
|---|---|--|
| <input type="radio"/> asthma                  | <input type="radio"/> heart attack                | <input type="radio"/> migraine headaches |
| <input type="radio"/> anemia                  | <input type="radio"/> heart malformation          | <input type="radio"/> rheumatic fever    |
| <input type="radio"/> arthritis               | <input type="radio"/> high cholesterol            | <input type="radio"/> tuberculosis       |
| <input type="radio"/> blood diseases          | <input type="radio"/> hypertension                | <input type="radio"/> ulcers             |
| <input type="radio"/> cancer                  | <input type="radio"/> liver disease               | <input type="radio"/> shingles           |
| <input type="radio"/> coronary artery disease | <input type="radio"/> polycystic kidney disease   | <input type="radio"/> blood transfusion  |
| <input type="radio"/> depression(chronic)     | <input type="radio"/> nervous or mental disorders | when _____                               |
| <input type="radio"/> diabetes                | <input type="radio"/> phlebitis/blood clots       | <input type="radio"/> syphilis           |
| <input type="radio"/> dyslexia                | <input type="radio"/> thyroid disease             | <input type="radio"/> gonorrhea          |
| <input type="radio"/> epilepsy                | <input type="radio"/> spina bifida                | <input type="radio"/> chlamydia          |
| <input type="radio"/> gall bladder problem    | <input type="radio"/> stroke                      | <input type="radio"/> genital herpes     |
| <input type="radio"/> glaucoma                | <input type="radio"/> head injury                 | <input type="radio"/> genital wart       |

**REVIEW OF SYSTEMS**

	WNL $\checkmark$	Comment if abnormal
General:		
Skin:		
Head:		
Eyes:		
Ears:		
Nose:		
Mouth/Throat:		
Cardio-pulmonary:		
Gastrointestinal:		
Genitourinary:		
Musculoskeletal:		
Neuropsychiatric:		
Hematopoetic:		
Endocrine:		
Diseases/Conditions		

\_\_\_\_\_  
**Signature (NP, PA or MD)**

\_\_\_\_\_  
**Print Name and Title**

\_\_\_\_\_  
**Date**

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**PHYSICAL EXAM**

HT \_\_\_\_\_ WT \_\_\_\_\_ P \_\_\_\_\_ RR \_\_\_\_\_ BP \_\_\_\_\_ DOB \_\_\_\_\_

	WNL <input type="checkbox"/>	Comment if abnormal
General:		
Skin:		
HEENT:		
Neck/Thyroid:		
Nodes:		
Breast:		
Chest:		
Cardio-vascular:		
Abdomen:		
Genitals:		
Musculoskeletal:		
Neurologic:		

\_\_\_\_\_  
**Signature (NP, PA or MD)**

\_\_\_\_\_  
**Print Name and Title**

\_\_\_\_\_  
**Date**

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All of the laboratory tests listed below **MUST** be completed without exception. Please have your health practitioner complete and sign this form. Return the completed form with lab documentation **NO LATER** than 7 days prior to your initial insemination/donation.

<b>CHECK LIST OF REQUIRED LAB TESTS</b>	<b>RESULTS (NP, PA or MD please fill in)</b>
<input type="radio"/> ABO and Rh	
<input type="radio"/> Comprehensive Metabolic Panel	
<input type="radio"/> CBC	
<input type="radio"/> Urinalysis	
<input type="radio"/> RPR	
<input type="radio"/> HBs Ag	
<input type="radio"/> HepC Ab	
<input type="radio"/> HTLV-1	
<input type="radio"/> HIV-1	
<input type="radio"/> HIV-2	
<input type="radio"/> CMV-IGM	
<input type="radio"/> CMV-IGG	
<input type="radio"/> GC	
<input type="radio"/> Chlamydia	
<input type="radio"/> Myco-ureaplasma	

All of the laboratory tests listed below are required only if you belong to the specified ethnic group.

<input type="radio"/> $\alpha$ -thalassemia HGB Elect (Southeastern Asians/Filipinos)	
<input type="radio"/> $\beta$ -thalassemia (Mediterranean populations)	
<input type="radio"/> Sickle cell disease (African-Americans)	
<input type="radio"/> Tay-Sachs (Jews)	

\_\_\_\_\_  
**Signature (NP, PA or MD)**\_\_\_\_\_  
**Print Name and Title**\_\_\_\_\_  
**Date****Address:** \_\_\_\_\_**Phone:** \_\_\_\_\_