

RECIPIENT PROFILE

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 _____

If you have a partner will she/he be the child's parent? Yes No

What is your partner's name? _____

Does your partner plan to adopt your child as the second parent? Yes No

If no, explain _____

Are you and your partner comfortable with Rainbow Flag Health Services' policy of informing you who the donor is when the child is 3 months old so that you may contact him before your child is one year old? Yes No

If no, explain _____

If you have a boy, do you plan to circumcise him? Yes No Unsure

If you have a girl, do you plan to circumcise her? Yes No Unsure

If unsure, would you like information about circumcision? Yes No

Do you have children who live with you? Yes No

How many _____ Ages _____

Do you plan to discuss bringing a baby into your home with the child(ren) who live there now?

Yes No

If your parents are alive, do they have grandchildren? Yes No

Will your parents want to welcome this child as their grandchild? Yes No

Will your partner's parents want to welcome this child as their grandchild?
 Yes No Unsure

Are you willing to recognize your partner's parents as grandparents if they wish to be so recognized? Yes No

Are you and your partner willing to recognize the donor's parents as grandparents if they wish to be so recognized? Yes No Unsure

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? _____

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- 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? _____
- 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? _____

REPRODUCTIVE HISTORY

- First day of last menstrual period? (date) _____
- Number of days between the first day of your period and the first day of your next period? _____
- Is you flow is: Heavy ___ Moderate ___ Light ___
- Do you usually have menstrual cramps? Yes No
If yes, are they: Mild ___ Moderate ___ Severe ___
- Do you usually have PMS? Yes No
If yes, what symptoms do you have? _____
- Current mode of contraception, if any _____
- Previous modes of contraception _____
- Have you ever had and I.U.D.? Yes No
If yes, when _____
- List the number and years of: Pregnancies _____
Live births _____
Miscarriages _____
Therapeutic abortions _____
- Any complications during past pregnancies? _____
- Do you know when you are ovulating? Yes No
- What symptoms do you have when you are ovulating? _____

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
- Will the child be covered by health insurance? Yes No
- My partner has health insurance? Yes No

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HEALTH SUMMARY

My general health status is: Excellent Good Fair Poor

CIRCLE 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

Breasts

- pain
- discharge
- lumps
- nipple retraction/ inversion
- dimpling

Gastrointestinal

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

Genitourinary

- pain or discomfort when urinating
- urinating frequently
- unusual vaginal bleeding or discharge
- PID

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

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

REVIEW OF SYSTEMS

	WNL <input type="checkbox"/>	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)

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CHECK LIST OF REQUIRED LAB TESTS	RESULTS (NP, PA or MD please fill in)
<input type="radio"/> ABO and Rh	
<input type="radio"/> Comprehensive Metabolic Panel (lytes, LFT's, Chol, Bun/Cr)	
<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"/> Rubella Titer	
<input type="radio"/> Toxoplasmosis antibody (suggested)	
<input type="radio"/> PAP smear	
<input type="radio"/> GC	
<input type="radio"/> Chlamydia	
<input type="radio"/> Myco-ureaplasma – vaginal culture	
<input type="radio"/> α -thalassemia HGB Elect (Southeastern Asians/Filipinos)	
<input type="radio"/> β -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