

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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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.

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	
<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"/> 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

Address: _____

Phone: _____