

IDANT Laboratory, 350 5th Avenue, Suite 7120, New York, NY 10118
IDANT SEMEN BANK POTENTIAL DONOR QUESTIONNAIRE

Date	
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Biographical Information

Please print all answers legibly.

Year of Birth	Place of Birth:		
Marital Status:	Children:	Proven Fertility	
Single Married Divorced Widowed			
Religion (if any):			

Physical Characteristics

Height:	Weight:	Body Build:			
		Small	Medium	Large	Very Large
Eye Color:					
Blue	Blue/Hazel	Green	Green/Hazel	Light Brown	Dark Brown Black
Skin Tone:					
Fair	Medium	Olive	Light Brown	Medium Brown	Dark Brown
Hair Color:					
Black	DkBrown	MedBrown	LtBrown	DkBlonde	MedBlonde LtBlonde Auburn DkRed LtRed Strawberry Blonde
Hair Type:		Hair Condition:			
Straight	Wavy	Curly	Thick	Fine	Coarse Thinning Moderate Balding Extensive Balding None
Vision:			Hearing:		
Excellent	Good	Fair	Poor	Excellent	Good Fair Poor
Dimples:		Freckles:		Cleft Chin:	
Yes	No	Yes	No	Yes	No
*Racial Group:		Maternal Ancestry		Paternal Ancestry	
				Blood Type:	
*If Jewish, <input type="checkbox"/> Ashkenazi <input type="checkbox"/> Sephardic <input type="checkbox"/> Oriental					

Educational Background

Occupation:			
Name of High School:	Year Graduated:	GPA:	SAT Scores:
Name of College	Year Graduated:	GPA:	Major:
Graduate School:	Year Graduated	GPA:	Major:
Professional School:	Year Graduated:	GPA:	Major
Degrees Attained:			
M.A.	M.S.	Ph.D.	M.D. J.D. D.D.S. Other:

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SKILLS AND PREFERENCES:

SKILLS: (low, below average, average, above average, high) Please elaborate on/give examples of the skills you rate as above average and high.

Artistic Skills:
Language Skills:
Mechanical Skills:
Athletic Skills:
Math Skills:
Music Skills:
Comments:

PREFERENCES: (like, dislike, no opinion) Please elaborate on/give examples of the preferences you like.

Reading:
School:
Sports:
Music:
Pets:
Interests / Hobbies:
Comments:

PERSONALITY TRAITS: (check appropriate boxes)

<input type="checkbox"/> EXTROVERT	<input type="checkbox"/> INTROVERT	<input type="checkbox"/> PASSIVE	<input type="checkbox"/> SUBMISSIVE
<input type="checkbox"/> ENTHUSIASTIC	<input type="checkbox"/> PESSIMISTIC	<input type="checkbox"/> THOUGHTFUL	<input type="checkbox"/> ENERGETIC
<input type="checkbox"/> INTENSE	<input type="checkbox"/> TEMPERAMENTAL	<input type="checkbox"/> MOODY	<input type="checkbox"/> FRIENDLY
<input type="checkbox"/> CARING	<input type="checkbox"/> KIND	<input type="checkbox"/> HUMOROUS	<input type="checkbox"/> INTELLIGENT
<input type="checkbox"/> ADVENTUROUS	<input type="checkbox"/> OUT-GOING	<input type="checkbox"/> EASY-GOING	<input type="checkbox"/> EGOTISTIC
<input type="checkbox"/> CREATIVE	<input type="checkbox"/> PERFECTIONIST		
Comments:			

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WHAT ARE YOUR FAVORITE FOODS?

WHAT PART OF THE WORLD WOULD YOU LIKE TO VISIT AND WHY?

WHAT IS YOUR GOAL IN LIFE? HOW DO YOU SEE YOURSELF IN 20 YEARS?

WHY DO YOU WANT TO BE A DONOR?

IF WE COULD PASS ON A MESSAGE TO THE RECIPIENT(S) OF YOUR SEMEN, WHAT WOULD THAT MESSAGE BE?

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Donor Medical History & Behavioral Risk Assessment Questionnaire (adopted from the American Association of Tissue Banks)

**The interviewee should be instructed to answer all questions, "to the best of your knowledge". The interviewer should comment and elaborate on all questions answered "yes".*

1. Has the potential donor been seen by a physician, or been hospitalized in the past two years? What physician, hospital, psychiatric, or long term care facility?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Has the potential donor had any serious illnesses or surgical procedures performed in the past?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Did the potential donor take any medications either on a regular basis or recently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Did/does the potential donor use tobacco products? Cigarettes? Packs per day? For how long? Other tobacco products?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. In the past three years has the potential donor traveled outside of the United States (except Canada)? Describe. Taken anti-malarial drug? Had malaria?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Did/does the potential donor suffer from any type of liver disease? Any history of yellow jaundice? Been told he had any type of hepatitis? Had a positive test for hepatitis? Any close contact with persons diagnosed with viral hepatitis? Was this contact in the past 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Has the potential donor ever received blood transfusions or blood products? What type? What amount? When?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Was the potential donor ever refused as a blood donor or told not to donate? Why?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Did the potential donor ever receive an organ or tissue transplant, e.g., bone, cornea, skin, heart, kidney, dura mater?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. In the past 12 months did the potential donor get a tattoo, ear/body piercing, acupuncture, or accidental needle stick? Where, by whom, how?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11. In the past 12 months, was the potential donor vaccinated or immunized for any reason? Was the potential donor vaccinated for hepatitis B? Was the potential donor vaccinated for smallpox or have close physical contact with a recipient of the smallpox vaccine?	<input type="checkbox"/> Yes If yes please indicate why	<input type="checkbox"/> No
12. Was the potential donor ever given human pituitary derived growth hormone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

USPHS Current Criteria for High Risk Behavior for HIV & Hepatitis

<p>13. In the past 12 months has the potential donor had or been treated for any sexually transmitted disease such as syphilis or gonorrhea, herpes, chlamydia, trichomonas, or venereal warts?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>14. Has the potential donor recently exhibited unexplained weakness, fatigue or flu-like symptoms such as cough, cold, shortness of breath, swollen lymph nodes, nausea, vomiting, persistent diarrhea, night sweats or fever > 100.5°F? Demonstrated blue or purple spots on the skin or mucous membranes? Experienced significant weight loss?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>15. Has the potential donor ever had a positive test for HIV or been diagnosed with HIV?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>16. Has the potential donor had sex with another male in the past 5 years?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>17. In the past 5 years has the potential donor used a needle to inject drugs into his veins, muscle, or under his skin for non-medical use?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>18. Has the potential donor engaged in sex in exchange for money or drugs in the past 5 years?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>19. Has the potential donor received human-derived clotting factor concentrates for hemophilia or related clotting disorders?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>20. Has the potential donor ever been exposed to known or suspected viral hepatitis or HIV-infected blood through an accidental needle stick or through contact with an open wound, non-intact skin, or mucous membrane in the past 12 months?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>21. Was the potential donor ever an inmate in a correctional system or jail, or has been released from a correctional system or jail in the past 12 months? (Was the potential donor confined for more than three consecutive days in a penal institution in the past 12 months?)</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>22. Has the potential donor had sex in the past 12 months with any person known or suspected to have viral hepatitis or HIV infection, or any person described in above questions #16-21?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>23. Has the potential donor been bitten by an animal suspected of rabies within the preceding six months.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>24. Has the potential donor been diagnosed with encephalitis or meningitis that is active? Does the potential donor have symptoms of the conditions above that have not been resolved for at least 28 days prior to donation?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

ADDITIONAL COMMENTS: (please refer to question numbers where applicable)

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DONOR / FAMILY / GENETIC HISTORY

The following medical conditions apply to you and your **BLOOD RELATIVES ONLY** (grandparents, parents, aunts, uncles, cousins, brothers, sisters, yourself, and any of your own children). Do not guess at any answer. If you are unsure of the definition of a condition or its existence in your family, leave the space blank.

Do any of the following medical conditions exist in you or any of your blood relatives? If so, tell which relative, and the age of onset.

D=Donor **M**=Mother **F**=Father **B**=Brother **S**=Sister **O**=Offspring
A=Aunt **U**=Uncle **C**=First Cousin **MGM**=Maternal Grandmother
MGF=Maternal Grandfather **PGM**=Paternal Grandmother **PGF**=Paternal Grandfather

	Yes	No	Which Relative?	Comments
Alcoholism				
Allergies				
Drug (specify)				
Food (specify)				
Hay Fever				
Insect				
Arthritis				
Gout				
Osteoarthritis				
Rheumatoid				
Joint Disease				
Connective tissue disease				
Autism				
Auto-immune Disease				
CREST Syndrome				
Lupus				
Scleroderma				
Sjorgen's Syndrome				
Blood Disease				
Anemia				
Hemophilia				
Hemochromatosis				
Sickle-cell				
Cancer or tumor				
Colon				
Hodgkin's				
Leukemia				
Lung				
Lymphoma				
Skin				
Congenital Hip Disease				
Cystic Fibrosis				
Deafness				
Diabetes, requiring insulin				
Diabetes, not requiring insulin				
Down Syndrome				
Drug Abuse				
Dyslexia				
Exposure to:				
Radiation				
Toxic chemicals				

IDANT SEMEN BANK POTENTIAL DONOR QUESTIONNAIRE**DONOR / FAMILY / GENETIC HISTORY (continued)**

Eye Deficiencies	Yes	No	Which Relative?	Comments
Blindness				
Color Blindness				
Cataracts				
Glaucoma				
Retinoblastoma				
Gastro-Intestinal Disorders				
Ulcers				
Ulcerative Colitis				
Crohns				
Diverticulitis				
Pyloric Stenosis				
Intestinal Surgery				
Heart Disorders				
Heart Attack				
Heart Disease (Congenital or otherwise)				
Hypertension				
Hypoglycemia				
Kidney Disorders				
Polycystic Kidney Disease				
Progressive Kidney Disease				
Kidney Stones				
Lesch-Nyhan Syndrome				
Loss of Muscle Coordination				
Leg Ulcers				
Lung Disease				
Asthma				
Emphysema				
Any lung disease				
Tuberculosis				
Malformation				
Cleft Palate				
Cleft Lip				
Club foot				
Polydactyl				
Hypospadias				
Mental Illness				
Depression				
Manic Depressive Psychosis (bipolar disorder)				
Mental Retardation				
Muscular Dystrophy				
Premature Senility				
Schizophrenia				
Neurological Disease – Degenerative or Infectious				
Alzheimer's				
Creutzfeld-Jacob Disease				
Epilepsy				
Guillain-Barre				
Huntington				

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Neurological Disease - continued	Yes	No	Which Relative?	Comments
JC Virus				
Lou Gehrig's Disease				
Multiple Sclerosis				
Parkinson's Disease				
Subacute sclerosing Panencephalitis				
Neurofibromatosis				
Neural Tube Defect				
PKU, or inherited metabolic disorder				
Sickle Cell				
Stroke				
Sudden Infant Death Syndrome (SIDS)				
Skin Disease				
Eczema				
Dermatitis				
Inflammatory skin disease or abrasions				
Tay-Sachs				
Thalassemia				
Thyroid Disorders				
Tuberculosis				
Have you or any blood relative ever had any other disease, illness, or condition not mentioned above?	If so, please explain.			
Do you know of any medical or genetic condition that runs in your family?	If so, please explain.			
Has there been any incident of early death (prior to age 55) of any relative?	If so, which relative, and what was the cause of death?			
Have you or your sexual partner been diagnosed or suspect exposure with any of the following sexually transmitted diseases below:				
STD	Yes	No	If yes, when?	Treatment Ended
Chlamydia				
CMV				
Genital Warts				
Gonorrhea				
Hepatitis				
HIV / AIDS				
Herpes				
Syphilis				
Trichomonas				
Have you had periods of unexplained:	Yes	No		
Weight Loss				
Shortness of breath				
Enlarged lymph nodes				
Dark colored urine				
Diarrhea				
Pale stool				
Night sweats				

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DONOR / FAMILY / GENETIC HISTORY (continued)

Malaise		
Persistent cough		
Low grade fever		
Nausea		
Loss of appetite		
Purplish-blue spots on skin or mucus membranes		
Skin rash		
Chest pain		

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Information on Family Members

If any family member is deceased, please indicate cause, in addition to the age at death. **Hair type:** straight, curly, wavy; **Hair condition:** thin, thick, average, balding; **Complexion:** fair, medium, olive, dark
Health Status: good, fair, poor.

Mother

Age:	Health Status:	Height:	Weight:	Body Type:
Hair Color:	Hair Type:	Hair Condition:	Eye Color:	Complexion:
Race:	Ethnicity	Education	Profession	
If deceased, her age at death?		Cause of death?		

Aunts and Uncles (your mother's side) If living, health status: good, fair, poor

Sex	Age	If deceased, cause of death	Health Status
Are there any incidents of stillbirth or miscarriage in any female member of this side of the family or in the wives or partners of any male member on this side of the family?		If so, who had them, how many, and at what point in the pregnancy did they occur?	
Are your cousins in good health?		If not, why?	

Father

Age:	Health Status:	Height:	Weight:	Body Type:
Hair Color:	Hair Type:	Hair Condition:	Eye Color:	Complexion:
Race:	Ethnicity	Education	Profession	
If deceased, his age at death?		Cause of death?		

Aunts and Uncles (your father's side) If living, health status: good, fair, poor

Sex	Age	If deceased, cause of death	Health Status
Are there any incidents of stillbirth or miscarriage in any female member of this side of the family or in the wives or partners of any male member on this side of the family?		If so, who had them, how many, and at what point in the pregnancy did they occur?	
Are your cousins in good health?		If not, why?	

IDANT SEMEN BANK POTENTIAL DONOR QUESTIONNAIRE**Information on Family Members (continued)****Brothers**

Age:	Health Status:	Height:	Weight:	Body Type:
Hair Color:	Hair Type:	Hair Condition:	Eye Color:	Complexion:
Race:	Ethnicity	Education	Profession	
If deceased, his age at death?		Cause of death?		

Age:	Health Status:	Height:	Weight:	Body Type:
Hair Color:	Hair Type:	Hair Condition:	Eye Color:	Complexion:
Race:	Ethnicity	Education	Profession	
If deceased, his age at death?		Cause of death?		

Age:	Health Status:	Height:	Weight:	Body Type:
Hair Color:	Hair Type:	Hair Condition:	Eye Color:	Complexion:
Race:	Ethnicity	Education	Profession	
If deceased, his age at death?		Cause of death?		

Sisters

Age:	Health Status:	Height:	Weight:	Body Type:
Hair Color:	Hair Type:	Hair Condition:	Eye Color:	Complexion:
Race:	Ethnicity	Education	Profession	
If deceased, her age at death?		Cause of death?		

Age:	Health Status:	Height:	Weight:	Body Type:
Hair Color:	Hair Type:	Hair Condition:	Eye Color:	Complexion:
Race:	Ethnicity	Education	Profession	
If deceased, her age at death?		Cause of death?		

Age:	Health Status:	Height:	Weight:	Body Type:
Hair Color:	Hair Type:	Hair Condition:	Eye Color:	Complexion:
Race:	Ethnicity	Education	Profession	
If deceased, her age at death?		Cause of death?		

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Information on Family Members (continued)

Maternal Grandfather

Age:	Health Status:	Height:	Weight:	Body Type:
Hair Color:	Hair Type:	Hair Condition:	Eye Color:	Complexion:
Race:	Ethnicity	Education	Profession	
If deceased, his age at death?		Cause of death?		

Maternal Grandmother

Age:	Health Status:	Height:	Weight:	Body Type:
Hair Color:	Hair Type:	Hair Condition:	Eye Color:	Complexion:
Race:	Ethnicity	Education	Profession	
If deceased, her age at death?		Cause of death?		

Paternal Grandfather

Age:	Health Status:	Height:	Weight:	Body Type:
Hair Color:	Hair Type:	Hair Condition:	Eye Color:	Complexion:
Race:	Ethnicity	Education	Profession	
If deceased, his age at death?		Cause of death?		

Paternal Grandmother

Age:	Health Status:	Height:	Weight:	Body Type:
Hair Color:	Hair Type:	Hair Condition:	Eye Color:	Complexion:
Race:	Ethnicity	Education	Profession	
If deceased, her age at death?		Cause of death?		

Children

Age:	Health Status:	Height:	Weight:	Body Type:
Hair Color:	Hair Type:	Hair Condition:	Eye Color:	Complexion:
Race:		Ethnicity:		
If deceased, age at death?		Cause of death?		

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Information on Family Members (continued)

Children

Age:	Health Status:	Height:	Weight:	Body Type:
Hair Color:	Hair Type:	Hair Condition:	Eye Color:	Complexion:
Race:		Ethnicity:		
If deceased, age at death?		Cause of death?		

Children

Age:	Health Status:	Height:	Weight:	Body Type:
Hair Color:	Hair Type:	Hair Condition:	Eye Color:	Complexion:
Race:		Ethnicity:		
If deceased, age at death?		Cause of death?		

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SEXUAL ACTIVITY HISTORY

Artificial insemination is a process that involves the placement of semen into a woman's body. Semen has been identified as one of many types of bodily fluids capable of directly transmitting infection. Infection can be spread through the insemination process. The nature of your sexual practices can influence your chances of acquiring an infection and of transmitting it through your semen. In order to provide safe and effective care for our recipients, we need to know about your sexual activity. **This information is strictly confidential.** Thank you for your cooperation.

<p>1. Please indicate with whom you have had sexual contact since 1977:</p> <p>WOMEN only MEN only BOTH</p>	<p>2. Do you currently have more than one sexual partner? If yes, how many?</p>
<p>3. How many sexual partners have you had in the last six months?</p>	<p>4. Do you currently have casual sexual contact with persons you do not know? If yes, how frequently?</p>
<p>5. Have you ever had casual sexual contact with persons you did not know or did not know well? If yes, please explain.</p>	<p>6. Have any of your sexual partners identified themselves as gay or bisexual?</p>
<p>7. Please indicate your sexual preference(s): vaginal insertive ejaculation oral insertive ejaculation anal insertive ejaculation</p>	<p>8. Do your sexual practices include the exchange of body fluids or substances other than semen and saliva (i.e. urine, feces, etc.)? If yes, please explain.</p>
<p>9. Have any of your partners had symptoms of or were diagnosed as having vaginal infections or recurring gynecological problems, such as trichomonas, chlamydia, bladder infection, herpes, PID, etc.?</p>	<p>10. What type of birth control do you and your partner(s) use?</p>
<p>11. Since 1977, have you had sexual contact with anyone in the high risk group for AIDS? (These include prostitutes, intravenous drug users, recipients of blood products/transfusions, and sexually active gay or bi-sexual men.) If yes, please elaborate.</p>	<p>12. To your knowledge, have any of your sexual partners, since 1977, been sexually active with anyone in the high risk groups for AIDS? If yes, please explain.</p>
<p>13. Is there any additional information you would like to share regarding your sexual practices (use back of sheet if necessary)</p>	

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