

DONOR PROFILE

PHYSICAL CHARACTERISTICS:

DONOR CODE #159

Birth year 1969 Height 5'9" Weight 145 Eye Color Brown
Hair Color Black Hair Type Straight Complexion Fair Body Type Small
Racial Group Caucasian Ethnic Origin Poland Ireland Religion at Birth Christian

ANCESTRAL ORIGIN: Father Poland/Ireland Mother Caucasian(European)

Paternal Grandfather Poland/Ireland Maternal Grandfather Caucasian(European)

Paternal Grandmother Poland/Ireland Maternal Grandmother Caucasian(European)

EDUCATIONAL HISTORY: Years Completed Date of Graduation Average Grade

High School 12 1987 B

College 2 - C

Graduate School N/A N/A N/A

Professional N/A N/A N/A

Major Study Psychology

Minor Study N/A

Occupation Student/Part-Time Clerk/Self-Employed

Special Skills, Talents, or Training Computer (word processing), Sports

Interests Sports, nature, reading, collecting comics

(FOR LABORATORY PERSONNEL ONLY)

General Comments Quiet, pleasant, entrepreneur

Tests to be performed on Donor Applicant:

Panel # 8100 & 8200

Circle if applicable: TAY-SACHS SICKLE CELL OTHER (Specify) N/A

FAMILY PHYSICAL CHARACTERISTICS:

DONOR CODE #159

How many natural brothers ? 1 How many natural sisters ? 0

EYE COLOR: PGF Blue PGM MGF Brown MGM
Father Blue Mother Brown

Brother(s) Blue Sister(s) N/A

NATURAL HAIR COLOR: (Please be specific - I.E. dark brown, light brown)

PGF Black PGM MGF Black MGM
Father Black Mother Black

Brother(s) Brownish/Black Sister(s) N/A

HEIGHT: Father Mother Brother(s) Sister(s)

FAMILY MEDICAL HISTORY:

Relation	Birth Year	Health	If deceased, cause of death	Age at death
Mother	<u>1948</u>	<u>good</u>	<u>N/A</u>	<u> </u>
Father	<u>1945</u>	<u>good</u>	<u>N/A</u>	<u> </u>
Children**	<u>N/A</u>	<u> </u>	<u> </u>	<u> </u>

(**Applies to donor applicant: I.E. 3G=3 year old girl)

Please circle one: Single Married

On each item listed below, if there is history of the condition, please indicate for each relationship:

- D=Donor
- C=Children
- F=Father
- A=Aunt
- MGF=Maternal Grandfather
- MGM=Maternal Grandmother
- PGF=Paternal Grandfather
- PGM=Paternal Grandmother
- M=Mother
- S=Sister
- B=Brother
- U=Uncle

Hay Fever N/A Circulatory/Cardiac Disease N/A

Asthma N/A Blood Disease N/A

Allergies D Epilepsy N/A

Eye Disorders N/A Mental Disorders N/A

Diabetes N/A Alcohol Abuse U-died in accident

Gout N/A Drug Abuse N/A

Albinism N/A Chemical Exposure N/A

Other N/A Radiation Exposure N/A

Previous exclusion from blood donations for reasons of infectious disease N/A

Receipt of blood transfusion within the past year N/A

Bear in mind that nobody is perfect. Write in any relevant details

1) Indicate which of the following you have had.

Yes No

Yes	No	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Psoriasis
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Dupuytren contracture, bands, nodules, or knucklepads
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Peptic (duodenal or gastric) ulcer
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Hot temper
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Drinking problem
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Psychiatric treatment
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Hallucinations
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Fainting or dizziness
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Spells of unreasonable anxiety
<input checked="" type="checkbox"/>	<input type="checkbox"/>	At times couldn't do anything because of emotional stress
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Headache, severe or disabling
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Homosexual experience since 1977
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Color blindness
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Cataract
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Glaucoma
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Strabismus
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Sight deficiency not correctable with glasses
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Hearing loss
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted disease: _____
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Periodontal disease
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Impacted wisdom tooth/teeth
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Orthodontal treatment or serious dental malocclusion
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Tremor or chorea
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Parkinson disease
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Stuttering
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Tic (habit spasm)
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Haemorrhoids
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Varicose veins of the scrotum
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Cardiovascular disease before age 55
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Diabetes; age of onset: _____ years
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Ankylosing spondylitis
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Gout, kidney stones, or hyperuricaemia
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Heberden nodes
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis; SCAT titre: 1/_____
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Back or neck pain, frequent or requiring treatment
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Sciatica, other nerve root compression, or deficient knee
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Irradiation, therapeutic or accidental
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Bruise easily

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<input checked="" type="checkbox"/>	Asthma
<input checked="" type="checkbox"/>	Eczema
<input checked="" type="checkbox"/>	Hay fever
<input checked="" type="checkbox"/>	Polycystic kidneys
<input checked="" type="checkbox"/>	Hernia, indirect inguinal
<input checked="" type="checkbox"/>	Congenital hip dislocation
<input checked="" type="checkbox"/>	Club foot (talipes equinovarus)
<input checked="" type="checkbox"/>	Cleft lip and/or palate

2) Ancestry: Poland/Ireland

3) Year of birth: 1969

4) Did you wear glasses before age 40?

Yes, present correction: 40/40
 No

5) Height: 5'9"

6) Describe any deformity of bones, joints, hands, feet, spine, mouth, or other features.

None

7) Give details of any psychosis or other mental disorder that has ever been diagnosed in yourself or one of your parents, sibs, or offspring.

None

8) List all surgical operations and any serious illnesses you have ever had.

None

9) Have you any disorder or abnormality not covered above which might be hereditary or which you share with one of your kin?

None

10) What drugs have you taken in the past 12 months? None

11) How many sexual partners have you had in the past 6 months? 0

12) Describe the health and give the age now or at death for each of your parents, sibs and offspring, and state any of their significant intellectual, artistic or academic achievements. Include any perinatal deaths, any history of cardiovascular disease before age 55, diabetes, hearing loss before age 70, surgical operations, serious illnesses, cataracts, Parkinson disease, Dupuytren disease and cause of death.