

DONOR PROFILE

PHYSICAL CHARACTERISTICS:

DONOR CODE #190

Birth year 1971 Height 5'11" Weight 135Lbs Eye Color Hazel
Hair Color L. Brown Hair Type Straight Complexion Fair Body Type Slim
German
Racial Group Caucasian Ethnic Origin European Religion at Birth Christian

ANCESTRAL ORIGIN: Father German/European Mother European

Paternal Grandfather European/American Maternal Grandfather European/American

Paternal Grandmother European/American Maternal Grandmother European/American

EDUCATIONAL HISTORY: Years Completed Date of Graduation Average Grade

High School 12 1989 3.0

College 1(still attends) B-C

Graduate School N/A N/A N/A

Professional N/A N/A N/A

Major Study Business Administration

Minor Study N/A

Occupation Student/Marketing Representative

Special skills, talents, or Training Automotive skills, marketing training,
mechanically inclined

Interests Water and snow skiing, drag racing

(FOR LABORATORY PERSONNEL ONLY)

General Comments Straight forward, articulate, polite, pleasant, slim, long face, clean
distinguish looking

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 #190

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

PGF _____ PGM _____ MGF _____ MGM _____

EYE COLOR: Father Blue Mother BrownBrother(s) N/A Sister(s) N/A

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

PGF _____ PGM _____ MGF _____ MGM _____

Father Light Brown Mother Dark BrownBrother(s) N/A Sister(s) N/AHEIGHT: Father 5'11" Mother 5'1" Brother(s) N/A Sister(s) N/A

FAMILY MEDICAL HISTORY:

Relation	Birth Year	Health	If deceased, cause of death	Age at death
Mother	1945	excellent		
Father	1945	excellent		
Children**	N/A			

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

Hay Fever N/A Circulatory/Cardiac Disease N/AAsthma MGM Blood Disease N/AAllergies N/A Epilepsy N/AEye Disorders N/A Mental Disorders N/ADiabetes N/A Alcohol Abuse N/AGout N/A Drug Abuse N/AAlbinism N/A Chemical Exposure N/AOther N/A Radiation Exposure N/APrevious exclusion from blood donations for reasons of infectious disease NoReceipt of blood transfusion within the past year NoAny known episodes of trichomoniasis in a sexual partner No

#190

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

1) Indicate which of the following you have had.

Yes No

<input checked="" type="checkbox"/>	XX	Psoriasis
<input checked="" type="checkbox"/>	XX	Dupuytren contracture, bands, nodules, or knucklepads
<input checked="" type="checkbox"/>	XX	Peptic (duodenal or gastric) ulcer
<input checked="" type="checkbox"/>	XX	Hot temper
<input checked="" type="checkbox"/>	XX	Drinking problem
<input checked="" type="checkbox"/>	XX	Psychiatric treatment
<input checked="" type="checkbox"/>	XX	Epilepsy
<input checked="" type="checkbox"/>	XX	Hallucinations
<input checked="" type="checkbox"/>	XX	Fainting or dizziness
<input checked="" type="checkbox"/>	XX	Spells of unreasonable anxiety
<input checked="" type="checkbox"/>	XX	At times couldn't do anything because of emotional stress
<input checked="" type="checkbox"/>	XX	Headache, severe or disabling
<input checked="" type="checkbox"/>	XX	Homosexual experience since 1977
<input checked="" type="checkbox"/>	XX	Color blindness
<input checked="" type="checkbox"/>	XX	Cataract
<input checked="" type="checkbox"/>	XX	Glaucoma
<input checked="" type="checkbox"/>	XX	Strabismus
<input checked="" type="checkbox"/>	XX	Sight deficiency not correctable with glasses
<input checked="" type="checkbox"/>	XX	Hearing loss
<input checked="" type="checkbox"/>	XX	Sexually transmitted disease: _____
<input checked="" type="checkbox"/>	XX	Hepatitis
<input checked="" type="checkbox"/>	XX	Periodontal disease
<input checked="" type="checkbox"/>	XX	Impacted wisdom tooth/teeth
<input checked="" type="checkbox"/>	XX	Orthodontal treatment or serious dental malocclusion
<input checked="" type="checkbox"/>	XX	Tremor or chorea
<input checked="" type="checkbox"/>	XX	Parkinson disease
<input checked="" type="checkbox"/>	XX	Stuttering
<input checked="" type="checkbox"/>	XX	Tic (habit spasm)
<input checked="" type="checkbox"/>	XX	Haemorrhoids
<input checked="" type="checkbox"/>	XX	Varicose veins of the scrotum
<input checked="" type="checkbox"/>	XX	Cardiovascular disease before age 55
<input checked="" type="checkbox"/>	XX	Diabetes; age of onset: _____ years
<input checked="" type="checkbox"/>	XX	Ankylosing spondylitis
<input checked="" type="checkbox"/>	XX	Gout, kidney stones, or hyperuricaemia
<input checked="" type="checkbox"/>	XX	Heberden nodes
<input checked="" type="checkbox"/>	XX	Rheumatoid arthritis; SCAT titre: 1/_____
<input checked="" type="checkbox"/>	XX	Back or neck pain, frequent or requiring treatment
<input checked="" type="checkbox"/>	XX	Sciatica, other nerve root compression, or deficient knee reflex
<input checked="" type="checkbox"/>	XX	Irradiation, therapeutic or accidental
<input checked="" type="checkbox"/>	XX	Bruise easily

#190

<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: Germany/European

3) Year of birth: 19 71

4) Did you wear glasses before age 40?

Yes, present correction: _____
 No

5) Height: 5'11"

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? One

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.

(SEE ATTACHED SHEET FOR INFORMATION - PAGE 8)

#190

FAMILY HEALTH HISTORY (INTERVIEWER'S COMMENTS ONLY)

Relationship	If deceased, age at death	Cause of Death	Level of Education	Occupation	Health
Father Age: 44	N/A	N/A	B.A. (Business)	Automotive Shop Owner	good
Mother Age: 44	N/A	N/A	1 year college	Housewife	good
Grandfather (Father's side) Age: 60's	N/A	N/A	?	Window Cleaning Business	good
Grandmother (Father's side) Age: 60's	N/A	N/A	?	Department Store Clerk	good
Grandfather (Mother's side) Age: 70's	N/A	N/A	?	Auto Shop Owner	good
Grandmother (Mother's side) Age: 60's	N/A	N/A	?	Housewife	(asthma) fair
Brother 1 Age:	N/A	N/A	N/A	N/A	N/A
Brother 2 Age:	N/A	N/A	N/A	N/A	N/A
Sister 1 Age:	N/A	N/A	N/A	N/A	N/A
Sister 2 Age:	N/A	N/A	N/A	N/A	N/A

 COMMENTS: _____

