

**ZyGen Laboratory**  
• ZYGOTE GENERATING PRODUCTS •

16742 Stagg St., Suite 105, Van Nuys, CA 914  
(818) 988-2500 • (818) 344-7777 • (800) 255-7242 • FAX (818) 988-27

DONOR PROFILE

PHYSICAL CHARACTERISTICS:

DONOR CODE #227

Birth year 1967 Height 5'10" Weight 150 Eye Color Brown  
Hair Color Brown Hair Type Sl. curly Complexion Medium Body Type Medium  
Racial Group Caucasian Ethnic Origin America Religion at Birth Dad-Christian  
German Mom-Jewish

ANCESTRAL ORIGIN: Father America Mother German

Paternal Grandfather America Maternal Grandfather German

Paternal Grandmother America Maternal Grandmother German

EDUCATIONAL HISTORY: Years Completed Date of Graduation Average Grade

High School 12 1987 C

College N/A N/A N/A

Graduate School N/A N/A N/A

Professional 2 1990 B

Major Study Broadcasting

Minor Study N/A

Occupation Radio Announcer (full time)

Special Skills, Talents, or Training Radio and television broadcasting, complete  
knowledge of studio equipment at radio station

Interests Photography, computers, and music.

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(FOR LABORATORY PERSONNEL ONLY)

General Comments Soft spoken, pleasant, cool, atheletic built, long hair, nice smile,  
straight teeth.

Tests to be performed on Donor Applicant:

Panel # 8100, 8200

Circle if applicable: TAY-SACHS SICKLE CELL OTHER (Specify) Negative

FAMILY PHYSICAL CHARACTERISTICS:

DONOR CODE #227

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

EYE COLOR: Father Brown Mother Brown  
 Brother(s) N/A Sister(s) Brown

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

Father Light Brown Mother Black  
 Brother(s) N/A Sister(s) light Brown

HEIGHT: Father 6'0" Mother 5'9" Brother(s) N/A Sister(s) 5'5"

FAMILY MEDICAL HISTORY:

Relation	Birth Year	Health	If deceased, cause of death	Age at death
Mother	<u>1948</u>	<u>good</u>		
Father	<u>1940</u>	<u>good</u>		
Children**	<u>N/A</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                      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/A  
 Asthma N/A                          Blood Disease N/A  
 Allergies N/A                          Epilepsy N/A  
 Eye Disorders N/A                      Mental Disorders N/A  
 Diabetes N/A                          Alcohol Abuse N/A  
 Gout N/A                                  Drug Abuse N/A  
 Albinism N/A                          Chemical Exposure N/A  
 Other E-had back from playing golf      Radiation Exposure N/A  
 Previous exclusion from blood donations for reasons of infectious disease No  
 Receipt of blood transfusion within the past year No  
 Any known episodes of trichomoniasis in a sexual partner No

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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
<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

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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: America & German

3) Year of birth: 19 67

4) Did you wear glasses before age 40?

Yes, present correction: \_\_\_\_\_

No

5) Height: 5'10"

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)

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FAMILY HEALTH HISTORY (INTERVIEWER'S COMMENTS ONLY)

Relationship	If deceased, age at death	Cause of Death	Level of Education	Occupation	Health
Father	N/A	N/A	College	Realtor	good
Mother	N/A	N/A	College	Registered Nurse	good
Grandfather (Father's side)	Late 70s	Natural	?	?	-
Grandmother (Father's side)	N/A	N/A	?	?	-
Grandfather (Mother's side)	80s	?	?	?	-
Grandmother (Mother's side)	Late 60s	Natural	?	?	-
Brother 1	N/A	N/A	N/A	N/A	N/A
Brother 2	N/A	N/A	N/A	N/A	N/A
Sister 1	N/A	N/A	Still in H.S.	Student	good
Sister 2	N/A	N/A	N/A	N/A	N/A

COMMENTS: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_