EMBRYO DONOR FAMILY INFORMATION

Please type or use black ink for the information on this sheet so the adoptive family may have some insight into the background of the child that may result from your frozen embryos. Please DO NOT list any identifying information such as a name.

HUSBAND

PHYSICAL CHARACTERISTICS:
Height: Weight:
Race (Circle all that apply): Caucasian, Black, American Indian, Asian, Hispanic, Other:_____
Family Ethnicity (Circle all that apply): English, Irish, Italian, Greek, Spanish, Swedish, German, Chinese, Japanese, Other: _____

_____
Drug Allergies: _____
Are You a Twin?: Yes: ___ (identical, fraternal) No:_____
Hands: Right Handed, Left Handed, Ambidextrous
Hair (circle most appropriate from each line):
Color at Birth: Blonde, Brown, Black, Red, other: _____
Present Color: Blonde, Brown, Black, Red, other: _____
Shade: Light, Medium, Dark
Texture: Wavy, Straight, Curly
Body: Thin, Medium, Thick
Eye Color: Blue, Green, Hazel, Brown, Black, other: _____
Complexion: Fair, Medium, Dark
Body Build: Small, Medium, Large

MEDICAL HISTORY:	YES_	NO__
Acne	____	____
Bleeding Tendency or Problem	____	____
Thyroid Disease	____	____
Prostrate Disease	____	____
Diabetes	____	____
High Blood Pressure	____	____
Heart Problems	____	____
Hepatitis	____	____
Mitral Valve Prolapse	____	____
Kidney Disease	____	____
Liver Disease	____	____
Urinary Tract Infections	____	____
Blood Clots in Legs or Lungs	____	____
Psychological or Emotional Problems	____	____
Depression	____	____
Victim of Sexual Abuse	____	____
Consume more than 7 alcoholic drinks/week	____	____

If you answered “YES” to any of the questions, please explain details: _____
_____
_____

Have you ever been hospitalized in the past? YES ____ NO ____
If “YES”

DATE	REASON
_____	_____
_____	_____
_____	_____

Please list all previous surgical procedures:

DATE	TYPE OF SURGERY	COMPLICATIONS
_____	_____	_____
_____	_____	_____
_____	_____	_____

GENETIC / FAMILY HISTORY:
Do any members of your immediate family or extended family (cousins, aunts, uncles, grandparents) have: (Please circle all that apply to your family)

Down’s Syndrome	Alzheimer’s
Tay Sach	Mental Illness
Thalassemia	Depression
Schizophrenia	Diabetes
Huntington’s Disease	Arthritis
Hemophilia	Cystic Fibrosis
Muscular Dystrophy	Marfan’s Syndrome
Neurofibromatosis	Hereditary Anemia
Von Recklinghausen’s Disease	Sickle Cell Anemia
Fragile X Syndrome	Mental Retardation
Congenital Heart Disease	Heart Attack before age 50

Please list type of relationship to each of the above: _____
_____
_____

EDUCATION:
Highest Educational Degree Obtained (Please circle One):
Middle School, High School, College, Graduate School, Post Graduate School
Major: _____
Occupation: _____

HOBBIES AND INTERESTS:
Personal Favorites:
Color: _____
Food: _____
Music / Band / Singer: _____
Movie: _____
Song: _____
Hobbies: _____
_____
_____
Athletic Enjoyments: _____
TALENTS:
Sports Played: Yes: _____ No: _____
If yes, what sport(s)?: _____
Musical Instrument Played?: Yes: _____ No: _____
If yes, what instrument(s): _____
Artistic Talents (circle all that apply): Painting, Drawing, Sculpting, Carving, Singing, Songwriting, Dancing, Writing, Acting,
Other:_____

WIFE

PHYSICAL CHARACTERISTICS:
Height: Weight:
Race (Circle all that apply): Caucasian, Black, American Indian, Asian, Hispanic, Other: _____
Family Ethnicity (Circle all that apply): English, Irish, Italian, Greek, Spanish, Swedish, German, Chinese, Japanese, Other: _____
_____
Drug Allergies: _____
Are You A Twin? Yes: _____(identical, faternal) No: _____
Hands: Right Handed, Left Handed, Ambidextrous
Hair (circle most appropriate from each lines:
Color at Birth: Blonde, Brown, Black, Red, Other: _____
Present Color: Blonde, Brown, Black, Red, Other: _____
Shade: Light, Medium, Dark
Texture: Wavy, Straight, Curly
Body: Thin, Medium, Thick
Eye Color: Blue, Green, Hazel, Brown, Black, other: _____
Complexion: Fair, Medium, Dark
Body Build: Small, Medium, Large

MEDICAL HISTORY:	YES	NO
Acne	____	____
Bleeding Tendency or Problem	____	____
Breast Discharge	____	____
Thyroid Disease	____	____
Diabetes	____	____
High Blood Pressure	____	____
Heart Problems	____	____
Hepatitis	____	____
Mitral Valve Prolapse	____	____
Kidney Disease	____	____
Liver Disease	____	____
Urinary Tract Infections	____	____
Blood Clots in Legs or Lungs	____	____
Psychological or Emotional Problems	____	____
Depression	____	____
Victim of Sexual Abuse	____	____
Consume more than 7 alcoholic drinks/week	____	____

If you answered "YES" to any of the questions, please explain details: _____
_____
_____
_____

Have you ever been hospitalized in the past? YES ____ NO ____
If "YES"

DATE	REASON
_____	_____
_____	_____
_____	_____

Please list all previous surgical procedures:

DATE	TYPE OF SURGERY	COMPLICATIONS
_____	_____	_____
_____	_____	_____
_____	_____	_____

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Neurofibromatosis	Hereditary Anemia
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Personal Favorites:
Color: _____
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Music / Band / Singer: _____
Song: _____
Hobbies: _____
_____
Athletic Enjoyments: _____

TALENTS:
Sports Played: Yes: _____ No: _____
If yes, what sport(s)?: _____
Musical Instrument(s) Played?: Yes: ____ No: ____
Artistic Talents (Circle all that apply): Painting, Drawing, Sculpting, Carving, Singing, Composing Songs, Dancing, Writing, Acting,
Other:_____

NEDC USE ONLY: (TO BE KEPT CONFIDENTIAL)

Wife's Name: _____

Husband's Name: _____

Address: _____

_____

Home Phone #: _____ Work Phone #: _____
Cell Phone #: _____ E-Mail Address: _____

Date Received by NEDC: _____ Donor # assigned: _____
Date Embryos Received: _____ Date Matched: _____
Date Transferred: _____ Pregnancy Result: _____