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”

<table>
<thead>
<tr>
<th>DATE</th>
<th>REASON</th>
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Please list all previous surgical procedures:

<table>
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<tr>
<th>DATE</th>
<th>TYPE OF SURGERY</th>
<th>COMPLICATIONS</th>
</tr>
</thead>
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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: __________________________

PHYSICAL CHARACTERISTICS:
WIFE
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, paternal)  No: _____
Hands:  Right Handed, Left Handed, Ambidextrous
Hair (circle most appropriate from each line):
  Color at Birth:  Blonde, Brown, Black, Red, Other: __________________________
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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: _____________