

Date: 24 Nov 2005

DONOR PROFILE

GENERAL INFORMATION

Year of Birth: 1979

Place of Birth: Denmark

Racial Group/Color Code:

Caucasian

Black/Black

Asian/Yellow

Other/Red

Ethnic Origin/Ancestry:

Mother: Denmark

Father: Denmark

Religion Born Into:

Donor: Christian Mother: Christian Father: Christian

If Jewish: Ashkenazi

Sephardic

Oriental

Height: 6' 0"

Weight: 190lbs

Eye Color: Blue

Hair Color: Blonde

Hair:

balding

thin

average

thick

Hair Type:

curly

wavy

straight

Corrective Lenses:

Yes

No

Corrective Eye Surgery

Yes

No

Blood Type: O negative

Bone Structure:

Small

Medium

Large

Very Large

Are you predominately:

right-handed

left-handed

ambidextrous

Other distinguishing features (dimples, cleft chin, Roman nose, etc.): Cleft chin, distinct cheekbones and athletic body

Skin Characteristics:

Freckles:

None

Few

Many

Very fair (little to no ability to tan on sun exposure)

Fair (skin will tan lightly on sun exposure)

Medium (light color but will tan moderate to dark)

Olive (pigmentation of unexposed skin)

Light

Moderate

Dark

Dark (unexposed skin)

Light tan

Dark Tan

Brown

Black

EDUCATIONAL BACKGROUND

(check highest level attained)

High School

1

2

3

4

GPA: Top 10%

College/University

1

2

3

4

GPA: Top 10 %

B.A.

B.S.

Major Area of Study: Economy

Post Graduate

1

2

3

4

5+

GPA: Top 10 %

Major: Economy

Degrees Attained: M.A.

M.S.

Ph.D.

M.D.

J.D.

D.D.S.

Other:

PERSONAL CHARACTERISTICS

(Please describe in some detail)

Math Skills/Ability: Good.

Mechanical Skills: Very good

Athletic Skills: Good - have played sports all my life

What is your favorite sport? Fotball, running and cycling

What is your native language? Danish.

What other languages do you speak? English, French and German

Hobbies/Talents: Friends, hiking, gardening, movies and travelling

Describe your artistic ability: I have taken some drama lessons but only for fun

What are your favorite foods? I don't have favorite foods - I like most foods. And is never affraid to try something different. But I try to eat as healthy as possible.

What is your favorite color? Deep blue and beige

Do you like animals? If so, which is your favorite? I really like animals and have grown up surrounded by pets. My favorite animal is the dog.

To where would you like to travel and why? I have been traveling a lot and visited many places. I just like to explore new cultures and meet other people. I don't really have a specific place to go right now but my big goal is to see most of the world. I would like to see the rainforrests in Peru.

How would you describe your personality? Understanding, kind, open, decent, honest, thoughtful and forthright.

What is your ultimate ambition or goal in life? How do you see yourself in twenty years? My ultimate ambition in life is to achieve happiness with a healthy family and make sure that im surrounded by people I love. To stand up as a good example and follow the ideals to which I believe. It is also very important for me to make a difference.

ADDITIONAL ACADEMIC INFORMATION

SAT Scores: Verbal Math Total
 LSAT MCAT GRE **DONOR DID NOT TAKE THESE TESTS**
 GMAT Other

Academic and professional societies to which you belong: national veterinary society

EMPLOYMENT/OCCUPATIONAL HISTORY

What is your current or most recent occupation? Full time student, job at clothes store.

List all the jobs you have had in the past five years and any exposure to chemicals and gases. Please consider carefully.

Jobs/Duties (Do not name employer)	Year employment		Exposure to which chemicals, gases, etc.
	Began	Ended	
1. Consultant	2004	2005	None.
2. Store clerk	2001	2004	None.
3. Store clerk	2002	To present	None.
4.	Click	Click	
5.	Click	Click	
6.	Click	Click	

FERTILITY HISTORY

Do you have any children? Yes

If yes, how many male children? 1 female children? 1

For each child, please give age, and list any health problems:

Age Special Health Problems

Have you ever been responsible for any pregnancies other than those listed above? No Yes

If yes, what year did it occur?

Have you ever been refused as a blood donor? No Yes

If yes, explain:

Has anyone in your family had difficulty in achieving pregnancy? No Yes

If yes, explain:

Are there any twins or triplets in your family? No Yes

If yes describe:

FAMILY MEDICAL HISTORY

Note: The following questions require knowledge about your family's medical history. You may wish to have your mother or father assist you in obtaining the necessary information.

Has any member of your family, including yourself, had a problem or defect at birth in any of the following body systems?

- | | | |
|----------------------------------------------|----------------------------------------|------------------------------|
| 1. Circulatory system | <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes |
| 2. Gastrointestinal system | <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes |
| 3. Genital/urinary system | <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes |
| 4. Metabolic (hormones, enzymes, etc.) | <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes |
| 5. Nervous system (brain, spinal cord, etc.) | <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes |
| 6. Respiratory system | <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes |
| 7. Skeletal system (bones, joints, muscles) | <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes |
| 8. Organ (heart, lung, kidney, etc.) | <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes |
| 9. Other: | <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes |

If yes to any of the above, please list below the specific defect in each case.

Type of birth defect	Affected family member	Age at diagnosis	Relevant circumstances

Do you have any brothers or sisters who died in infancy or childhood? No Yes

If yes, what was the cause?

Are there any diseases or abnormalities that appear to run in your family? No Yes

If yes, indicate the disease(s) and the family member(s) affected.

Has anyone in your family, including yourself, experienced recurring and/or chronic symptoms that have not been evaluated by a physician? (Please include those symptoms that you may not consider serious.)

No Yes

If yes, please describe:

Relatives	Mother	Father	Siblings		Grandparents				Aunts		Uncles		Maternal Cousins		Paternal Cousins	
			F	M	MGM	MGF	PGM	PGF	Mat	Pat	Mat	Pat	F	M	F	M
Indicate number of relatives→	1	1	0	2	1	1	1	1	0	0	2	1	2	3	2	1

Medical Problem	You	Mother	Father	Siblings		Grandparents				Aunts		Uncles		Maternal Cousins		Paternal Cousins		No one	
				F	M	MGM	MGF	PGM	PGF	Mat	Pat	Mat	Pat	F	M	F	M		
1. Cardiovascular																			
A. congenital heart defect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
B. atherosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
C. arteriosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
D. heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
E. high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Blood																			
A. anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
B. sickle cell anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
C. hemophilia or other bleeding problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
D. leukemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
E. immune deficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
F. other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Respiratory (lungs)																			
A. hay fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
D. tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
E. lung cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
F. pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
G. other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Skin																			
A. acne	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
B. eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
C. melanoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
D. skin cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
E. pigmentation disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
F. other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Comments:

Medical Problem	You	Mother	Father	Siblings		Grandparents				Aunts		Uncles		Maternal Cousins		Paternal Cousins		No one	
				F	M	MGM	MGF	PGM	PGF	Mat	Pat	Mat	Pat	F	M	F	M		
5. Gastro-intestinal																			
A. ulcer of stomach or duodenum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
B. gall stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
C. hepatitis A (infectious)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
D. hepatitis B (serum)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
E. other liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
F. colon cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
G. ulcerative colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
H. Crohn's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
I. cystic fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
J. intestinal cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
K. other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Urinary																			
A. kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
B. disease of the urinary tract (urethra,bladder, ureter)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
C. other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Genital/Reproductive system																			
A. undescended testicle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
B. hypospadias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
C. prostate cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
D. uterine fibroids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
E. ovarian cysts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
F. cancer of cervix or uterus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
G. breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
H. ovarian cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
I. Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Comments:

Medical Problem	You	Mother	Father	Siblings		Grandparents				Aunts		Uncles		Maternal Cousins		Paternal Cousins		No one	
				F	M	MGM	MGF	PGM	PGF	Mat	Pat	Mat	Pat	F	M	F	M		
8. Metabolic/Endocrine																			
A. diabetes mellitus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
B. hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
C. thyroid cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
D. thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
E. goiter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
F. adrenal dysfunction or disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
G. other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Neurological																			
A. migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
B. mental retardation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
C. senility before age 50	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
D. Alzheimer's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
E. multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
F. epilepsy or seizure disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
H. hydrocephalus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
I. disorders of spinal cord	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
J. Huntington's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
K. Gaucher disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
L. Wilson's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
M. delay in growth and/or development	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
N. learning disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
O. other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. Mental Health																			
A. schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
B. manic depressive illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
C. other mental health disorders requiring hospitalization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
D. severe depression with periods of inability to function	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
E. other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Comments:

Medical Problem	You	Mother	Father	Siblings		Grandparents				Aunts		Uncles		Maternal Cousins		Paternal Cousins		No one	
				F	M	MGM	MGF	PGM	PGF	Mat	Pat	Mat	Pat	F	M	F	M		
11. Muscles/Bones/Joints																			
A. muscular dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
B. other chronic muscle disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
C. lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
D. deformity of spine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
E. osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
F. dwarfism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
G. hereditary low back disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
H. arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
I. gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
J. other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
12. Sight/sound/smell																			
A. deafness before age 60	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
B. significant hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
C. deformity of the ear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
D. cataracts before age 50	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
E. blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
F. color blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
G. glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
H. deviated septum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
I. any other sight/sound/smell disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
13. Other																			
A. alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
B. drug abuse, misuse, or addiction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
C. any other cancer not mentioned above	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
D. any other condition not mentioned above	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Comments:

PERSONAL HEALTH HISTORY

Do you currently have any allergies? No Yes

If yes, they are to: Food Drugs Plants Other

Please list specific substances and reaction (s) produced:

Substance	Reaction

Describe any childhood allergies you had: None

How is your vision (without corrective lenses)? Excellent Good Fair Poor

Do you wear corrective lenses? No Yes Your vision is:

Are you: Nearsighted Farsighted Other (specify)

Have you undergone corrective eye surgery? No Yes

Do you have any hearing impairments? No Yes
If yes, please describe:

Condition of your teeth (check one): Good Fair Poor

Your diet is: Good Fair Poor

Any dietary restrictions? No

Dietary supplements (vitamins, etc.)? Vitamins

How often do you exercise? Regularly Occasionally Rarely

Type of exercise: Football and running

Have you ever had surgery? No Yes

If yes, please list all surgeries:

- 1)
- 2)
- 3)
- 4)

Year:
Year:
Year:
Year:

Have you had any hospitalization not already mentioned? No Yes

If yes, please explain:

PERSONAL HEALTH HISTORY
(Continued)

Have you had major x-ray exposure or other radiation exposure? No Yes

If yes, please explain:

Have you or your sexual partners ever had:	Myself	Partner	When
NSU (non-specific urethritis)	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
Chlamydia	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
Genital Warts (HPV)	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
Genital Herpes	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
Other (s) Type (s):	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	

Have you ever been treated for any sexually-transmitted disease(s)? No Yes

If yes, for which disease(s):

When? Details?

When was the last time that you were treated?

Have you ever had any major illnesses such as amoebic dysentery, hepatitis, pneumonia, mononucleosis, etc.? No Yes

If yes, please explain:

Do you have any chronic medical problems or conditions? No Yes

If yes, please explain:

Have you ever been exposed to herbicides or toxic chemicals? No Yes

If yes, please explain:

Have you ever served in the military? No Yes

If yes, please explain: Compulsory service for 10 months.

PERSONAL HEALTH HISTORY

(Continued)

Please list any medications you are currently taking: None

Please list any prescription, non-prescription or recreational drugs that you have used or are currently using.

Describe any drug use as indicated below. None

Name of Drug	Date Started	Date Ended	Frequency of use	How used?

How many alcoholic drinks do you consume during an average week? 0-3

Have you ever had a drinking problem? No Yes

If yes, describe:

Have you ever been treated for alcohol or drug abuse? No Yes

If yes, describe:

Do you smoke cigarettes? No Yes

If yes, how many packs/day?

How long have you been smoking regularly?

FAMILY HISTORY SECTION

Pages 15 through 26 contain detailed information regarding the donor's family members, including his parents, siblings, grandparents, aunts and uncles. One page is used for each family member. Therefore, if the donor has more than one sister, you will find more than one page 17. If the donor has no sisters, page 17 will be blank. The same applies to brothers, aunts and uncles.

For a summary of the number of family members, please refer to the top portion of page 6 in this profile.

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FAMILY HISTORY

Mother of Donor

Year of Birth 1943

Place of Birth: Denmark

Racial Group:

Caucasian Black Asian Other

If Jewish:

Ashkenazi Sephardic Oriental

Height: 5' 8"

Weight: 125lbs

Eye Color: blue

Hair Color: Blonde

Hair:

Balding
 Thin
 Average
 Thick

Hair Type:

Curly
 Wavy
 Straight

Vision:

Excellent
 Good
 Fair
 Poor

Bone structure:

Small
 Medium
 Large
 Very Large

Other distinguishing features (dimples, cleft chin, Roman nose, etc.): Distinct cheekbones.

Skin Characteristics

Freckles:

None Few Many

Very fair (little to no ability to tan on sun exposure)

Fair (skin will tan lightly on sun exposure)

Medium (light color but will tan moderate to dark)

Olive (pigmentation of unexposed skin)

Dark (unexposed skin)

Light

Moderate

Dark

Light tan

Dark Tan

Brown

Black

Occupation: Midwife

Education: M.S. (midwife)

Special Skills or Characteristics: The best mother one could ever imagine!

If living, describe her health:

Excellent Good Fair Poor

If deceased, give cause and age at time of death:

What kind of person is/was she?

Optimistic

1

2

3

4

Pessimistic

Assertive

1

2

3

4

Passive

Leader

1

2

3

4

Follower

Easy going

1

2

3

4

Controlling, rigid

FAMILY HISTORY

Father of Donor

Year of Birth 1944

Place of Birth: Denmark

Racial Group:

Caucasian Black Asian Other

If Jewish:

Ashkenazi Sephardic Oriental

Height: 6' 0"

Weight: 160lbs

Eye Color: blue

Hair Color: Blonde

Hair:

Balding
 Thin
 Average
 Thick

Hair Type:

Curly
 Wavy
 Straight

Vision:

Excellent
 Good
 Fair
 Poor

Bone structure:

Small
 Medium
 Large
 Very Large

Other distinguishing features (dimples, cleft chin, Roman nose, etc.):

Skin Characteristics

Freckles:

None Few Many

Very fair (little to no ability to tan on sun exposure)

Fair (skin will tan lightly on sun exposure)

Medium (light color but will tan moderate to dark)

Olive (pigmentation of unexposed skin)

Dark (unexposed skin)

Light

Dark Tan

Moderate

Brown

Dark

Black

Occupation: Manager / own firm

Education: Educated in the shipping industry (B.S. equivalent).

Special Skills or Characteristics:

If living, describe his health:

Excellent Good Fair Poor

If deceased, give cause and age at time of death:

What kind of person is/was he?

Optimistic

1

2

3

4

Pessimistic

Assertive

1

2

3

4

Passive

Leader

1

2

3

4

Follower

Easy going

1

2

3

4

Controlling, rigid

FAMILY HISTORY Sister of Donor

Year of Birth 19

Place of Birth:

Relationship to Donor:

- Full sibling
- Half sibling: maternal paternal
- Adopted into family (DO NOT COMPLETE THIS FORM)

Height: Click for drop-down

Weight:

lbs

Eye Color:

Hair Color:

Hair:

- Balding
- Thin
- Average
- Thick

Hair Type:

- Curly
- Wavy
- Straight

Vision:

- Excellent
- Good
- Fair
- Poor

Bone structure:

- Small
- Medium
- Large
- Very Large

Other distinguishing features (dimples, cleft chin, Roman nose, etc.):

Skin Characteristics

Freckles:

- None
- Few
- Many

- Very fair (little to no ability to tan on sun exposure)
- Fair (skin will tan lightly on sun exposure)
- Medium (light color but will tan moderate to dark)
- Olive (pigmentation of unexposed skin)
- Dark (unexposed skin)
- Light
- Moderate
- Dark
- Light tan
- Dark Tan
- Brown
- Black

Occupation:

Education:

Special Skills or Characteristics:

Does she have any children?

- No
- Yes

If yes, how many female children?

male children?

If living, describe her health:

- Excellent
- Good
- Fair
- Poor

If deceased, give cause and age at time of death:

What kind of person is/was she?

- | | | | | | |
|------------|----------------------------|----------------------------|----------------------------|----------------------------|--------------------|
| Optimistic | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | Pessimistic |
| Assertive | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | Passive |
| Leader | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | Follower |
| Easy going | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | Controlling, rigid |

FAMILY HISTORY

Brother of Donor

Year of Birth 1970

Place of Birth: Denmark

Relationship to Donor:

- Full sibling
 Half sibling: maternal paternal
 Adopted into family (DO NOT COMPLETE THIS FORM)

Height: 6' 1"

Weight: 180lbs

Eye Color: blue

Hair Color: Blonde

Hair:

- Balding
 Thin
 Average
 Thick

Hair Type:

- Curly
 Wavy
 Straight

Vision:

- Excellent
 Good
 Fair
 Poor

Bone structure:

- Small
 Medium
 Large
 Very Large

Other distinguishing features (dimples, cleft chin, Roman nose, etc.): Cleft chin, distinct cheekbones

Skin Characteristics

Freckles:

- None Few Many

Very fair (little to no ability to tan on sun exposure)

Fair (skin will tan lightly on sun exposure)

Medium (light color but will tan moderate to dark)

Olive (pigmentation of unexposed skin)

Dark (unexposed skin)

Light

Dark Tan

Moderate

Brown

Dark

Black

Occupation: Sales manager

Education: Sales (B.S. equivalent).

Special Skills or Characteristics:

Does he have any children?

- No Yes

If yes, how many female children?

male children?

If living, describe his health:

- Excellent Good Fair Poor

If deceased, give cause and age at time of death:

What kind of person is/was he?

Optimistic

1

2

3

4

Pessimistic

Assertive

1

2

3

4

Passive

Leader

1

2

3

4

Follower

Easy going

1

2

3

4

Controlling, rigid

FAMILY HISTORY

Brother of Donor

Year of Birth 1972

Place of Birth: Denmark

Relationship to Donor:

- Full sibling
 Half sibling: maternal paternal
 Adopted into family (DO NOT COMPLETE THIS FORM)

Height: 5' 11"

Weight: 176lbs

Eye Color: blue

Hair Color: Blonde

Hair:

- Balding
 Thin
 Average
 Thick

Hair Type:

- Curly
 Wavy
 Straight

Vision:

- Excellent
 Good
 Fair
 Poor

Bone structure:

- Small
 Medium
 Large
 Very Large

Other distinguishing features (dimples, cleft chin, Roman nose, etc.): Round face.

Skin Characteristics

Freckles:

- None Few Many

Very fair (little to no ability to tan on sun exposure)

Fair (skin will tan lightly on sun exposure)

Medium (light color but will tan moderate to dark)

Olive (pigmentation of unexposed skin)

Dark (unexposed skin)

Light

Dark Tan

Moderate

Brown

Dark

Black

Occupation: Paramedic, firefighter.

Education: Paramedic, firefighter.

Special Skills or Characteristics:

Does he have any children?

- No Yes

If yes, how many female children?

male children?

If living, describe his health:

- Excellent Good Fair Poor

If deceased, give cause and age at time of death:

What kind of person is/was he?

Optimistic

1

2

3

4

Pessimistic

Assertive

1

2

3

4

Passive

Leader

1

2

3

4

Follower

Easy going

1

2

3

4

Controlling, rigid

FAMILY HISTORY

Maternal Grandmother of Donor

Year of Birth 1918

Place of Birth: Denmark

Racial Group:

Caucasian Black Asian Other

If Jewish:

Ashkenazi Sephardic Oriental

Height: 5' 8"

Weight: 132lbs

Eye Color: blue

Hair Color: Blonde

Hair:

Balding
 Thin
 Average
 Thick

Hair Type:

Curly
 Wavy
 Straight

Vision:

Excellent
 Good
 Fair
 Poor

Bone structure:

Small
 Medium
 Large
 Very Large

Other distinguishing features (dimples, cleft chin, Roman nose, etc.):

Skin Characteristics

Freckles:

None Few Many

Very fair (little to no ability to tan on sun exposure)
 Fair (skin will tan lightly on sun exposure)
 Medium (light color but will tan moderate to dark)
 Olive (pigmentation of unexposed skin) Light Moderate Dark
 Dark (unexposed skin) Light tan Dark Tan Brown Black

Occupation: Psychiatrist

Education: Psychiatrist

Special Skills or Characteristics:

If living, describe her health: Excellent Good Fair Poor

If deceased, give cause and age at time of death: Natural causes at age 86.

What kind of person is/was she?

Optimistic	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	Pessimistic
Assertive	<input type="checkbox"/> 1	<input checked="" type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	Passive
Leader	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input checked="" type="checkbox"/> 3	<input type="checkbox"/> 4	Follower
Easy going	<input type="checkbox"/> 1	<input checked="" type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	Controlling, rigid

FAMILY HISTORY

Maternal Grandfather of Donor

Year of Birth 1918

Place of Birth: Denmark

Racial Group:

Caucasian Black Asian Other

If Jewish:

Ashkenazi Sephardic Oriental

Height: 6' 0"

Weight: 167lbs

Eye Color: blue

Hair Color: brown

Hair:

Balding
 Thin
 Average
 Thick

Hair Type:

Curly
 Wavy
 Straight

Vision:

Excellent
 Good
 Fair
 Poor

Bone structure:

Small
 Medium
 Large
 Very Large

Other distinguishing features (dimples, cleft chin, Roman nose, etc.): Cleft chin, distinct cheekbones

Skin Characteristics

Freckles:

None Few Many

Very fair (little to no ability to tan on sun exposure)

Fair (skin will tan lightly on sun exposure)

Medium (light color but will tan moderate to dark)

Olive (pigmentation of unexposed skin)

Light

Moderate

Dark

Dark (unexposed skin)

Light tan

Dark Tan

Brown

Black

Occupation: Major in the Army

Education: Major in the Army

Special Skills or Characteristics:

If living, describe his health:

Excellent Good Fair Poor

If deceased, give cause and age at time of death:

What kind of person is/was he?

Optimistic

1

2

3

4

Pessimistic

Assertive

1

2

3

4

Passive

Leader

1

2

3

4

Follower

Easy going

1

2

3

4

Controlling, rigid

FAMILY HISTORY

Paternal Grandmother of Donor

Year of Birth 1910

Place of Birth: Denmark

Racial Group:

Caucasian Black Asian Other

If Jewish:

Ashkenazi

Sephardic

Oriental

Height: 5' 8"

Weight: 150lbs

Eye Color: blue

Hair Color: brown

Hair:

Balding
 Thin
 Average
 Thick

Hair Type:

Curly
 Wavy
 Straight

Vision:

Excellent
 Good
 Fair
 Poor

Bone structure:

Small
 Medium
 Large
 Very Large

Other distinguishing features (dimples, cleft chin, Roman nose, etc.):

Skin Characteristics

Freckles:

None Few Many

Very fair (little to no ability to tan on sun exposure)

Fair (skin will tan lightly on sun exposure)

Medium (light color but will tan moderate to dark)

Olive (pigmentation of unexposed skin)

Dark (unexposed skin)

Light

Dark Tan

Moderate

Brown

Dark

Black

Occupation: Teacher

Education: Teacher

Special Skills or Characteristics:

If living, describe her health:

Excellent Good Fair Poor

If deceased, give cause and age at time of death:

What kind of person is/was she?

Optimistic

1

2

3

4

Pessimistic

Assertive

1

2

3

4

Passive

Leader

1

2

3

4

Follower

Easy going

1

2

3

4

Controlling, rigid

FAMILY HISTORY

Paternal Grandfather of Donor

Year of Birth 1917

Place of Birth: Denmark

Racial Group:

Caucasian Black Asian Other

If Jewish:

Ashkenazi Sephardic Oriental

Height: 6' 0"

Weight: 165lbs

Eye Color: blue

Hair Color: Blonde

Hair:

Balding
 Thin
 Average
 Thick

Hair Type:

Curly
 Wavy
 Straight

Vision:

Excellent
 Good
 Fair
 Poor

Bone structure:

Small
 Medium
 Large
 Very Large

Other distinguishing features (dimples, cleft chin, Roman nose, etc.):

Skin Characteristics

Freckles:

None Few Many

Very fair (little to no ability to tan on sun exposure)

Fair (skin will tan lightly on sun exposure)

Medium (light color but will tan moderate to dark)

Olive (pigmentation of unexposed skin)

Dark (unexposed skin)

Light

Dark Tan

Moderate

Brown

Dark

Black

Occupation: Real estate agent

Education: High school graduate, real estate agent.

Special Skills or Characteristics:

If living, describe his health:

Excellent Good Fair Poor

If deceased, give cause and age at time of death: Died in his sleep at age 66 (heavy smoker).

What kind of person is/was he?

Optimistic

1

2

3

4

Pessimistic

Assertive

1

2

3

4

Passive

Leader

1

2

3

4

Follower

Easy going

1

2

3

4

Controlling, rigid

NONE

FAMILY HISTORY
Maternal Aunt of Donor

Year of Birth 19

Place of Birth:

Racial Group:

Caucasian Black Asian Other

If Jewish:

Ashkenazi

Sephardic

Oriental

Height: Click for drop-down

Weight:

lbs

Eye Color:

Hair Color:

Hair:

Balding
 Thin
 Average
 Thick

Hair Type:

Curly
 Wavy
 Straight

Vision:

Excellent
 Good
 Fair
 Poor

Bone structure:

Small
 Medium
 Large
 Very Large

Other distinguishing features (dimples, cleft chin, Roman nose, etc.):

Skin Characteristics

Freckles:

None Few Many

Very fair (little to no ability to tan on sun exposure)
 Fair (skin will tan lightly on sun exposure)
 Medium (light color but will tan moderate to dark)
 Olive (pigmentation of unexposed skin) Light Moderate Dark
 Dark (unexposed skin) Light tan Dark Tan Brown Black

Occupation:

Education:

Special Skills or Characteristics:

Does she have any children?

No Yes

If yes, how many female children?

male children?

If living, describe her health:

Excellent Good Fair Poor

If deceased, give cause and age at time of death:

What kind of person is/was she?

Optimistic	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	Pessimistic
Assertive	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	Passive
Leader	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	Follower
Easy going	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	Controlling, rigid

FAMILY HISTORY

Maternal Uncle of Donor

Year of Birth 1953

Place of Birth: Denmark

Racial Group:

Caucasian Black Asian Other

If Jewish:

Ashkenazi Sephardic Oriental

Height: 5' 10"

Weight: 160lbs

Eye Color: blue

Hair Color: Blonde

Hair:

Balding
 Thin
 Average
 Thick

Hair Type:

Curly
 Wavy
 Straight

Vision:

Excellent
 Good
 Fair
 Poor

Bone structure:

Small
 Medium
 Large
 Very Large

Other distinguishing features (dimples, cleft chin, Roman nose, etc.): Distinct cheekbones.

Skin Characteristics

Freckles:

None Few Many

Very fair (little to no ability to tan on sun exposure)

Fair (skin will tan lightly on sun exposure)

Medium (light color but will tan moderate to dark)

Olive (pigmentation of unexposed skin)

Dark (unexposed skin)

Light

Dark Tan

Moderate

Brown

Dark

Black

Occupation: Social worker, driver

Education: Social worker, driver

Special Skills or Characteristics: Very artistic and plays many instruments.

Does he have any children?

No Yes

If yes, how many female children? 2

male children? 0

If living, describe his health:

Excellent Good Fair Poor

If deceased, give cause and age at time of death:

What kind of person is/was he?

Optimistic	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	Pessimistic
Assertive	<input type="checkbox"/> 1	<input checked="" type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	Passive
Leader	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input checked="" type="checkbox"/> 3	<input type="checkbox"/> 4	Follower
Easy going	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	Controlling, rigid

FAMILY HISTORY

Maternal Uncle of Donor

Year of Birth 1950

Place of Birth: Denmark

Racial Group:

Caucasian Black Asian Other

If Jewish:

Ashkenazi Sephardic Oriental

Height: 6' 0"

Weight: 176lbs

Eye Color: blue

Hair Color: darkblond

Hair:

Balding
 Thin
 Average
 Thick

Hair Type:

Curly
 Wavy
 Straight

Vision:

Excellent
 Good
 Fair
 Poor

Bone structure:

Small
 Medium
 Large
 Very Large

Other distinguishing features (dimples, cleft chin, Roman nose, etc.):

Skin Characteristics

Freckles:

None Few Many

Very fair (little to no ability to tan on sun exposure)

Fair (skin will tan lightly on sun exposure)

Medium (light color but will tan moderate to dark)

Olive (pigmentation of unexposed skin)

Dark (unexposed skin)

Light

Dark Tan

Moderate

Brown

Dark

Black

Occupation: Veterinary

Education: Veterinarian (M.S.)

Special Skills or Characteristics:

Does he have any children?

No Yes

If yes, how many female children? 0

male children? 3

If living, describe his health:

Excellent Good Fair Poor

If deceased, give cause and age at time of death:

What kind of person is/was he?

Optimistic

1

2

3

4

Pessimistic

Assertive

1

2

3

4

Passive

Leader

1

2

3

4

Follower

Easy going

1

2

3

4

Controlling, rigid

NONE

FAMILY HISTORY Paternal Aunt of Donor

Year of Birth 19

Place of Birth:

Racial Group:

Caucasian

Black

Asian

Other

If Jewish:

Ashkenazi

Sephardic

Oriental

Height: Click for drop-down

Weight:

lbs

Eye Color:

Hair Color:

Hair:

Balding

Thin

Average

Thick

Hair Type:

Curly

Wavy

Straight

Vision:

Excellent

Good

Fair

Poor

Bone structure:

Small

Medium

Large

Very Large

Other distinguishing features (dimples, cleft chin, Roman nose, etc.):

Skin Characteristics

Freckles:

None

Few

Many

Very fair (little to no ability to tan on sun exposure)

Fair (skin will tan lightly on sun exposure)

Medium (light color but will tan moderate to dark)

Olive (pigmentation of unexposed skin)

Dark (unexposed skin)

Light

Moderate

Dark

Light tan

Dark Tan

Brown

Black

Occupation:

Education:

Special Skills or Characteristics:

Does she have any children?

No

Yes

If yes, how many female children?

male children?

If living, describe her health:

Excellent

Good

Fair

Poor

If deceased, give cause and age at time of death:

What kind of person is/was she?

Optimistic

1

2

3

4

Pessimistic

Assertive

1

2

3

4

Passive

Leader

1

2

3

4

Follower

Easy going

1

2

3

4

Controlling, rigid

FAMILY HISTORY

Paternal Half-Uncle of Donor

Year of Birth 1950

Place of Birth: Denmark

Racial Group:

Caucasian Black Asian Other

If Jewish:

Ashkenazi Sephardic Oriental

Height: 5' 11"

Weight: 170lbs

Eye Color: blue

Hair Color: Blonde

Hair:

Balding
 Thin
 Average
 Thick

Hair Type:

Curly
 Wavy
 Straight

Vision:

Excellent
 Good
 Fair
 Poor

Bone structure:

Small
 Medium
 Large
 Very Large

Other distinguishing features (dimples, cleft chin, Roman nose, etc.):

Skin Characteristics

Freckles:

None Few Many

Very fair (little to no ability to tan on sun exposure)

Fair (skin will tan lightly on sun exposure)

Medium (light color but will tan moderate to dark)

Olive (pigmentation of unexposed skin)

Dark (unexposed skin)

Light

Dark Tan

Moderate

Brown

Dark

Black

Occupation: Sales manager.

Education: High school

Special Skills or Characteristics:

Does he have any children?

No Yes

If yes, how many female children? 2

male children? 1

If living, describe his health:

Excellent Good Fair Poor

If deceased, give cause and age at time of death:

What kind of person is/was he?

Optimistic	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	Pessimistic
Assertive	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	Passive
Leader	<input type="checkbox"/> 1	<input checked="" type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	Follower
Easy going	<input type="checkbox"/> 1	<input checked="" type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	Controlling, rigid

In Your Own Words...

Why do you want to be a donor? I love children and I am really looking forward to having some on my own, and therefore I can see the need for donors to help people that are childless. I am very grateful for the opportunity to help in a way that, at the same time, can give me financial support to cover some of the expenses of my study.

What did you do immediately after high school? Compulsory service.

Which words describe your personality? Understanding, kind, open, decent, honest, thoughtful and forthright.

Which sports do you like to participate in? Football, running and cycling

Which sports did you play as a child? Team handball, swimming and football. I was a boyscout for many years.

Which sports do you enjoy watching? The Olympics, Superbowl and football world cup.

Do you play any musical instruments? No

What is your most memorable childhood experience? I remember playing with my friends and my father outdoors in the winter. We made a huge fort out of snow, divided us in 2 teams, and then there were this huge snowball-fight.

To which countries have you traveled? Almost all countries in Europe, Caribbean, Malaysia, Thailand, Kenya i Afrika and Brazil.

Describe one of your favorite vacations to another country: A trekking trip in the jungles of Thailand three years ago is probably my favorite vacation memory. Or perhaps mountain climbing last year.

Describe things you like the most about your own country: The people. The government with all our public services - especially our free education with means everybody can be exactly what they want. And the fact that it is my home. I have all my family and friends here - and that is the most important in my life.

Describe a few of your strong sides: Good at optimizing, efficient, self-disciplined, realistic and conscientious.

Describe a few of your weak sides: Sometimes I put myself under too much pressure. Sometimes I am rational instead of trusting my feelings.

Handwritten message

If you could pass on a message to the recipient(s) of your semen, what would that message be?

Dear recipient.

I am happy to help you in this way.

I hope you will have the family you so desire.

Remember to love and respect your children - also when the things are tough.

Sincerely yours.