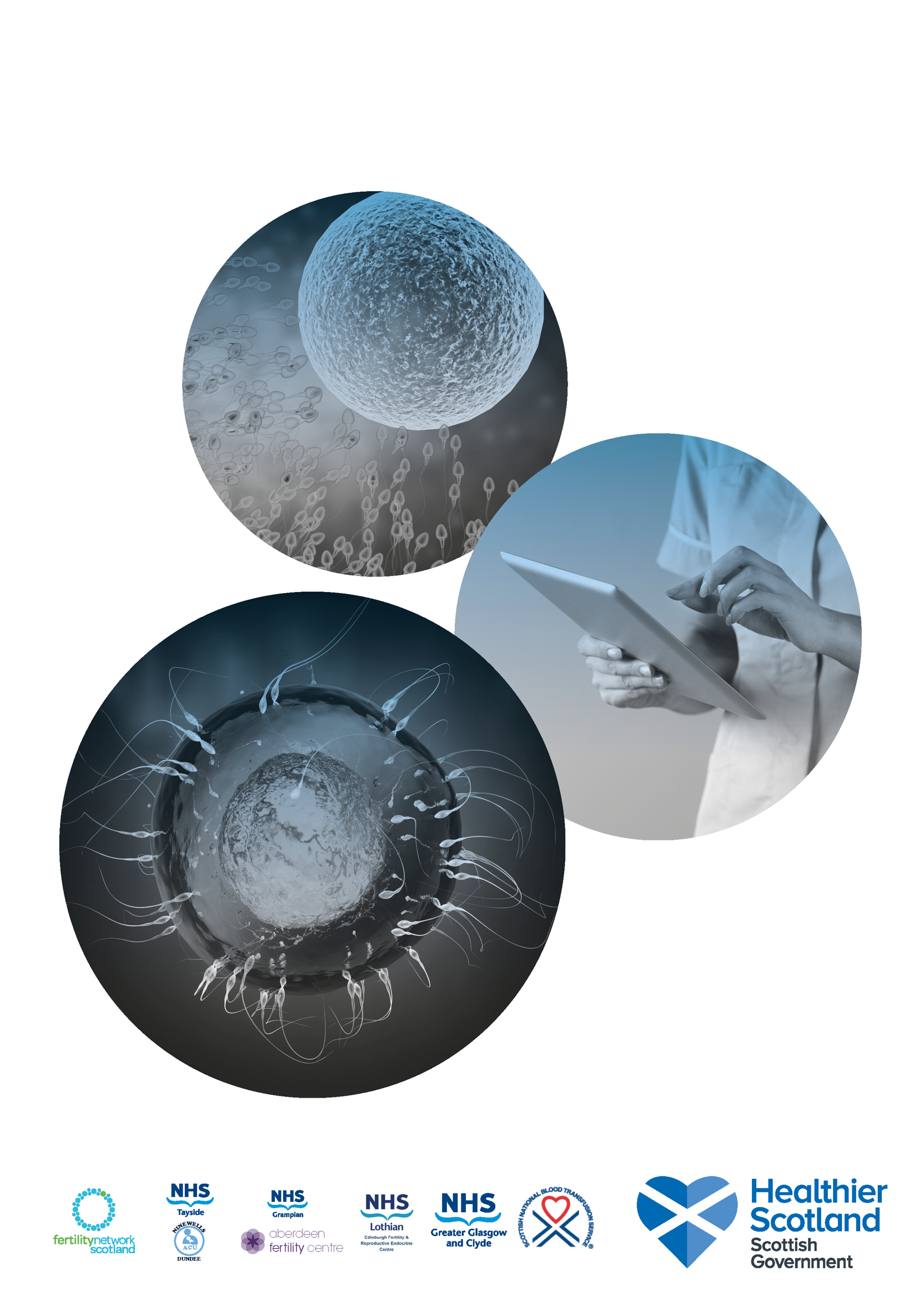
**Donor Profile and  
Health Questionnaire**

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## Please complete the following questionnaire carefully, using BLOCK CAPITALS throughout. We will go over this form with you at your appointment and discuss any questions that you are not sure about. Please be aware that you may be held legally liable for any adverse outcome if you KNOWINGLY withhold information or supply false information. Any person born disabled as a result of your failure to disclose information, you ought reasonably to have known about, may be able to sue you for damages.

**General details**

|  |  |
| --- | --- |
| Current first name |  |
| First name(s) at birth (if different from current) |  |
| Current surname |  |
| Surname at birth (if different from current) |  |
| Date of birth |  |
| Town of birth |  |
| Country of birth |  |
| NHS/CHI number for UK residents (if known) |  |
| Passport/verified photo ID card number |  |
| Country of issue |  |
| Address (including Postcode) |  |
| Occupation |  |
| Sexual Orientation |  |
| Height |  |
| Weight |  |

What will you be donating?

  Eggs    Sperm

**Marital Status**

   Single   Married    Civil Partnership    Cohabit    Divorced    Widowed

Other

**Were you adopted?**    Yes  No

Were you conceived by donation?    Yes    No

Ethnic group

|  |  |  |  |
| --- | --- | --- | --- |
|  | *You* | *Biological Mother* | *Biological Father* |
| White British |  |  |  |
| White Irish |  |  |  |
| Any other white background |  |  |  |
| White & Black Caribbean |  |  |  |
| White & Black African |  |  |  |
| White & Asian |  |  |  |
| Any other mixed background |  |  |  |
| Indian |  |  |  |
| Pakistani |  |  |  |
| Bangladeshi |  |  |  |
| Any other Asian background |  |  |  |
| Black Caribbean |  |  |  |
| Black African |  |  |  |
| Other black background |  |  |  |
| Chinese |  |  |  |
| Other |  |  |  |

If other, please give details:

|  |
| --- |
|  |

|  |  |
| --- | --- |
| Religion born into (You) |  |
| Religion born into (Biological Mother) |  |
| Religion born into (Biological Father) |  |

If Jewish, please select

Ashkenazi Sephardic Oriental

# Fertility History

Have you ever been associated with any pregnancies?

   Yes  No

Do you have your own biological children?

   Yes  No

If Yes, please give details:

|  |  |
| --- | --- |
| Year of birth | Gender |

Have you ever had any fertility treatment?

   Yes     No

If Yes, please give details:

|  |  |  |
| --- | --- | --- |
| Year of Treatment | Hospital/Clinic of Treatment | Details of Treatment? |

# Personal and Biological Family History

## Please fill the next section to the best of your knowledge. The information is necessary to provide us with guidance to ask questions relevant to yourself. Please tick the box as indicated if the condition is/was present in the relevant family member. Ticking any of these conditions does not necessarily exclude you from donating.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Family Member** | | **Living?** | **Are you able to provide medical history for?** | **Comments** |
| Mother | | Choose an item. | Choose an item. |  |
| Father | | Choose an item. | Choose an item. |  |
| Brother(s) | How many: | Choose an item. | Choose an item. |  |
| Sister(s) | How many: | Choose an item. | Choose an item. |  |
| Maternal Grandmother (MGM) | | Choose an item. | Choose an item. |  |
| Maternal Grandfather (MGF) | | Choose an item. | Choose an item. |  |
| Paternal Grandmother (PGM) | | Choose an item. | Choose an item. |  |
| Paternal Grandfather (PGF) | | Choose an item. | Choose an item. |  |
| Children | How many: | Choose an item. | Choose an item. |  |

Please enter as much information as possible about all the family members

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Cardiovascular disease** | *You* | *Mother* | *Father* | *Brother* | *Sister* | *MGM* | *MGF* | *PGM* | *PGF* | *Children* | *None* |
| Heart defect at birth |  |  |  |  |  |  |  |  |  |  |  |
| Any heart disease |  |  |  |  |  |  |  |  |  |  |  |
| Heart attack |  |  |  |  |  |  |  |  |  |  |  |
| High blood pressure |  |  |  |  |  |  |  |  |  |  |  |
| Stroke |  |  |  |  |  |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |  |  |  |  |  |
| Comments |  | | | | | | | | | | |
|  | | | | | | | | | | | |
| **Blood disorders** | *You* | *Mother* | *Father* | *Brother* | *Sister* | *MGM* | *MGF* | *PGM* | *PGF* | *Children* | *None* |
| Anaemia |  |  |  |  |  |  |  |  |  |  |  |
| Sickle cell anaemia |  |  |  |  |  |  |  |  |  |  |  |
| Haemophilia |  |  |  |  |  |  |  |  |  |  |  |
| Other bleeding disorders |  |  |  |  |  |  |  |  |  |  |  |
| Immunodeficiency |  |  |  |  |  |  |  |  |  |  |  |
| Thalassemia |  |  |  |  |  |  |  |  |  |  |  |
| Thromboembolism |  |  |  |  |  |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |  |  |  |  |  |
| Comments |  | | | | | | | | | | |
|  |  | | | | | | | | | | |
| **Respiratory (Lungs)** | *You* | *Mother* | *Father* | *Brother* | *Sister* | *MGM* | *MGF* | *PGM* | *PGF* | *Children* | *None* |
| Severe asthma |  |  |  |  |  |  |  |  |  |  |  |
| Emphysema |  |  |  |  |  |  |  |  |  |  |  |
| Tuberculosis |  |  |  |  |  |  |  |  |  |  |  |
| Cystic fibrosis |  |  |  |  |  |  |  |  |  |  |  |
| Pneumonia |  |  |  |  |  |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |  |  |  |  |  |
| Comments |  | | | | | | | | | | |
| **Skin** | *You* | *Mother* | *Father* | *Brother* | *Sister* | *MGM* | *MGF* | *PGM* | *PGF* | *Children* | *None* |
| Acne |  |  |  |  |  |  |  |  |  |  |  |
| Eczema |  |  |  |  |  |  |  |  |  |  |  |
| Psoriasis |  |  |  |  |  |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |  |  |  |  |  |
| Comments |  | | | | | | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Gastrointestinal** | *You* | *Mother* | *Father* | *Brother* | *Sister* | *MGM* | *MGF* | *PGM* | *PGF* | *Children* | *None* |
| Ulcer of stomach/ duodenum |  |  |  |  |  |  |  |  |  |  |  |
| Gall stones |  |  |  |  |  |  |  |  |  |  |  |
| Ulcerative colitis |  |  |  |  |  |  |  |  |  |  |  |
| Crohn’s disease |  |  |  |  |  |  |  |  |  |  |  |
| Bowel polyp |  |  |  |  |  |  |  |  |  |  |  |
| Jaundice |  |  |  |  |  |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |  |  |  |  |  |
| Comments |  | | | | | | | | | | |
| **Urinary** | *You* | *Mother* | *Father* | *Brother* | *Sister* | *MGM* | *MGF* | *PGM* | *PGF* | *Children* | *None* |
| Kidney disease |  |  |  |  |  |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |  |  |  |  |  |
| Comments |  | | | | | | | | | | |
| **Genital/Reproductive system** | *You* | *Mother* | *Father* | *Brother* | *Sister* | *MGM* | *MGF* | *PGM* | *PGF* | *Children* | *None* |
| Undescended testis |  |  |  |  |  |  |  |  |  |  |  |
| Hypospadias |  |  |  |  |  |  |  |  |  |  |  |
| Fibroid uterus |  |  |  |  |  |  |  |  |  |  |  |
| Endometriosis |  |  |  |  |  |  |  |  |  |  |  |
| Polycystic ovaries |  |  |  |  |  |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |  |  |  |  |  |
| Comments |  | | | | | | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Cancer** | *You* | *Mother* | *Father* | *Brother* | *Sister* | *MGM* | *MGF* | *PGM* | *PGF* | *Children* | *None* |
| Prostate cancer |  |  |  |  |  |  |  |  |  |  |  |
| Cervix/uterus cancer |  |  |  |  |  |  |  |  |  |  |  |
| Breast cancer |  |  |  |  |  |  |  |  |  |  |  |
| Ovarian cancer |  |  |  |  |  |  |  |  |  |  |  |
| Bowel cancer |  |  |  |  |  |  |  |  |  |  |  |
| Lung cancer |  |  |  |  |  |  |  |  |  |  |  |
| Skin cancer |  |  |  |  |  |  |  |  |  |  |  |
| Melanoma |  |  |  |  |  |  |  |  |  |  |  |
| Leukaemia |  |  |  |  |  |  |  |  |  |  |  |
| Thyroid cancer |  |  |  |  |  |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |  |  |  |  |  |
| Comments |  | | | | | | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Metabolic/Endocrine** | *You* | *Mother* | *Father* | *Brother* | *Sister* | *MGM* | *MGF* | *PGM* | *PGF* | *Children* | *None* |
| Diabetes mellitus |  |  |  |  |  |  |  |  |  |  |  |
| Thyroid disease |  |  |  |  |  |  |  |  |  |  |  |
| Adrenal disorder |  |  |  |  |  |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |  |  |  |  |  |
| Comments |  | | | | | | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Neurological** | *You* | *Mother* | *Father* | *Brother* | *Sister* | *MGM* | *MGF* | *PGM* | *PGF* | *Children* | *None* |
| Mental disability |  |  |  |  |  |  |  |  |  |  |  |
| Alzheimer’s disease |  |  |  |  |  |  |  |  |  |  |  |
| Multiple sclerosis |  |  |  |  |  |  |  |  |  |  |  |
| Epilepsy/seizures |  |  |  |  |  |  |  |  |  |  |  |
| Hydrocephalus |  |  |  |  |  |  |  |  |  |  |  |
| Disorders of spinal cord |  |  |  |  |  |  |  |  |  |  |  |
| Huntington’s disease |  |  |  |  |  |  |  |  |  |  |  |
| Gaucher’s disease |  |  |  |  |  |  |  |  |  |  |  |
| Wilson’s disease |  |  |  |  |  |  |  |  |  |  |  |
| Delay in growth & development |  |  |  |  |  |  |  |  |  |  |  |
| Learning disability/disorder |  |  |  |  |  |  |  |  |  |  |  |
| Confusion/memory loss |  |  |  |  |  |  |  |  |  |  |  |
| Unsteady gait |  |  |  |  |  |  |  |  |  |  |  |
| CJD |  |  |  |  |  |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |  |  |  |  |  |
| Comments |  | | | | | | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Mental health** | *You* | *Mother* | *Father* | *Brother* | *Sister* | *MGM* | *MGF* | *PGM* | *PGF* | *Children* | *None* |
| Schizophrenia |  |  |  |  |  |  |  |  |  |  |  |
| Bipolar disorder |  |  |  |  |  |  |  |  |  |  |  |
| Severe depression |  |  |  |  |  |  |  |  |  |  |  |
| Autism |  |  |  |  |  |  |  |  |  |  |  |
| Asperger’s syndrome |  |  |  |  |  |  |  |  |  |  |  |
| Other mental health disorders requiring treatment |  |  |  |  |  |  |  |  |  |  |  |
| Comments |  | | | | | | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Muscles/Bones/Joints** | *You* | *Mother* | *Father* | *Brother* | *Sister* | *MGM* | *MGF* | *PGM* | *PGF* | *Children* | *None* |
| Muscular dystrophy |  |  |  |  |  |  |  |  |  |  |  |
| Systemic lupus erythematosus |  |  |  |  |  |  |  |  |  |  |  |
| Deformity of spine |  |  |  |  |  |  |  |  |  |  |  |
| Osteoporosis |  |  |  |  |  |  |  |  |  |  |  |
| Dwarfism |  |  |  |  |  |  |  |  |  |  |  |
| Rheumatoid arthritis |  |  |  |  |  |  |  |  |  |  |  |
| Gout |  |  |  |  |  |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |  |  |  |  |  |
| Comments |  | | | | | | | | | | |
|  | | | | | | | | | | | |
| **Sight/sound/smell** | *You* | *Mother* | *Father* | *Brother* | *Sister* | *MGM* | *MGF* | *PGM* | *PGF* | *Children* | *None* |
| Deafness before age 60 |  |  |  |  |  |  |  |  |  |  |  |
| Significant hearing loss |  |  |  |  |  |  |  |  |  |  |  |
| Deformity of ear |  |  |  |  |  |  |  |  |  |  |  |
| Cataracts before age 50 |  |  |  |  |  |  |  |  |  |  |  |
| Blindness |  |  |  |  |  |  |  |  |  |  |  |
| Colour blindness |  |  |  |  |  |  |  |  |  |  |  |
| Glaucoma |  |  |  |  |  |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |  |  |  |  |  |
| Comments |  | | | | | | | | | | |
|  | | | | | | | | | | | |
| **Miscellaneous** | *You* | *Mother* | *Father* | *Brother* | *Sister* | *MGM* | *MGF* | *PGM* | *PGF* | *Children* | *None* |
| Alcoholism |  |  |  |  |  |  |  |  |  |  |  |
| Non prescribed drug use |  |  |  |  |  |  |  |  |  |  |  |
| Unplanned weight loss |  |  |  |  |  |  |  |  |  |  |  |
| Comments |  | | | | | | | | | | |

**Personal Health History**

In the last 2 years have you seen or are you waiting to see your GP or any other health professional for any reason?

   Yes     No

|  |
| --- |
| If Yes, please give details: |

Do you have any allergies?

   Yes    No

If yes, are they to:

Food Plants/Animals

Medication Other

|  |
| --- |
| Please describe specific substances that you are allergic to and reactions that have happened after taking them: |

Have you ever been admitted to hospital?

   Yes    No

|  |
| --- |
| If Yes, please list all admissions and reasons: |

Have you had a CT Scan / X-Ray / MRI Scan / Ultrasound?

   Yes    No

|  |
| --- |
| If Yes, please give details: |

Have you or your sexual partner ever had or been treated for any of the following infections?

   Yes    No

If Yes, please provide details:

|  |  |  |
| --- | --- | --- |
|  | *You* | *Partner* |
| Non-specific urethritis |  |  |
| Chlamydia |  |  |
| Genital herpes |  |  |
| Genital Warts (HPV) |  |  |
| Gonorrhoea |  |  |
| Syphilis |  |  |
| Hepatitis B |  |  |
| Hepatitis C |  |  |
| HIV/AIDS |  |  |
| HTLV |  |  |
| Zika virus |  |  |
| Tuberculosis |  |  |
| Brucellosis |  |  |
| Viral Haemorrhagic Fever |  |  |
| Other sexually transmitted infection |  |  |

|  |
| --- |
| If Yes, to any of the above, please give details: |

# Recent Exposures

Have you recently been exposed to or suffered from any infections or viral diseases, or do you currently have an infection (e.g. hepatitis or diarrhoea)?

   Yes    No

|  |
| --- |
| If Yes, please give details: |

In the last 3 months have you had an injury, which may have put you at risk of acquiring hepatitis or HIV (e.g. a needlestick)?

   Yes    No

|  |
| --- |
| If Yes, please give details: |

**In the last 3 months have you had:**

|  |  |  |
| --- | --- | --- |
|  | *Yes* | *No* |
| Acupuncture |  |  |
| Botox |  |  |
| Colonic irrigation |  |  |
| Tattoo |  |  |
| Face/Body/Ear piercing |  |  |
| Cosmetic treatment involving skin piercing |  |  |
| Any other invasive treatment/procedure including dermarolling or facials |  |  |
| Chemsex i.e. use of drugs solely to enhance sexual experience? |  |  |

|  |
| --- |
| If Yes, please give details: |

Have you ever been told that you cannot donate blood?

   Yes    No

|  |
| --- |
| If Yes, please give details: |

Did you ever have injections of growth hormones, injections for fertility treatment or test injections for hormone imbalance?

   Yes    No

|  |
| --- |
| If Yes, please give details: |

Have you ever had, or think you may have had a blood transfusion, bone, tissue or skin graft?

   Yes     No

|  |
| --- |
| If Yes, please give details: |

**Have you ever been told that you are at as risk of CJD?**

   Yes    No

|  |
| --- |
| If Yes, please give details: |

Have you ever injected or been injected with illegal or non-prescribed substances including body building drugs or injectable tanning agents or injected chemsex drugs?

   Yes    No

|  |
| --- |
| If Yes, please provide details, including name/type of drugs and date of last injection: |

In the last 3 months have you had sex with anyone who:

|  |  |  |
| --- | --- | --- |
|  | *Yes* | *No* |
| Is or may be HIV or HTLV positive |  |  |
| Is or may be hepatitis B or C positive |  |  |
| Has ever been paid for sex such as with money or drugs |  |  |
| Has paid you for sex such as with money or drugs |  |  |
| Has ever injected drugs, injectable tanning agents or injected chemsex drugs |  |  |
| Has syphilis or other sexually transmitted infection? |  |  |

In the last 3 months have you had a new or more than one sexual partner?

   Yes    No

If yes, did you have anal sex?

   Yes    No    N/A

Have you had sex in the last 6 months with anyone who has visited a country known to have Zika virus or who has been diagnosed with Zika infection?

   Yes    No

Have you ever been exposed to toxic substances (such as cyanide, lead, mercury and gold) that required medical attention?

   Yes    No

|  |
| --- |
| If Yes, please give details: |

**Have you had immunizations or vaccinations in the last 8 weeks?**

   Yes    No

|  |
| --- |
| If Yes, please give details and reason for vaccination e.g. following exposure or prior to travel: |

**Have you ever stayed in Central America, Mexico or South America for a continuous period of 1 month or more or was your mother born in any of these countries?**

|  |
| --- |
| If Yes, please give details: |

Have you ever been diagnosed with malaria or have you had an unexplained fever which you could have picked up whilst abroad or were you present in an area with an active outbreak of Viral Haemorrhagic Fever?

|  |
| --- |
| If Yes, please give details: |

Have you ever stayed outside the UK for a continuous period of 6 months or more?

   Yes     No

If yes, please provide details:

|  |  |
| --- | --- |
| Date: | Country |

Have you been outside the UK in last 12 months (include both holidays and work trips)?

   Yes    No

If yes, please provide details:

|  |  |
| --- | --- |
| Date: | Country |

Were you unwell while abroad or within 4 weeks of returning to the UK?

   Yes    No

|  |
| --- |
| If Yes, please provide details of illness, country and date: |

In the last year have you been bitten or scratched by any animal or been bitten by a human; or, have you ever been bitten or in close contact with bats anywhere in the world or been bitten by a mammal outside the UK?

   Yes    No

|  |
| --- |
| If Yes, please provide details, including type of animal, date and country: |

**Medication**

Please list any medications that you are taking or have taken in the last 2 years, including  
non-prescribed drugs that you may have bought over the counter/online.

If Yes, please give details:

|  |  |  |
| --- | --- | --- |
| Date: | Medication: | Reason taken: |

Have you ever had treatment for acne, psoriasis, prostate problems or taken medication (PrEP/PEP) to reduce the risk of HIV?

If Yes, please give details:

|  |  |  |
| --- | --- | --- |
| Date: | Medication: | Reason taken: |

How many units of alcohol do you consume during an average week? \_\_

Have you ever had a drinking problem?

   Yes    No

Do you take recreational drugs?

   Yes    No

|  |
| --- |
| If Yes, please give details: |

Have you ever been treated for alcohol/drug abuse?

   Yes    No

|  |
| --- |
| If Yes, please give details: |

What is your current smoking status?

Current smoker    Ex-smoker    Never smoked

If you are a current smoker, how many cigarettes per day (on average) do you smoke? \_

If you are an ex-smoker, how many cigarettes per day (on average) did you smoke? \_

If relevant, when did you stop smoking? \_\_

I confirm that I have read this questionnaire fully and filled it to the best of my knowledge.

|  |
| --- |
| Signature: |
| Print Name: Date: |

The information collected from you on this form will be stored securely. Additionally, information may be passed onto other healthcare professionals in support of a safe donation process.