TO BE COMPLETED BY MONASH IVF
Donor Code: LD2M

Donor Details			
Donor Code or MIVF Patient ID: LD2M			Date Donor Profile Completed: 11/12/24 (updated)
Donor type	☑ Sperm Donor	☐ Egg Donor	☐ Embryo Donor: ☐ Sperm Source / ☐ Egg Source **Both donors must provide a declaration**
Country of Birth: Iran			Ethnicity: Iranian

Health Questions			
Height cm: 177			Weight (Kg): 101
Do you smoke? ☑ No / ☐ Yes	*if yes how many per day:*		*per week:*
Do you drink alcohol? ☑ No / ☐ Yes	*if yes how many per day:*		*per week:*
Do you currently engage in any recreational drug use? ☑ No / ☐ Yes, *if Yes please list which recreational drug and how often:*			
Do you exercise/engage in physical activity? ☐ No / ☐ Occasionally / ☑ Often	*hrs per week:* 10		
Do you have issues with your eyesight? ☑ No / ☐ Yes			
Do you wear glasses? ☐ No / ☑ Yes	*If you do wear glasses, please provide additional information:*		
Do you have issues with your hearing? ☑ No / ☐ Yes			Do you wear hearing aids? ☑ No / ☐ Yes
Have you had a fever and/or illness within the last three months: ☐ No / ☐ Yes			
Have you travelled out of Australia in the last six months? ☑ No / ☐ Yes	*If Yes, list countries:*		
Have you or any member of your extended family had consultations at a genetic clinic? ☑ No / ☐ Yes *Please provide further details if you answer yes.*			
Have you or any member of your extended family been diagnosed with a genetic condition? ☑ No / ☐ Yes *Please provide further details if you answer yes.*			
Have any members of your extended family died suddenly at an early age? ☑ No / ☐ Yes *Please provide further details if you answer yes.*			

Some of the listed conditions below are known to be genetic or have a genetic contribution, meaning that they could be inherited by a donor conceived child. If **you** or **any member of your biological family** has been diagnosed as being affected by one of these conditions or as being a carrier of one of these conditions, please tick yes and add the age of onset. If a relative has been affected by the condition, describe the relationship of the person to yourself (i.e., grandparent, parent, sibling, aunt, uncle or cousin) as well as if they are maternal (mothers side) or paternal (fathers side). If you would like to provide further information about any condition(s) you indicate as yes, please add this information in the box at the end of this document. We acknowledge that donors who were adopted, or born via donor conception themselves may not be able to provide certain information.

Auto Immune Conditions

	No	Yes *(self)*	Age of onset	Yes *(relation)*	Age of Onset	Relation to you
Lupus	✓					
Multiple Sclerosis	✓					
Scleroderma	✓					
Arthritis	✓					
Rheumatoid Arthritis	✓					
Osteoarthritis	✓					
Osteoporosis	✓					
Sjogren's Syndrome	✓					
Other	✓					

Kidney Conditions

	No	Yes *(self)*	Age of onset	Yes *(relation)*	Age of Onset	Relation to you
Polycystic Kidney Disease	✓					
Born with one kidney	✓					
Urinary tract disorders	✓					

Neurological Conditions

	No	Yes *(self)*	Age of onset	Yes *(relation)*	Age of Onset	Relation to you
Attention-Deficit Hyperactivity Disorder	✓					
Autism Spectrum Disorder	✓					
Asperger's Syndrome	✓					
Chromosome Condition *(e.g. Down syndrome)*	✓					
Dyslexia Disorder	✓					
Chronic Migraines	✓					
Alzheimer's Disease	✓					
Huntington's Disease	✓					
Epilepsy	✓					
Cerebral Palsy	✓					
Creutzfeldt-Jakob Disease	✓					
Friedreich Ataxia	✓					
Parkinson's Disease	✓					
Spina Bifida	✓					
Tourette Syndrome	✓					
Intellectual Disability	✓					
Neurofibromatosis	✓					
Spinal Muscular Atrophy	✓					
Other Neurological Conditions *If yes, please provide details*	✓					

Cancer						
	No	Yes *(self)*	Age of onset	Yes *(relation)*	Age of Onset	Relation to you
Breast	✓					
Lung	✓					
Skin	✓					
Bowel	✓					
Lymphoma	✓					
Leukaemia	✓					
Melanoma	✓					
Other cancer *If yes, please provide details*	✓					

Blood Conditions						
	No	Yes *(self)*	Age of onset	Yes *(relation)*	Age of Onset	Relation to you
Haemochromatosis	✓					
Anaemia	✓					
Haemophilia	✓					
Sickle Cell Anaemia	✓					
Thalassemia	✓					
Other	✓					

Skeletal Conditions						
	No	Yes *(self)*	Age of onset	Yes *(relation)*	Age of Onset	Relation to you
Muscular Dystrophy	✓					
Marfan Syndrome	✓					
Scoliosis	✓					
Skeletal Dysplasia *(e.g. Achondroplasia)*	✓					
Other	✓					

Cardiovascular Conditions						
	No	Yes *(self)*	Age of onset	Yes *(relation)*	Age of Onset	Relation to you
Arrhythmia condition *(e.g. Long QT Syndrome)*	✓					
Cardiomyopathy	✓					
Heart Attack	✓					
Stroke	✓					
High Cholesterol	✓					
Structural Heart Defect from Birth	✓					
Sudden Cardiac Death	✓					
Other	✓					

Mental Health	No	Yes *(self)*	Age of onset	Yes *(relation)*	Age of Onset	Relation to you
Clinical Depression	✓					
Schizophrenia	✓					
Bipolar Disorder	✓					
Obsessive-Compulsive Disorder (OCD)	✓					
Other	✓					

Metabolic/Endocrine	No	Yes *(self)*	Age of onset	Yes *(relation)*	Age of Onset	Relation to you
Tay-Sachs Disease	✓					
Type 1 Diabetes	✓			✓		type not disclosed
Type 2 Diabetes	✓			✓		type not disclosed
Thyroid Disease	✓					
Genetic Metabolic Condition (e.g. Phenylketonuria -PKU)	✓					
Hypoglycaemia	✓					
Other	✓					

Congenital Malformations	No	Yes *(self)*	Age of onset	Yes *(relation)*	Age of Onset	Relation to you
Cleft Lip/Palate	✓					
Talipes/Club Foot	✓					
Hypospadias	✓					
Undescended Testicles	✓					
Polydactyly	✓					
Other congenital abnormalities *If yes, please provide details*	✓					

Respiratory Conditions	No	Yes *(self)*	Age of onset	Yes *(relation)*	Age of Onset	Relation to you
Cystic Fibrosis	✓					
Asthma	✓					
Allergies (Food)	✓					
Allergies (Drug)	✓					
Allergies (Pet)	✓					
Allergies (Hay fever)	✓					
Other	✓					

Skin Conditions	No	Yes *(self)*	Age of onset	Yes *(relation)*	Age of Onset	Relation to you
Psoriasis	✓					
Eczema	✓					
Albinism	✓					
Vitiligo (pigmentation disorder)	✓					

Sight/Sound Conditions						
	No	Yes *(self)*	Age of onset	Yes *(relation)*	Age of Onset	Relation to you
Colour Blindness	✓					
Cataracts	✓			✓		parents
Keratoconus	✓					
Glaucoma	✓					
Retinoblastoma	✓					
Macular Degeneration	✓					
Deafness	✓					
Other	✓					

Gastrointestinal Conditions						
	No	Yes *(self)*	Age of onset	Yes *(relation)*	Age of Onset	Relation to you
Crohn's Disease	✓					
Ulcers	✓					
Diverticulitis	✓					
Ulcerative Colitis	✓					
Other	✓					

If you have ticked yes to any of the above, please can you provide further information.

i.e. have you or your family ever had genetic testing performed? if so, were there any additional investigations?

Type of diabetes in family was not disclosed
Parents had to have surgery for cataracts