Monash IVF Group

Donor Medical and Genetic Questionnaire

TO BE COMPLETED BY MONASH IVF
Donor Code: LD5Y

Donor Details

Donor Code or MIVF Patient ID: LD5Y			Date Donor Profile Completed: 18/04/2024
Donor type	☑ Sperm Donor	☐ Egg Donor	☐ Embryo Donor: ☐ Sperm Source / ☐ Egg Source **Both donors must provide a declaration**
Country of Birth: Australia			Ethnicity: Italian - Filipino

Health Questions

Height cm: 171	Weight (Kg): 67
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:* 1 *per week:* 1	
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:*	
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 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.

Auto Immune Conditions	No	Yes *(self)*	Age of onset	Yes *(relation)*	Age of Onset	Relation to you
Lupus	✓					
Multiple Sclerosis	✓					
Scleroderma	✓					
Arthritis				✓	60s	Father
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 2 Diabetes	✓					
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 further details	✓					

Respiratory Conditions	No	Yes *(self)*	Age of onset	Yes *(relation)*	Age of Onset	Relation to you
Cystic Fibrosis	✓					
Asthma				✓	17	Sisters
Allergies (Food)	✓					
Allergies (Drug)	✓					
Allergies (Pet)	✓					
Allergies (Hay fever)				✓	20s	Mother, sister
Other	✓					

Sight/Sound Conditions	No	Yes *(self)*	Age of onset	Yes *(relation)*	Age of Onset	Relation to you
Colour Blindness	✓					
Cataracts				✓	60s	Father
Keratoconus	✓					
Glaucoma	✓					
Retinoblastoma	✓					
Macular Degeneration	✓					
Deafness				✓	70s	Father
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?

My father started going deaf around age 70, his deafness more pronounced in his left ear than his right. This was due to him deep diving without proper equipment when he was young, and another contributing factor was industrial deafness caused by machinery when he was working in Australia in the factories in the late 1900s.
His cataracts developed around his mid 60s, where he underwent surgery to have them removed
Sister's asthma is triggered by cold weather
Mother developed hay fever when she moved to Aus