

Please ensure you do not include any identifying information about yourself or any members of your family in the following pages of this document.

**To be completed by Monash IVF**

Donor Code: V019Y

**Donor Details**

Date Donor Profile Completed:

Donor Type:	<input checked="" type="checkbox"/> Sperm Donor	<input type="checkbox"/> Egg Donor	<input type="checkbox"/> Embryo Donor: <input type="checkbox"/> Sperm Source / <input type="checkbox"/> Egg Source
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*Note: Both donors must provide a declaration*

**Please describe your general health:**

Healthy

**Health Questions**

Do you smoke?	<input checked="" type="checkbox"/> No / <input type="checkbox"/> Yes	per day	per week
Do you drink alcohol?	<input checked="" type="checkbox"/> No / <input type="checkbox"/> Yes	per day	per week
Do you or have you engaged in any recreational drug use?	<input checked="" type="checkbox"/> No / <input type="checkbox"/> Yes		
Do you exercise/engage in physical activity?	<input type="checkbox"/> No / <input type="checkbox"/> Occasionally / <input checked="" type="checkbox"/> Often	<u>5</u> hrs per week	
Do you have issues with your eyesight?	<input checked="" type="checkbox"/> No / <input type="checkbox"/> Yes	Do you wear glasses?	<input type="checkbox"/> No / <input checked="" type="checkbox"/> Yes
Do you have issues with your hearing?	<input checked="" type="checkbox"/> No / <input type="checkbox"/> Yes	Do you wear hearing aids?	<input checked="" type="checkbox"/> No / <input type="checkbox"/> Yes
Have you had a fever and/or illness within the last three months?	<input type="checkbox"/> No / <input checked="" type="checkbox"/> Yes	<u>no</u>	
Have you travelled out of Australia in the last six months?	<input type="checkbox"/> No / <input checked="" type="checkbox"/> Yes		
Have you or any member of your extended family had consultations at a genetic clinic? <i>Please provide further details if you answer yes.</i>	<input checked="" type="checkbox"/> No / <input type="checkbox"/> Yes		
Have you or any member of your extended family been diagnosed with a genetic condition? <i>Please provide further details if you answer yes.</i>	<input checked="" type="checkbox"/> No / <input type="checkbox"/> Yes		
Have any members of your extended family died suddenly at an early age? <i>Please provide further details if you answer yes.</i>	<input checked="" type="checkbox"/> No / <input type="checkbox"/> Yes		

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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). 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	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Multiple Sclerosis	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Scleroderma	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Arthritis	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Rheumatoid Arthritis	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Osteoarthritis	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Osteoporosis	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Sjogren's Syndrome	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		

Kidney Conditions						
	No	Yes (self)	Age of onset	Yes (relation)	Age of Onset	Relation to you
Polycystic Kidney Disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Born with one kidney	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Urinary tract disorders	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		

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

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<b>Cancer</b>						
	No	Yes (self)	Age of onset	Yes (relation)	Age of Onset	Relation to you
Breast	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Lung	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Skin	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Bowel	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Lymphoma	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Leukaemia	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Melanoma	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Other cancer <i>If yes, please provide details</i>	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		

<b>Blood Conditions</b>						
	No	Yes (self)	Age of onset	Yes (relation)	Age of Onset	Relation to you
Haemochromatosis	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Anaemia	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Haemophilia	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Sickle Cell Anaemia	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Thalassemia	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		

<b>Skeletal Conditions</b>						
	No	Yes (self)	Age of onset	Yes (relation)	Age of Onset	Relation to you
Muscular Dystrophy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Marfan Syndrome	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Scoliosis	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Skeletal Dysplasia (e.g. Achondroplasia)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		

<b>Cardiovascular Conditions</b>						
	No	Yes (self)	Age of onset	Yes (relation)	Age of Onset	Relation to you
Arrhythmia condition (e.g. Long QT Syndrome)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Cardiomyopathy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Heart Attack	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Stroke	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
High Cholesterol	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Structural Heart Defect from Birth	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Sudden Cardiac Death	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		

<b>Mental Health</b>						
	No	Yes (self)	Age of onset	Yes (relation)	Age of Onset	Relation to you
Clinical Depression	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Schizophrenia	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Bipolar Disorder	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Obsessive-Compulsive Disorder (OCD)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		

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Metabolic/Endocrine						
	No	Yes (self)	Age of onset	Yes (relation)	Age of Onset	Relation to you
Tay-Sachs Disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Type 1 Diabetes	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Type 2 Diabetes	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Thyroid Disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Genetic Metabolic Condition (e.g. Phenylketonuria -PKU)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Hypoglycaemia	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		

Congenital Malformations						
	No	Yes (self)	Age of onset	Yes (relation)	Age of Onset	Relation to you
Cleft Lip/Palate	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Talipes/Club Foot	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Hypospadias	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Undescended Testicles	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Polydactyly	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Other congenital abnormalities <i>If yes, please provide further details</i>	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		

Respiratory Conditions						
	No	Yes (self)	Age of onset	Yes (relation)	Age of Onset	Relation to you
Cystic Fibrosis	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Asthma	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Allergies (Food)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Allergies (Drug)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Allergies (Pet)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Allergies (Hay fever)	<input type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/>		

Skin Conditions						
	No	Yes (self)	Age of onset	Yes (relation)	Age of Onset	Relation to you
Psoriasis	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Eczema	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Albinism	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Vitiligo (pigmentation disorder)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		

Sight/Sound Conditions						
	No	Yes (self)	Age of onset	Yes (relation)	Age of Onset	Relation to you
Colour Blindness	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Cataracts	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Glaucoma	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Retinoblastoma	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Macular Degeneration	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Deafness	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		

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Gastrointestinal Conditions						
	No	Yes (self)	Age of onset	Yes (relation)	Age of Onset	Relation to you
Crohn's Disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Ulcers	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Diverticulitis	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Ulcerative Colitis	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		

**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?*

Allergy to grass pollen.

**Monash IVF Fertility Specialist and Genetics Comments (to be completed by Monash IVF if applicable)**