Donor Medical and Genetic Questionnaire
Donor Non-Identifying Information

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: V051J

Donor Details			
Date Donor Profile Completed: 09/11/2023			
Donor Type:	☒ Sperm Donor	☐ Egg Donor	☐ Embryo Donor: ☐ Sperm Source / ☐ Egg Source *Note: Both donors must provide a declaration*

Please describe your general health:
I am totally fit and fine.

Health Questions			
Do you smoke?	■ No / ☐ Yes	per day	per week
Do you drink alcohol?	■ No / ☐ Yes	per day	per week
Do you or have you engaged in any recreational drug use?	☒ No / ☐ Yes		
Do you exercise/engage in physical activity?	☐ No / ☐ Occasionally / ☒ Often	Daily	hrs per week
Do you have issues with your eyesight?	■ No / ☐ Yes	Do you wear glasses?	☐ No / ☑ Yes
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		
Have you or any member of your extended family had consultations at a genetic clinic? *Please provide further details if you answer **yes.***			■ No / ☐ Yes
Have you or any member of your extended family been diagnosed with a genetic condition? *Please provide further details if you answer **yes.***			☒ No / ☐ Yes
Have any members of your extended family died suddenly at an early age? *Please provide further details if you answer **yes.***			■ No / ☐ 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	☑	☐		☐		
Multiple Sclerosis	☑	☐		☐		
Scleroderma	☑	☐		☐		
Arthritis	☑	☐		☐		
Rheumatoid Arthritis	☑	☐		☐		
Osteoarthritis	☑	☐		☐		
Osteoporosis	☑	☐		☐		
Sjogren's Syndrome	☑	☐		☐		

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*	☑	☐		☐		

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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	☑	☐		☐		

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)	☑	☐		☐		

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	☑	☐		☐		

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)	☑	☐		☐		

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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	☑	☐		☑	75	Grandparents
Thyroid Disease	☑	☐		☐		
Genetic Metabolic Condition (e.g. Phenylketonuria -PKU)	☑	☐		☐		
Hypoglycaemia	☑	☐		☐		

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	☑	☐		☐		
Allergies (Food)	☑	☐		☐		
Allergies (Drug)	☑	☐		☐		
Allergies (Pet)	☑	☐		☐		
Allergies (Hay fever)	☑	☐		☐		

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	☑	☐		☐		
Glaucoma	☑	☐		☐		
Retinoblastoma	☑	☐		☐		
Macular Degeneration	☑	☐		☐		
Deafness	☑	☐		☐		

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

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?

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