Donor Profile and Health Questionnaire

fertilitynetwork scotland

NHS Tayside

NINEWELLS ACU DUNDEE

NHS Grampian

aberdeen fertility centre

NHS Lothian

Edinburgh Fertility & Reproductive Endocrine Centre

NHS Greater Glasgow and Clyde

SCOTTISH NATIONAL BLOOD TRANSFUSION SERVICE

Healthier Scotland

Scottish Government

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	

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		Yes / No	Yes / No	
Father		Yes / No	Yes / No	
Brother(s)	How many:	Yes / No	Yes / No	
Sister(s)	How many:	Yes / No	Yes / No	
Maternal Grandmother (MGM)		Yes / No	Yes / No	
Maternal Grandfather (MGF)		Yes / No	Yes / No	
Paternal Grandmother (PGM)		Yes / No	Yes / No	
Paternal Grandfather (PGF)		Yes / No	Yes / No	
Children	How many:	Yes / No	Yes / No	

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 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	☐	☐

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?

☐ 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 or injectable tanning agents	☐	☐
Has ever had sex in parts of the world where AIDS/HIV is very common	☐	☐
Has syphilis or other sexually transmitted infection?	☐	☐

How many sexual partners have you had in the last 3 months? Please indicate their gender._____

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:

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?

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 or (for males) prostate problems?

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.