

Date: 31-Jul-15

DONOR PROFILE

GENERAL INFORMATION

Year of Birth: 1995

Place of Birth: United States of America

Racial Group/Color Code:

Caucasian Black/Black Asian/Yellow Other/Red

Ethnic Origin/Ancestry: Mother: English Father: German

Religion Born Into:

Donor: None Mother: None Father: None

If Jewish: Ashkenazi Sephardic Oriental

Height: 6'2" Weight: 195 lbs Eye Color: Blue Hair Color: Brown (Blond as a kid)

Hair:

balding
 thin
 average
 thick

Hair Type:

curly
 wavy
 straight

Corrective Lenses:

Yes
 No

Corrective Eye Surgery

Yes
 No

Blood Type: O Rh+

Bone Structure: Small Medium Large Very Large

Are you predominately: right-handed left-handed ambidextrous

Other distinguishing features (dimples, cleft chin, Roman nose, etc.): none

Skin Characteristics:

Freckles: None Few Many

Very fair (little to no ability to tan on sun exposure)

Fair (skin will tan lightly on sun exposure)

Medium (light color but will tan moderate to dark)

Olive (pigmentation of unexposed skin) Light Moderate Dark

Dark (unexposed skin) Light tan Dark Tan Brown Black

EDUCATIONAL BACKGROUND

(check highest level attained)

High School 1 2 3 4 GPA:3.82

College/University 1 2 3 4 GPA:3.8 B.A. B.S.

Major Area of Study: Music

Post Graduate 1 2 3 4 5+ GPA:_____

Major:

Degrees Attained: M.A. M.S. Ph.D. M.D. J.D. D.D.S. Other:

PERSONAL CHARACTERISTICS

(Please describe in some detail)

What is your native language?

english

What other languages do you speak?

none

Math Skills/Ability:

advanced

Mechanical Skills:

none

Athletic Skills:

moderate

What is your favorite sport?

baseball

What are your Hobbies/Interests/Talents:

music

Describe your artistic ability:

very high

What are your favorite foods?

chips, tofu, soup

What is your favorite color?

none

Do you like animals? If so, which is your favorite?

yes, dogs

To where would you like to travel and why?

Turkey, for the food

How would you describe your personality?

extroverted yet reserved

What is your ultimate ambition or goal in life and how do you see yourself in twenty years?

College professor, and concert performer

ADDITIONAL ACADEMIC INFORMATION

SAT Scores: Verbal 1200 Math 570 Total 1770

LSAT MCAT GRE

GMAT Other

EMPLOYMENT/OCCUPATIONAL HISTORY

What is your current or most recent occupation? Private Music Instructor of Children

List all the jobs you have had in the past five years and any exposure to chemicals and gases. Please consider carefully.

Jobs/Duties (Do not name employer)	Year employment		Exposure to which chemicals, gases, etc.
	Began	Ended	
1. Clerck	2010	2014	none
2. Grain Elevator Operator	2013	2015	none
3.	Click	Click	
4.	Click	Click	
5.	Click	Click	
6.	Click	Click	

FERTILITY HISTORY

Do you have any children? none

If yes, how many male children? none female children? none

For each child, please give age, and list any health problems:

Age Special Health Problems

none none

none none

none none

Have you ever been responsible for any pregnancies other than those listed above? No Yes

If yes, what year did it occur? none

Have you ever been refused as a blood donor? No Yes

If yes, explain: none

Has anyone in your family had difficulty in achieving pregnancy? No Yes

If yes, explain: none

Are there any twins or triplets in your family? No Yes

If yes describe: I am a twin

FAMILY MEDICAL HISTORY

Note: The following questions require knowledge about your family’s medical history. You may wish to have your mother or father assist you in obtaining the necessary information.

Has any member of your family, including yourself, had a problem or defect at birth in any of the following body systems?

- | | | |
|--|--|------------------------------|
| 1. Circulatory system | <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes |
| 2. Gastrointestinal system | <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes |
| 3. Genital/urinary system | <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes |
| 4. Metabolic (hormones, enzymes, etc.) | <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes |
| 5. Nervous system (brain, spinal cord, etc.) | <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes |
| 6. Respiratory system | <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes |
| 7. Skeletal system (bones, joints, muscles) | <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes |
| 8. Organ (heart, lung, kidney, etc.) | <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes |
| 9. Other: | <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes |

If yes to any of the above, please list below the specific defect in each case.

Type of birth defect	Affected family member	Age at diagnosis	Relevant circumstances

Do you have any brothers or sisters who died in infancy or childhood? No Yes

If yes, what was the cause?

Are there any diseases or abnormalities that appear to run in your family? No Yes
 If yes, indicate the disease(s) and the family member(s) affected.

Has anyone in your family, including yourself, experienced recurring and/or chronic symptoms that have not been evaluated by a physician? (Please include those symptoms that you may not consider serious.) No Yes

If yes, please describe:

Relatives	Mother	Father	Siblings		Grandparents				Aunts		Uncles		Maternal Cousins		Paternal Cousins	
			F	M	MGM	MGF	PGM	PGF	Mat	Pat	Mat	Pat	F	M	F	M
Indicate number of relatives→	1	1	2	4	1	1	1	1	2	1	1	1	2	2	2	1

Medical Problem	You	Mother	Father	Siblings		Grandparents				Aunts		Uncles		Maternal Cousins		Paternal Cousins		No one	
				F	M	MGM	MGF	PGM	PGF	Mat	Pat	Mat	Pat	F	M	F	M		
1. Cardiovascular																			
A. congenital heart defect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
B. atherosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
C. arteriosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
D. heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
E. high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
G. other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Blood																			
A. anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
B. sickle cell anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
C. hemophilia or other bleeding problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
D. leukemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
E. immune deficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
F. other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Respiratory (lungs)																			
A. hay fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
B. asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
C. emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
D. tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
E. lung cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
F. pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
G. other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Skin																			
A. acne	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
B. eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
C. melanoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
D. skin cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
E. pigmentation disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
F. other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Comments: **My Grandfather has High Blood pressure however it has caused no cardiovascular issues, he has had this since he was a young man**

Medical Problem	You	Mother	Father	Siblings		Grandparents				Aunts		Uncles		Maternal Cousins		Paternal Cousins		No one	
				F	M	MGM	MGF	PGM	PGF	Mat	Pat	Mat	Pat	F	M	F	M		
5. Gastro-intestinal																			
A. ulcer of stomach or duodenum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
B. gall stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
C. hepatitis A (infectious)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
D. hepatitis B (serum)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
E. other liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
F. colon cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
G. ulcerative colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
H. Crohn's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
I. cystic fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
J. intestinal cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
K. other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Urinary																			
A. kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
B. disease of the urinary tract (urethra,bladder, ureter)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
C. other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Genital/Reproductive system																			
A. undescended testicle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
B. hypospadias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
C. prostate cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
D. uterine fibroids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
E. ovarian cysts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
F. cancer of cervix or uterus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
G. breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
H. ovarian cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
I. Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Comments: N/A

Medical Problem	You	Mother	Father	Siblings		Grandparents				Aunts		Uncles		Maternal Cousins		Paternal Cousins		No one	
				F	M	MGM	MGF	PGM	PGF	Mat	Pat	Mat	Pat	F	M	F	M		
8. Metabolic/Endocrine																			
A. diabetes mellitus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
B. hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
C. thyroid cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
D. thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
E. goiter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
F. adrenal dysfunction or disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
G. other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Neurological																			
A. migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
B. mental retardation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
C. senility before age 50	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
D. Alzheimer's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
E. multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
F. epilepsy or seizure disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
H. hydrocephalus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
I. disorders of spinal cord	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
J. Huntington's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
K. Gaucher disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
L. Wilson's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
M. delay in growth and/or development	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
N. learning disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
O. other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. Mental Health																			
A. schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
B. manic depressive illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
C. other mental health disorders requiring hospitalization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
D. severe depression with periods of inability to function	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
E. other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Comments: N/A

Medical Problem	You	Mother	Father	Siblings		Grandparents				Aunts		Uncles		Maternal Cousins		Paternal Cousins		No one	
				F	M	MGM	MGF	PGM	PGF	Mat	Pat	Mat	Pat	F	M	F	M		
11. Muscles/Bones/Joints																			
A. muscular dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
B. other chronic muscle disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
C. lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
D. deformity of spine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
E. osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
F. dwarfism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
G. hereditary low back disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
H. arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
J. other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
12. Sight/sound/smell																			
A. deafness before age 60	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
B. significant hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
C. deformity of the ear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
D. cataracts before age 50	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
E. blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
F. color blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
G. glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
H. deviated septum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
I. any other sight/sound/smell disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
13. Other																			
A. alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
B. drug abuse, misuse, or addiction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
C. any other cancer not mentioned above	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
D. any other condition not mentioned above	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Comments: My Grandmother has arthritis, she has had it since her Forties, it is in her hands, it is not debilitating, she is still very functional

PERSONAL HEALTH HISTORY

Do you currently have any allergies? No Yes

If yes, they are to: Food Drugs Plants Other

Please list specific substances and reaction (s) produced:

Substance	Reaction

Describe any childhood allergies you had: none

How is your vision (without corrective lenses)? Excellent Good Fair Poor

Do you wear corrective lenses? No Yes Your vision is: 20/20 w/corrective

Are you: Nearsighted Farsighted Other (specify)

Have you undergone corrective eye surgery? No Yes

Do you have any hearing impairments? No Yes
If yes, please describe:

Condition of your teeth (check one): Good Fair Poor
Your diet is: Good Fair Poor

Any dietary restrictions? no

Dietary supplements (vitamins, etc.)?biotin

How often do you exercise? Regularly Occasionally Rarely
Type of exercise: cardio vascular and weight training

Have you ever had surgery? No Yes

If yes, please list all surgeries:

- 1)
- 2)
- 3)
- 4)

Year:
Year:
Year:
Year:

Have you had any hospitalization not already mentioned? No Yes
If yes, please explain:

PERSONAL HEALTH HISTORY

(Continued)

Have you had major x-ray exposure or other radiation exposure? No Yes

If yes, please explain:

Have you or your sexual partners ever had:	Myself	Partner	When
NSU (non-specific urethritis)	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
Chlamydia	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
Genital Warts (HPV)	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
Genital Herpes	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
Other (s) Type (s):	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	

Have you ever been treated for any sexually-transmitted disease(s)? No Yes

If yes, for which disease(s):

When? Details?

When was the last time that you were treated?

Have you ever had any major illnesses such as amoebic dysentery, hepatitis, pneumonia, mononucleosis, etc.? No Yes

If yes, please explain:

Do you have any chronic medical problems or conditions? No Yes

If yes, please explain:

Have you ever been exposed to herbicides or toxic chemicals? No Yes

If yes, please explain:

Have you ever served in the military? No Yes

If yes, please explain:

PERSONAL HEALTH HISTORY

(Continued)

Please list any medications you are currently taking: none

Please list any prescription, non-prescription or recreational drugs that you have used or are currently using.

Describe any drug use as indicated below.

Name of Drug	Date Started	Date Ended	Frequency of use	How used?

How many alcoholic drinks do you consume during an average week? 0

Have you ever had a drinking problem? No Yes

If yes, describe:

Have you ever been treated for alcohol or drug abuse? No Yes

If yes, describe:

Do you smoke cigarettes? No Yes

If yes, how many packs/day?

How long have you been smoking regularly?

FAMILY HISTORY SECTION

The following pages contain detailed information regarding the donor's family members. There is one page of information for each family member, including his parents, siblings, grandparents, aunts and uncles. If the donor has more than one sister, you will find more than one page with the title, "Sister of Donor". If the donor has no sisters, this page will be blank. The same applies to brothers, aunts and uncles.

For a summary of the number of family members, please refer to the top portion of page 6 in this profile.

FAMILY HISTORY

Mother of Donor

Year of Birth 1970

Place of Birth: USA

Racial Group:

Caucasian Black Asian Other

If Jewish:

Ashkenazi Sephardic Oriental

Height: 5' 7" Weight: 130lbs Eye Color: Brown Hair Color: Black

Hair:

Balding
 Thin
 Average
 Thick

Hair Type:

Curly
 Wavy
 Straight

Vision:

Excellent
 Good
 Fair
 Poor

Bone Structure:

Small
 Medium
 Large
 Very Large

Other distinguishing features (dimples, cleft chin, Roman nose, etc.):

Skin Characteristics

Freckles: None Few Many

Very fair (little to no ability to tan on sun exposure)
 Fair (skin will tan lightly on sun exposure)
 Medium (light color but will tan moderate to dark)
 Olive (pigmentation of unexposed skin) Light Moderate Dark
 Dark (unexposed skin) Light tan Dark Tan Brown Black

Occupation: mail room

Education: some high school

Special Skills or Characteristics:

If living, describe her health: Excellent Good Fair Poor

If deceased, give cause and age at time of death:

What kind of person is/was she?

Optimistic	<input type="checkbox"/> 1	<input checked="" type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	Pessimistic
Assertive	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	Passive
Leader	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	Follower
Easy going	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	Controlling, rigid

FAMILY HISTORY

Father of Donor

Year of Birth 1971

Place of Birth: USA

Racial Group:

Caucasian Black Asian Other

If Jewish:

Ashkenazi Sephardic Oriental

Height: 6' 0" Weight: 213lbs Eye Color: Brown Hair Color: Brown (Blond as a kid)

Hair:

Balding
 Thin
 Average
 Thick

Hair Type:

Curly
 Wavy
 Straight

Vision:

Excellent
 Good
 Fair
 Poor

Bone Structure:

Small
 Medium
 Large
 Very Large

Other distinguishing features (dimples, cleft chin, Roman nose, etc.):

Skin Characteristics

Freckles: None Few Many

Very fair (little to no ability to tan on sun exposure)
 Fair (skin will tan lightly on sun exposure)
 Medium (light color but will tan moderate to dark)
 Olive (pigmentation of unexposed skin) Light Moderate Dark
 Dark (unexposed skin) Light tan Dark Tan Brown Black

Occupation: Political work

Education: high school

Special Skills or Characteristics:

If living, describe his health: Excellent Good Fair Poor

If deceased, give cause and age at time of death:

What kind of person is/was he?

Optimistic	<input type="checkbox"/> 1	<input checked="" type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	Pessimistic
Assertive	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	Passive
Leader	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input checked="" type="checkbox"/> 3	<input type="checkbox"/> 4	Follower
Easy going	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	Controlling, rigid

FAMILY HISTORY

Sister of Donor

Year of Birth 1990

Place of Birth: USA

Relationship to Donor:

- Full sibling
 Half sibling: maternal paternal
 Adopted into family (DO NOT COMPLETE THIS FORM)

Height: 5' 8" Weight: 130lbs Eye Color: Brown Hair Color: Black

Hair:

- Balding
 Thin
 Average
 Thick

Hair Type:

- Curly
 Wavy
 Straight

Vision:

- Excellent
 Good
 Fair
 Poor

Bone Structure:

- Small
 Medium
 Large
 Very Large

Other distinguishing features (dimples, cleft chin, Roman nose, etc.):

Skin Characteristics

Freckles: None Few Many

- Very fair (little to no ability to tan on sun exposure)
 Fair (skin will tan lightly on sun exposure)
 Medium (light color but will tan moderate to dark)
 Olive (pigmentation of unexposed skin) Light Moderate Dark
 Dark (unexposed skin) Light tan Dark Tan Brown Black

Occupation: Barista

Education: high school

Special Skills or Characteristics:

Does she have any children? No Yes

If yes, how many female children? male children?

If living, describe her health: Excellent Good Fair Poor

If deceased, give cause and age at time of death:

What kind of person is/was she?

- | | | | | | |
|------------|---------------------------------------|----------------------------|----------------------------|---------------------------------------|--------------------|
| Optimistic | <input checked="" type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | Pessimistic |
| Assertive | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input checked="" type="checkbox"/> 4 | Passive |
| Leader | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input checked="" type="checkbox"/> 4 | Follower |
| Easy going | <input checked="" type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | Controlling, rigid |

FAMILY HISTORY

Sister of Donor

Year of Birth 2002

Place of Birth: USA

Relationship to Donor:

- Full sibling
 Half sibling: maternal paternal
 Adopted into family (DO NOT COMPLETE THIS FORM)

Height: 5'0" Weight: 100lbs Eye Color: Brown Hair Color: Blond

Hair:

- Balding
 Thin
 Average
 Thick

Hair Type:

- Curly
 Wavy
 Straight

Vision:

- Excellent
 Good
 Fair
 Poor

Bone Structure:

- Small
 Medium
 Large
 Very Large

Other distinguishing features (dimples, cleft chin, Roman nose, etc.):

Skin Characteristics

Freckles: None Few Many

- Very fair (little to no ability to tan on sun exposure)
 Fair (skin will tan lightly on sun exposure)
 Medium (light color but will tan moderate to dark)
 Olive (pigmentation of unexposed skin) Light Moderate Dark
 Dark (unexposed skin) Light tan Dark Tan Brown Black

Occupation:

Education: middle school

Special Skills or Characteristics:

Does she have any children? No Yes

If yes, how many female children? male children?

If living, describe her health: Excellent Good Fair Poor

If deceased, give cause and age at time of death:

What kind of person is/was she?

- | | | | | | |
|------------|---------------------------------------|----------------------------|----------------------------|---------------------------------------|--------------------|
| Optimistic | <input checked="" type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | Pessimistic |
| Assertive | <input checked="" type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | Passive |
| Leader | <input checked="" type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | Follower |
| Easy going | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input checked="" type="checkbox"/> 4 | Controlling, rigid |

FAMILY HISTORY

Brother of Donor

Year of Birth 1993

Place of Birth: USA

Relationship to Donor:

- Full sibling
 Half sibling: maternal paternal
 Adopted into family (DO NOT COMPLETE THIS FORM)

Height: 6' 1" Weight: 180lbs Eye Color: Brown Hair Color: Black

Hair:

- Balding
 Thin
 Average
 Thick

Hair Type:

- Curly
 Wavy
 Straight

Vision:

- Excellent
 Good
 Fair
 Poor

Bone Structure:

- Small
 Medium
 Large
 Very Large

Other distinguishing features (dimples, cleft chin, Roman nose, etc.):

Skin Characteristics

Freckles: None Few Many

- Very fair (little to no ability to tan on sun exposure)
 Fair (skin will tan lightly on sun exposure)
 Medium (light color but will tan moderate to dark)
 Olive (pigmentation of unexposed skin) Light Moderate Dark
 Dark (unexposed skin) Light tan Dark Tan Brown Black

Occupation: Barista

Education: High school

Special Skills or Characteristics:

Does he have any children? No Yes

If yes, how many female children? male children?

If living, describe his health: Excellent Good Fair Poor

If deceased, give cause and age at time of death:

What kind of person is/was he?

- | | | | | | |
|------------|---------------------------------------|---------------------------------------|----------------------------|---------------------------------------|--------------------|
| Optimistic | <input type="checkbox"/> 1 | <input checked="" type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | Pessimistic |
| Assertive | <input checked="" type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | Passive |
| Leader | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input checked="" type="checkbox"/> 4 | Follower |
| Easy going | <input checked="" type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | Controlling, rigid |

FAMILY HISTORY

Brother of Donor

Year of Birth 1995

Place of Birth: USA

Relationship to Donor:

- Full sibling
 Half sibling: maternal paternal
 Adopted into family (DO NOT COMPLETE THIS FORM)

Height: 6' 2" Weight: 220lbs Eye Color: Blue Hair Color: Light Brown (Blond as a kid)

Hair:

- Balding
 Thin
 Average
 Thick

Hair Type:

- Curly
 Wavy
 Straight

Vision:

- Excellent
 Good
 Fair
 Poor

Bone Structure:

- Small
 Medium
 Large
 Very Large

Other distinguishing features (dimples, cleft chin, Roman nose, etc.):

Skin Characteristics

Freckles: None Few Many

- Very fair (little to no ability to tan on sun exposure)
 Fair (skin will tan lightly on sun exposure)
 Medium (light color but will tan moderate to dark)
 Olive (pigmentation of unexposed skin) Light Moderate Dark
 Dark (unexposed skin) Light tan Dark Tan Brown Black

Occupation:

Education: high school

Special Skills or Characteristics:

Does he have any children? No Yes

If yes, how many female children? male children?

If living, describe his health: Excellent Good Fair Poor

If deceased, give cause and age at time of death:

What kind of person is/was he?

- | | | | | | |
|------------|---------------------------------------|----------------------------|----------------------------|----------------------------|--------------------|
| Optimistic | <input checked="" type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | Pessimistic |
| Assertive | <input checked="" type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | Passive |
| Leader | <input checked="" type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | Follower |
| Easy going | <input checked="" type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | Controlling, rigid |

FAMILY HISTORY

Brother of Donor

Year of Birth 2007

Place of Birth: USA

Relationship to Donor:

- Full sibling
 Half sibling: maternal paternal
 Adopted into family (DO NOT COMPLETE THIS FORM)

Height: 5'0" Weight: 100lbs Eye Color: Blue Hair Color: Blond

Hair:

- Balding
 Thin
 Average
 Thick

Hair Type:

- Curly
 Wavy
 Straight

Vision:

- Excellent
 Good
 Fair
 Poor

Bone Structure:

- Small
 Medium
 Large
 Very Large

Other distinguishing features (dimples, cleft chin, Roman nose, etc.):

Skin Characteristics

Freckles: None Few Many

- Very fair (little to no ability to tan on sun exposure)
 Fair (skin will tan lightly on sun exposure)
 Medium (light color but will tan moderate to dark)
 Olive (pigmentation of unexposed skin) Light Moderate Dark
 Dark (unexposed skin) Light tan Dark Tan Brown Black

Occupation:

Education: grade school

Special Skills or Characteristics:

Does he have any children? No Yes

If yes, how many female children? male children?

If living, describe his health: Excellent Good Fair Poor

If deceased, give cause and age at time of death:

What kind of person is/was he?

- | | | | | | |
|------------|---------------------------------------|----------------------------|----------------------------|---------------------------------------|--------------------|
| Optimistic | <input checked="" type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | Pessimistic |
| Assertive | <input checked="" type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | Passive |
| Leader | <input checked="" type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | Follower |
| Easy going | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input checked="" type="checkbox"/> 4 | Controlling, rigid |

FAMILY HISTORY

Brother of Donor

Year of Birth 2008

Place of Birth: USA

Relationship to Donor:

- Full sibling
 Half sibling: maternal paternal
 Adopted into family (DO NOT COMPLETE THIS FORM)

Height: 5'0" Weight: 100lbs Eye Color: Blue Hair Color: Blond

Hair:

- Balding
 Thin
 Average
 Thick

Hair Type:

- Curly
 Wavy
 Straight

Vision:

- Excellent
 Good
 Fair
 Poor

Bone Structure:

- Small
 Medium
 Large
 Very Large

Other distinguishing features (dimples, cleft chin, Roman nose, etc.):

Skin Characteristics

Freckles: None Few Many

- Very fair (little to no ability to tan on sun exposure)
 Fair (skin will tan lightly on sun exposure)
 Medium (light color but will tan moderate to dark)
 Olive (pigmentation of unexposed skin) Light Moderate Dark
 Dark (unexposed skin) Light tan Dark Tan Brown Black

Occupation:

Education: grade school

Special Skills or Characteristics:

Does he have any children? No Yes

If yes, how many female children? male children?

If living, describe his health: Excellent Good Fair Poor

If deceased, give cause and age at time of death:

What kind of person is/was he?

- | | | | | | |
|------------|---------------------------------------|----------------------------|----------------------------|----------------------------|--------------------|
| Optimistic | <input checked="" type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | Pessimistic |
| Assertive | <input checked="" type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | Passive |
| Leader | <input checked="" type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | Follower |
| Easy going | <input checked="" type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | Controlling, rigid |

FAMILY HISTORY

Maternal Grandmother of Donor

Year of Birth 1942

Place of Birth: USA

Racial Group:

Caucasian Black Asian Other

If Jewish:

Ashkenazi Sephardic Oriental

Height: 5'2" Weight: 130lbs Eye Color: Brown Hair Color: Black

Hair:

Balding
 Thin
 Average
 Thick

Hair Type:

Curly
 Wavy
 Straight

Vision:

Excellent
 Good
 Fair
 Poor

Bone Structure:

Small
 Medium
 Large
 Very Large

Other distinguishing features (dimples, cleft chin, Roman nose, etc.):

Skin Characteristics

Freckles: None Few Many

Very fair (little to no ability to tan on sun exposure)
 Fair (skin will tan lightly on sun exposure)
 Medium (light color but will tan moderate to dark)
 Olive (pigmentation of unexposed skin) Light Moderate Dark
 Dark (unexposed skin) Light tan Dark Tan Brown Black

Occupation: grocer

Education: high school

Special Skills or Characteristics:

If living, describe her health: Excellent Good Fair Poor

If deceased, give cause and age at time of death:

What kind of person is/was she?

Optimistic	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	Pessimistic
Assertive	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	Passive
Leader	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	Follower
Easy going	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input checked="" type="checkbox"/> 3	<input type="checkbox"/> 4	Controlling, rigid

FAMILY HISTORY

Maternal Grandfather of Donor

Year of Birth 1937

Place of Birth: USA

Racial Group:

Caucasian Black Asian Other

If Jewish:

Ashkenazi Sephardic Oriental

Height: 6' 3" Weight: 190lbs Eye Color: Blue Hair Color: Dark Brown

Hair:

Balding
 Thin
 Average
 Thick

Hair Type:

Curly
 Wavy
 Straight

Vision:

Excellent
 Good
 Fair
 Poor

Bone Structure:

Small
 Medium
 Large
 Very Large

Other distinguishing features (dimples, cleft chin, Roman nose, etc.):

Skin Characteristics

Freckles: None Few Many

Very fair (little to no ability to tan on sun exposure)
 Fair (skin will tan lightly on sun exposure)
 Medium (light color but will tan moderate to dark)
 Olive (pigmentation of unexposed skin) Light Moderate Dark
 Dark (unexposed skin) Light tan Dark Tan Brown Black

Occupation: mechanic

Education: high school

Special Skills or Characteristics:

If living, describe his health: Excellent Good Fair Poor

If deceased, give cause and age at time of death:

What kind of person is/was he?

Optimistic	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	Pessimistic
Assertive	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	Passive
Leader	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	Follower
Easy going	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	Controlling, rigid

FAMILY HISTORY

Paternal Grandmother of Donor

Year of Birth 1955

Place of Birth: USA

Racial Group:

Caucasian Black Asian Other

If Jewish:

Ashkenazi Sephardic Oriental

Height: 5'2" Weight: 130lbs Eye Color: Blue Hair Color: Light Brown

Hair:

Balding
 Thin
 Average
 Thick

Hair Type:

Curly
 Wavy
 Straight

Vision:

Excellent
 Good
 Fair
 Poor

Bone Structure:

Small
 Medium
 Large
 Very Large

Other distinguishing features (dimples, cleft chin, Roman nose, etc.):

Skin Characteristics

Freckles: None Few Many

Very fair (little to no ability to tan on sun exposure)
 Fair (skin will tan lightly on sun exposure)
 Medium (light color but will tan moderate to dark)
 Olive (pigmentation of unexposed skin) Light Moderate Dark
 Dark (unexposed skin) Light tan Dark Tan Brown Black

Occupation: Nurse

Education: BA

Special Skills or Characteristics:

If living, describe her health: Excellent Good Fair Poor

If deceased, give cause and age at time of death:

What kind of person is/was she?

Optimistic	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	Pessimistic
Assertive	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	Passive
Leader	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	Follower
Easy going	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input checked="" type="checkbox"/> 3	<input type="checkbox"/> 4	Controlling, rigid

FAMILY HISTORY

Paternal Grandfather of Donor

Year of Birth 1954

Place of Birth: USA

Racial Group:

Caucasian Black Asian Other

If Jewish:

Ashkenazi Sephardic Oriental

Height: 5' 11" Weight: 175lbs Eye Color: Blue Hair Color: Brown

Hair:

Balding
 Thin
 Average
 Thick

Hair Type:

Curly
 Wavy
 Straight

Vision:

Excellent
 Good
 Fair
 Poor

Bone Structure:

Small
 Medium
 Large
 Very Large

Other distinguishing features (dimples, cleft chin, Roman nose, etc.):

Skin Characteristics

Freckles: None Few Many

Very fair (little to no ability to tan on sun exposure)
 Fair (skin will tan lightly on sun exposure)
 Medium (light color but will tan moderate to dark)
 Olive (pigmentation of unexposed skin) Light Moderate Dark
 Dark (unexposed skin) Light tan Dark Tan Brown Black

Occupation:

Education:

Special Skills or Characteristics:

If living, describe his health: Excellent Good Fair Poor

If deceased, give cause and age at time of death:

What kind of person is/was he?

Optimistic	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	Pessimistic
Assertive	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	Passive
Leader	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	Follower
Easy going	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	Controlling, rigid

FAMILY HISTORY

Maternal Aunt of Donor

Year of Birth 1960

Place of Birth: USA

Racial Group:

Caucasian Black Asian Other

If Jewish:

Ashkenazi Sephardic Oriental

Height: 5' 7" Weight: 150lbs Eye Color: Brown Hair Color: Dark Brown

Hair:

Balding
 Thin
 Average
 Thick

Hair Type:

Curly
 Wavy
 Straight

Vision:

Excellent
 Good
 Fair
 Poor

Bone Structure:

Small
 Medium
 Large
 Very Large

Other distinguishing features (dimples, cleft chin, Roman nose, etc.):

Skin Characteristics

Freckles: None Few Many

Very fair (little to no ability to tan on sun exposure)
 Fair (skin will tan lightly on sun exposure)
 Medium (light color but will tan moderate to dark)
 Olive (pigmentation of unexposed skin) Light Moderate Dark
 Dark (unexposed skin) Light tan Dark Tan Brown Black

Occupation: Banker

Education: BA

Special Skills or Characteristics:

Does she have any children?

No Yes

If yes, how many female children? 2

male children? 1

If living, describe her health:

Excellent Good Fair Poor

If deceased, give cause and age at time of death:

What kind of person is/was she?

Optimistic	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	Pessimistic
Assertive	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	Passive
Leader	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	Follower
Easy going	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input checked="" type="checkbox"/> 4	Controlling, rigid

FAMILY HISTORY

Maternal Aunt of Donor

Year of Birth 1961

Place of Birth: Washington

Racial Group:

Caucasian Black Asian Other

If Jewish:

Ashkenazi Sephardic Oriental

Height: 5' 7" Weight: 150lbs Eye Color: Brown Hair Color: Dark Brown

Hair:

Balding
 Thin
 Average
 Thick

Hair Type:

Curly
 Wavy
 Straight

Vision:

Excellent
 Good
 Fair
 Poor

Bone Structure:

Small
 Medium
 Large
 Very Large

Other distinguishing features (dimples, cleft chin, Roman nose, etc.):

Skin Characteristics

Freckles: None Few Many

Very fair (little to no ability to tan on sun exposure)
 Fair (skin will tan lightly on sun exposure)
 Medium (light color but will tan moderate to dark)
 Olive (pigmentation of unexposed skin) Light Moderate Dark
 Dark (unexposed skin) Light tan Dark Tan Brown Black

Occupation: Clerk

Education: high school

Special Skills or Characteristics:

Does she have any children?

No Yes

If yes, how many female children? 0

male children? 1

If living, describe her health:

Excellent Good Fair Poor

If deceased, give cause and age at time of death:

What kind of person is/was she?

Optimistic	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	Pessimistic
Assertive	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input checked="" type="checkbox"/> 3	<input type="checkbox"/> 4	Passive
Leader	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input checked="" type="checkbox"/> 3	<input type="checkbox"/> 4	Follower
Easy going	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	Controlling, rigid

FAMILY HISTORY

Maternal Uncle of Donor

Year of Birth 1985

Place of Birth: USA

Racial Group:

Caucasian Black Asian Other

If Jewish:

Ashkenazi Sephardic Oriental

Height: 5' 10" Weight: 180lbs Eye Color: Blue Hair Color: Light Brown (Blond as a kid)

Hair:

Balding
 Thin
 Average
 Thick

Hair Type:

Curly
 Wavy
 Straight

Vision:

Excellent
 Good
 Fair
 Poor

Bone Structure:

Small
 Medium
 Large
 Very Large

Other distinguishing features (dimples, cleft chin, Roman nose, etc.):

Skin Characteristics

Freckles: None Few Many

Very fair (little to no ability to tan on sun exposure)
 Fair (skin will tan lightly on sun exposure)
 Medium (light color but will tan moderate to dark)
 Olive (pigmentation of unexposed skin) Light Moderate Dark
 Dark (unexposed skin) Light tan Dark Tan Brown Black

Occupation: agriculture

Education: high school

Special Skills or Characteristics:

Does he have any children? No Yes

If yes, how many female children? male children?

If living, describe his health: Excellent Good Fair Poor

If deceased, give cause and age at time of death:

What kind of person is/was he?

Optimistic	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	Pessimistic
Assertive	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	Passive
Leader	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input checked="" type="checkbox"/> 3	<input type="checkbox"/> 4	Follower
Easy going	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	Controlling, rigid

FAMILY HISTORY

Paternal Aunt of Donor

Year of Birth 1975

Place of Birth: USA

Racial Group:

Caucasian Black Asian Other

If Jewish:

Ashkenazi Sephardic Oriental

Height: 5' 5" Weight: 180lbs Eye Color: Blue Hair Color: Red

Hair:

Balding
 Thin
 Average
 Thick

Hair Type:

Curly
 Wavy
 Straight

Vision:

Excellent
 Good
 Fair
 Poor

Bone Structure:

Small
 Medium
 Large
 Very Large

Other distinguishing features (dimples, cleft chin, Roman nose, etc.):

Skin Characteristics

Freckles: None Few Many

Very fair (little to no ability to tan on sun exposure)
 Fair (skin will tan lightly on sun exposure)
 Medium (light color but will tan moderate to dark)
 Olive (pigmentation of unexposed skin) Light Moderate Dark
 Dark (unexposed skin) Light tan Dark Tan Brown Black

Occupation: Hair stylist

Education: high school

Special Skills or Characteristics:

Does she have any children?

No Yes

If yes, how many female children? 2

male children? 1

If living, describe her health:

Excellent Good Fair Poor

If deceased, give cause and age at time of death:

What kind of person is/was she?

Optimistic	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	Pessimistic
Assertive	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input checked="" type="checkbox"/> 3	<input type="checkbox"/> 4	Passive
Leader	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input checked="" type="checkbox"/> 3	<input type="checkbox"/> 4	Follower
Easy going	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	Controlling, rigid

FAMILY HISTORY

Paternal Uncle of Donor

Year of Birth 1985

Place of Birth: USA

Racial Group:

Caucasian Black Asian Other

If Jewish:

Ashkenazi Sephardic Oriental

Height: 5' 10" Weight: 180lbs Eye Color: Blue Hair Color: Light Brown (Blond as a kid)

Hair:

Balding
 Thin
 Average
 Thick

Hair Type:

Curly
 Wavy
 Straight

Vision:

Excellent
 Good
 Fair
 Poor

Bone Structure:

Small
 Medium
 Large
 Very Large

Other distinguishing features (dimples, cleft chin, Roman nose, etc.):

Skin Characteristics

Freckles: None Few Many

Very fair (little to no ability to tan on sun exposure)
 Fair (skin will tan lightly on sun exposure)
 Medium (light color but will tan moderate to dark)
 Olive (pigmentation of unexposed skin) Light Moderate Dark
 Dark (unexposed skin) Light tan Dark Tan Brown Black

Occupation: Agriculture

Education: high school

Special Skills or Characteristics:

Does he have any children?

No Yes

If yes, how many female children?

male children?

If living, describe his health:

Excellent Good Fair Poor

If deceased, give cause and age at time of death:

What kind of person is/was he?

Optimistic	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	Pessimistic
Assertive	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input checked="" type="checkbox"/> 3	<input type="checkbox"/> 4	Passive
Leader	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input checked="" type="checkbox"/> 4	Follower
Easy going	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	Controlling, rigid

In Your Own Words...

What did you do immediately after high school?

I got a Summer Job and began college in the fall.

Which words describe your personality and character?

I am extroverted, yet reserved. I might not approach a stranger, but my friends know me to be excited and playful.

Which sports do you like to participate in?

I didn't grow up playing sports, but I really enjoyed playing baseball in Highschool.

Which sports did you play as a child?

Baseball is the sport I played as a child.

Which sports do you enjoy watching?

My brother is a huge football fan so I like to hang out and watch the games with him.

Do you play any musical instruments?

I play guitar and piano.

What is your most memorable childhood experience?

I remember really enjoying camping trips with my family.

To which countries have you traveled?

I have never left America.

Describe one of your favorite vacations to another country:

None

Describe things you like the most about your own country:

I love the country, it's like the Wild West. Also I enjoy the incredible amount of financial aid my government has given me for school.

Describe a few of your strong sides:

Some of the things I excel at are math, sciences, Music, and cooking.

Describe a few of your weak sides:

Some things I'm not very good at are romantic relationships, reading

Donor Essay

Why do you want to be a donor?

I want to be a donor because I believe in community service and giving back, I have been donating blood for years now and thought this would be a good next step.

Describe your relationship with your family. How has your family shaped your values and who you are today?

I have a very loving relationship with my family, I consider my father and my brother to be my closest friends. My parents actively taught myself and my siblings the importance of common respect to all people and this has really shaped my values towards being accepting and outwardly kind.

What makes you unique?

I would say my perspective: my parents were separated while I was growing up, my dad living in the city and my mother living in the country. As a young person I was able to observe these two sharply contrasting viewpoints (rural vs urban) and try to develop a unique perspective of my own.

What are you most proud of and why?

I am the most proud of my educational achievements, it is very satisfying to see my hardwork pay off.

Handwritten message

If you could pass on a message to the recipient(s) of your semen, what would that message be?

I'm glad I could help you out with this endeavor, I hope you enjoy parenthood!