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Donor Sticker

**Initial Assessment – Embryo Donor**

**Personal Information**

Surname……………………………………………………… Forename (s) ………………………..…………………

Surname at birth (if different)……………………………………… D.O.B…………………………………………………..……

Address………………………………………………………………………………………………………………………………..…………………….….

……………………………………………………………………………………………………………………………..………………………………...……..

Postcode…………………………………………………… Tel No…………………….…………………………………………..….

Mobile………………………………………………………. E mail………………………………..……………………………..…….

Town or district of birth……………………………… Country of birth……………………………………….……….……

Occupation ………………………………………………. Religion ……………………………………………………….…….…..

NHS number (if known)..………………………..… Ethnic Group ……………………………………………..……………

Marital status……………………………………….…… Sexual Orientation……………………………………………..……

Passport number (+ country of issue) ..…………………………………………………………………………………………………….….….

Nationality ……………………………………………….. Parent’s nationality …………………………………………………

Mothers Ethnic Group ……………………………… Fathers Ethnic Group ………………………………………………

Do you have your own children: YES / NO No. of girls…………….....… No. of boys………….….…

Height : metres/feet……………………………………. Natural Hair Colour:……………………………………….……….

Eye Colour …………………………………………….. Build/Weight kgs/stone………………………………….………

Skin Tone…………………………………………………….. Left Handed or Right Handed……………………….…………

How were you recruited? …………………………… Reasons for donating ……………………………………..………

Donations at other centres? …………………….. If so what centres? ……………………………………….…….….

**Personal History**

Any history of STDs? …………………………………………………………………….…..…….……………………………………………………..

Ever had genital warts / herpes? ..............................................................................................................

Number of sexual partners where intercourse was unprotected?..............................................................

Have you ever used recreational drugs, such as cannabis or intravenous drugs, such as heroin or cocaine?...................................................................................................................................................

Were you on any medication (prescribed or over the counter) at the time of embryo creation…………………………………………………………………………………….................……………………………………………………..

**Medical History**

G.P. Name………………………………………………………………………………………………………………………..……………………..……….

G.P. Address………………………………………………………………………………………………………………………….…………………..…...

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**Do you or any of your family suffer from (or at higher risk of):**

Diabetes ……………………………………………………………………………………………………………………………………………….…………

Epilepsy……………………………………………………………………………………………………….…………………………………….…………….

Debilitating Asthma.………………………………………………………………………………………………………………………………….…….

Rheumatoid arthritis…………………………………………………………………………………………………….…………..…………………….

Severe refractive disorder……………………………………………………………………………………………….………..….………………..

Sickle cell / Thalassaemia/ glucose-6-phosphate dehydrogenase deficiency …………………………….…………………

Tay Sachs………………………………………………………………………………………………………………………………….……………….……..

Talipes..…………………………………………………………………………………………………………………………………….……………………..

Mental disorders incl. psychosis………………………………………………………………………………………………..……………………

Severe hypertension…………………………………………………………………………………………………………………..………..………..

Chromosomal rearrangement………………………………………………………………………………………….…………....………………

Autosomal recessive disease e.g. Cystic Fibrosis ………………………………..………………………………..………………….…..

Autosomal dominant / X-linked disorders e.g. Huntingdon’s………………………………………………..……………..………

Congenital or inherited abnormalities inc. hip dislocation, heart malformation, cleft lip/palate, neural tube defects inc. spina bifida, club foot, hypospadia …………………………………………………….………………………………………

Mendelian disorders: albinism, haemophilia, haemoglobin disorders, hereditary hypercholesterolaemia, neurofibromatosis, tuberous sclerosis……………………………………………………………………………………………………….…….

Transmissible Spongiform Encephalopathies (prion diseases)………………………………....………………………………………

Have you had an invasive neurosurgery procedure?.......................................................................................

Have you received human pituitary derived growth hormone or cornea or sclera or dura mater?........................................................................................................................................................

**Clinic use only**

Reviewed at face-to-face by registered professional to verify medical history:

Signed (Clinic staff)…………………………………..……………..… Date………………………………

Assessed by medical practitioner at CRM with GP response and hospital notes (if available)

Signed (Medical Practitioner)……………………………………………. Date……………………………….