Known Donor Questionnaire

A donor's answers to these questions will provide the person conceiving with a wealth of information about the donor's health, similar to what a recipient would receive from a sperm bank (or items that would be used to screen potential sperm bank donors). You'll probably need assistance from a health care provider to interpret how some of these questions may affect the health of the recipient and future child. If the donor is planning to undergo a physical exam, which we recommend, it would be useful to bring this completed form so that the health care provider can review it. The questionnaire is probably more in-depth than the list of questions a health care provider would normally ask.
During a physical exam, the health care provider will also take a health history and review of systems, which includes many questions about past and current symptoms or health conditions. We haven't included basic questions of this nature here.

Environmental Exposures

In your work are you exposed to any health hazards such as asbestos, radiation, heavy metals, toxic chemicals, etc.?

Have you been exposed to any of these in any of your hobbies or pastimes?

Have you been exposed to any toxic agents in the military or anywhere else?

What kind of regular, everyday use of chemicals do you have at home or in your hobbies?

Sexual Practices

Do you have sex with people assigned male at birth, people assigned female at birth, or both?

Have you recently had an HIV test? If so, how long ago and what were the results?

Have you recently been tested for other sexually transmitted infections? Results?

Do you have a regular partner?

Do you have sex with people other than your partner?

Does your partner have sex with people other than you?

Has your partner had an HIV test? When was the most recent? Was it negative or positive?

Has your partner had tests for other sexually transmitted infections? Results?

How many people have you had sex with in the past year?

Please mark the activities you engage in sexually, even if not frequently. Note how often you use condoms or other barriers: always, sometimes, or never.

Activity	**How Frequently? (daily, monthly, yearly)**	**I ALWAYS use a condom, glove, etc or for this activity**	**I SOMETIMES use a condom, glove, etc for this activity**	**I NEVER use a condom, glove, etc for this activity**
Put someone's penis in your rectum				
Put someone's penis in your mouth				
Put your penis in someone's rectum				
Put your penis in someone's mouth				
Put your penis in someone's vagina				
Put your mouth on someone's anus				
Put your mouth on someone's vagina				
Put your hand in someone's vagina				
Put your hand in someone's rectum				
Share sex toys				
Only engage in mutual masturbation				
No sexual activity				
Participate in BDSM activities: Please list of what nature and what forms of protection				

If you have used condoms, have any broken in the past year?

In the past year have you experienced a change in the type or safety of your sexual activities on occasions when you have been drinking alcohol, used drugs, or partied?

Drug and Alcohol Use

How often do you drink alcohol:

___ not at all

___ once a week or less

___ 2-3 times a week

___ daily or almost daily

Which of these applies to your alcohol consumption:

___ When I drink it's usually one or two.

___ When I drink it's usually three or more.

___ When I drink I never get drunk.

___ When I drink I rarely have gotten drunk.

___ When I drink I occasionally get drunk.

___ When I drink I usually get drunk.

___ I get drunk most weekends.

Do you smoke cigarettes? If so, how many per day?

Are you exposed to secondhand smoke at work, home, with friends, or when you're out socially?

Do you smoke marijuana? If so, how often?

Do you use other recreational drugs? If so, which ones and how often?

Are you in recovery from alcohol or substance abuse? If yes, from which substances and how long have you been clean and sober?

Do you use needles with any of your drug use?

Medical History

Has anyone conceived with your sperm in the past? If so, how many times?

How many children have you helped conceive?

Are you adopted?

Do you have access to the medical history of both of your biological parents?

If no, which do you not have access to?

Do you have any inherited disorder, such as hemophilia or sickle-cell anemia?

Do you carry a gene for any inherited disorder, such as anemias caused by thalassemia, sickle-cell anemia, or Tay-Sachs disease? Cystic fibrosis?

Have you ever had a serious illness or accident? If so, explain.

Have you ever had surgery?

Have you ever been hospitalized for anything other than surgery?

Have you ever had a blood transfusion? If so, when and where?

Do you currently take any medications? If so, for what?

Check and describe if you've had any of the following diseases or conditions:

___ allergies
___ anemia
___ arthritis
___ asthma
___ blood diseases
___ cancer
___ coronary artery disease
___ depression
___ diabetes
___ dyslexia
___ epilepsy
___ gallbladder problems
___ glaucoma
___ heart attack
___ heart malformation
___ high cholesterol

___ hypertension
___ liver disease
___ migraine headaches
___ polycystic renal disease
___ nervous or mental disorders
___ phlebitis/blood clots
___ respiratory illness
___ shingles
___ spina bifida
___ stroke
___ thyroid disease
___ tuberculosis
___ ulcers

Sexually Transmitted Infections:
___ chlamydia
___ genital herpes
___ genital warts
___ gonorrhea
___ syphilis
___ hepatitis
___ other sexually transmitted infections

Family History

Do twins or multiple births run in your family?

Does any member of your family have a serious birth defect?

Are there known genetic diseases in your family?

Did your mother take the drug DES when she was pregnant with you?

Did any of your siblings die in infancy or childhood?

Do you or any member of your family have any diseases or conditions that you haven't already mentioned in the questionnaire?

Have any of your blood relatives had any of the following problems? (include your parents, your children, your siblings, grandparents, first cousins, aunts and uncles)

___ alcoholism/drug addiction
___ any medical problem with a possible genetic cause
___ blindness
___ colon cancer
___ congenital anomalies (birth defects)
___ congenital heart disease
___ congenital hip dysplasia
___ convulsive disorders
___ deafness
___ diabetes before age 50 controlled by diet
___ diabetes before age 50 not controlled by diet (type 1 or 2)
___ heart disease before age 50
___ intestinal cancer
___ manic depression/bipolar disorder
___ mental retardation
___ muscular dystrophy