



4845 Knightsbridge Blvd.
Suite 200
Columbus, OH 43214
Phone: (614) 451-4375
Fax: (614) 451-5284

Personal and Medical History

Enclosed is the medical history for

PC 1152

There are instances where Cryobio redacts certain identifying information from the Donor Medical History, an example could be the name of the college the donor attended, or a sports team they were on. If this is the case you will notice a typed reason for the redaction, accompanied by an initial and date. We want to assure you that no medical information has been changed or deleted from the donor's medical history.

The Cryobio Team

Personal Characteristics

Ethnic origin/Ancestry: Mother Eastern European Father South Asian

Religion born into Hinduism

Do you have any biological relatives of Jewish descent? ___ Yes No If yes, please list: _____

Education

Check all that apply:

completed high school

currently in college

degree being pursued Bachelor's Degree area of study Physics

total number of years attended college 1st

___ completed college

___ Bachelor's degree in _____

___ Master's degree in _____

___ Ph.D. in _____

___ OTHER EDUCATION total number of years attended _____

facility and/or subject _____

___ Scholarships or awards (artistic, athletic, scholastic, other...) _____

Fertility History

Do you have any children? ___ Yes No

if yes, how many male children? _____ How many female children? _____

For each child please write below their ages and any special health problems they have:

Age Special Health Problems

Fertility History continued...

Has a woman ever conceived with your sperm? Yes No

If yes, what years did these pregnancies occur? _____

Have you ever been told that you were infertile? Yes No

If yes, when? _____ On what basis? _____

Is there any history of fertility problems in your family (difficulty in conceiving or miscarriage)? Yes No

If yes, please explain _____

Did your parents have difficulty conceiving? _____

Do any of your brothers have fertility problems? _____

Do any of your uncles have fertility problems? _____

Are you exposed to excess heat in the way of saunas, hot tubs, steam rooms? Yes No

Personal Health History

Do you currently have any allergies? Yes No

If yes, are they to: food drugs environmental other

Please list below specific substances and reaction(s) produced:

Substance	Reaction
_____	_____
_____	_____
_____	_____

As per the above, please describe any childhood allergies you have outgrown: _____

Do you wear corrective vision lenses? Yes No Sometimes (specify) _____

Are you: Nearsighted Farsighted Other (specify) _____

Have you ever had a hearing loss diagnosed? Yes No

If yes, please explain _____

Personal Health History continued...

Condition of your teeth (check one): Poor Fair Good Excellent

Have you ever had braces? Yes No If yes, when? _____

Have you ever had any other orthodonture or major dental work? Yes No
 If yes, what and when? _____

Do you have any speech impairment? Yes No
 If yes, please explain _____

Your diet is (check one): Vegetarian Non-vegetarian

Your diet is (check one): Poor Fair Good Excellent

How much exercise do you get? (check one): None Occasionally Regularly

At the level of a professional athlete What type of exercise? Basketball & weightlifting

Are you right or left-handed? _____ Ambidextrous? Yes No

Have you ever received pituitary derived human growth hormone? Yes No
 If yes, when? _____

Have you ever had surgery? Yes No
 If yes, please explain: _____

Have you had any hospitalization other than above? Yes No
 If yes, please explain: _____

Have you had major radiation exposure or [X-ray exposure]? Yes No

If yes, please explain: sprained my ankle in high school, I had an X-ray to make sure nothing severe. Also dentist X-rays

Have you ever had any major illnesses such as amoebic dysentery, hepatitis, pneumonia, mononucleosis, etc.? Yes No
 If yes, please explain: _____

Do you have any current or chronic medical problems/conditions? Yes No
 If yes, please explain: _____

Have you been vaccinated or immunized in the past 12 months? Yes No

If yes, please explain: Most recent vaccination was Covid booster Jan 4/2023 I'm fully vaccinated otherwise.

Have you received a hepatitis B immune globulin injection or gamma globulin injection? Yes No
 If yes, when? _____

Personal Health: Exposures

Have you ever served in the military? Yes No Branch _____

Have you ever been exposed to biological and/or chemical warfare agents or any other herbicides or chemicals (forest service, highway maintenance, military service, etc.)? Yes No

If yes, which substance(s)? _____

Have you ever lived in or visited a foreign country for an extended period of time? Yes No

If yes, when and where? _____

List any medications you are currently taking and what they are for: No Medications at this time

Have you ever used or do you currently use any of the following drugs? Yes No

If yes, please check: Frequency/When (years) How used?

Marijuana _____

Cocaine _____

Barbituates _____

Narcotics
(heroin, methadone, opium, morphine, codeine) _____

Amphetamines _____

Hallucinogens _____

Tranquillizers _____

Anti-depressants _____

PCP _____

Inhalants *Albuterol sulfate inhalation aerosol* *For 1 week in 2022* *Used to treat minor bronchitis*
(amyl or butyl nitrate, aerosol propellants)

Over the counter drugs *Ibuprofen (Advil, Aleve or Tylenol). Use it [occasionally] when sick or muscular aches* *Used for when sick or muscular aches from extreme exercise (occasional use) or injury (sprain/strain)*
please list: *injury (sprain/strain)*

Personal Health: Exposures continued...

Do you currently drink alcoholic beverages? ___ Yes No

If yes, which kinds? ___ beer ___ wine ___ liquor

Approximately how many drinks do you consume: _____ per day? _____ per week?

If you now drink less than 3 drinks per day, was there ever a time when you drank more? ___ Yes ___ No

If yes, how much _____ when _____ (give years)

If you do not drink alcoholic beverages now, have you ever regularly drank alcoholic beverages?

___ Yes No If yes, when? _____

Do you currently smoke cigarettes? ___ Yes No If yes, how many cigarettes or packs a day? _____

How long have you been smoking regularly? _____

If no, have you ever regularly smoked cigarettes? ___ Yes No If yes, when? _____

Do you currently drink coffee? ___ Yes No If yes, how many cups a day? _____

If no, have you ever drank coffee regularly? NO When? _____

Family Health History

Please describe your natural (biological) family members by the following physical characteristics:

1 = under 5'5
2 = 5'6 to 5'10
3 = over 5'11
1 = good
2 = glasses or contacts
Vision

	Eye Color	Hair Color	Complexion	Height	Bone Type	Vision
Mother	Blue	Blond	Fair	2 = 5'9"	Normal/Medium	1
Father	Brown	Black	Medium (Brown)	3 = 6'2"	Normal/Medium	2
Sisters:						
1.						
2.						
3.						
Brothers:						
1.	Brown	Brown	Fair	3 = 6'5"	Large/Normal	2
2.	Brown	Brown	Fair	1 = (under 18 age)	Medium/Normal	2
3.						
MGM	Green	Brown	Fair	2 = 5'7"	Medium/Normal	1
MGP	Blue	Blond	Fair	3 = 6'2"	Large/Normal	2
PGM	Brown	Black	Medium (Brown)	1 = ?	Medium/Normal	1
PGF	Brown	Black	Medium (Brown)	3 = 6'0"	Medium/Normal	2

MGM = Maternal grandmother
PGM = Paternal grandmother, etc.

Family Health History continued...

How many blood siblings are in your immediate family (including yourself)? 3

How many males? 3 How many females 0

Have twins or multiple births occurred in your family? Yes No

If yes, what relation to you? N/A

Please list below the age at which members of your family died and the cause of their death. *Be very specific.*

	Relation	age if living	age at time of death	approximate year of death	cause of death
dead	Grandfather (paternal)		70	2014	Heart / Natural Causes (age-related)
living	Grandmother (paternal)	79			Stomach Cancer (Stage 4) smoked his whole life.
dead	Grandfather (maternal)		70	2018	Stomach cancer (Stage 4) smoked his whole life
living	Grandmother (maternal)	75			
	Father	49			
	Mother	47			
	Brothers	1. 17			
		2. 8			
		3.			
	Sisters	1.			
		2.			
		3.			

heavy smoker for 40 years, grew up in USSR

Family Health History continued...

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

- | | | | |
|----|--------------------------|-------------------------------------|-------------------------------------|
| | YES | NO | |
| 1. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | Bones, muscles, joints, limbs |
| 2. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | Gastrointestinal systems |
| 3. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | Nervous system, brain, spinal cord |
| 4. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | Blood/circulatory system |
| 5. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | Respiratory system |
| 6. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | Organ (heart, lung, kidney, etc.) |
| 7. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | Genital/urinary |
| 8. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | Metabolic (hormones, enzymes, etc.) |
| 9. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | Eye, ear |

If yes, please list below the specific defect in each case:

Birth defect	Who?	When did this happen	Relevant circumstances

Is there any member of your family who has had or currently has a learning disorder? Yes No

If yes, please explain: _____

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

If yes, what was the cause? _____

Are there any known genetic diseases or conditions that run in your family? Yes No

If yes, what are they? _____

Has anyone in your family, including yourself, experienced recurring and/or chronic physical symptoms that have not been evaluated by a physician? (Please include those symptoms that you may not consider serious.)

Yes No

If yes, please explain: _____

Family Health History continued...

Review the following list of medical problems and indicate which ones you or one of your blood relatives have had. Please consider each condition carefully for each natural family member and include maternal and paternal grandparents, parents, siblings, aunts, uncles and cousins.

Medical Problem	None affected	Self	Relative(s)/ relationship	Comments - be specific - indicate age at onset
1. Heart				
A. stroke	X			
B. heart attack			Paternal Grandfather	Passed away at age 70 from a sudden heart attack
C. heart disease	X			
1. from birth	X			
2. other - specify	X			
D. hardening of arteries	X			
E. high blood pressure			Paternal & Maternal GM	Onset for both after 70 (age-related)
F. heart malformation	X			
2. Blood				
A. anemia	X			
B. sickle-cell anemia	X			
C. hemophilia or other bleeding problem	X			
D. leukemia	X			
E. Immune deficiency	X			
F. other blood disorder - specify	X			
3. Respiratory (lungs)				
A. hayfever	X			
B. asthma	X			
C. emphysema	X			
D. tuberculosis	X			
E. lung cancer	X			
F. pneumonia	X			
G. other lung disease - specify	X			

Heart lodged a couple hours I passed away in the ER. (Doctor's say age related)

Family Health History continued...

None affected; 1 confused "gall stones" with "kidney stones"

Medical Problem	None affected	Self	Relative(s)/ relationship	Comments - be specific - indicate age at onset
4. Gastro-Intestinal				
A. ulcer of stomach or duodenum	X			
B. gall stones	X		Paternal Grandfather	Had them middle-age
C. hepatitis A (infectious)	X			
D. hepatitis B (serum)	X			
E. hepatitis C	X			
F. other liver disease - specify	X			
G. colon cancer	X			
H. ulcerative colitis	X			
I. Crohn's disease	X			
J. cystic fibrosis	X			
K. intestinal cancer			Maternal Grandfather	Doctors say it was onset in his 60's but didn't choose to go to the doctors until 70.
L. rectal disorder	X			
M. any other cancer/problem of digestive system - specify	X			the cause was that he was a heavy smoker for 40 years.
5. Metabolic/Endocrine				
A. diabetes mellitus			Paternal Grandfather	Had developed Type II in (later years in life) (took daily insulin) after 60
B. hypoglycemia	X			
C. thyroid cancer	X			
D. thyroid disease	X			
E. goiter	X			
F. adrenal dysfunction or disorder	X			
G. hyperactivity	X			
H. hormonal dysfunction or disorder	X			

Family Health History continued...

Medical Problem	None affected	Self	Relative(s)/ relationship	Comments - <i>be specific</i> - Indicate age at onset
6. Urinary				
A. polycystic kidney disease	X			
B. other kidney disease - specify	X			
C. other disease of urinary tract (urethra, bladder, ureter) - spec.	X			
7. Genital/Reproductive System				
A. undescended testicle	X			
B. hypospadias	X			
C. prostate cancer	X			
D. uterine fibroids	X			
E. ovarian cysts	X			
F. cancer of cervix, ovaries or uterus	X			
8. Neurological				
A. migraines	X			
B. mental retardation	X			
C. senility before age 50	X			
D. multiple sclerosis	X			
E. cerebral palsy	X			
F. epilepsy	X			
G. convulsive disorders	X			
H. hydrocephalus (water on brain)	X			
I. disorders of spinal cord - specify	X			
J. Huntington's chorea	X			
K. Gaucher's disease	X			
L. Wilson's disease	X			

Family Health History continued...

Medical Problem	None affected	Self	Relative(s)/ relationship	Comments - <i>be specific</i> - indicate age at onset
M. Alzheimer's disease	X			
N. other diseases of the nervous system - specify	X			
9. Mental Health				
A. schizophrenia	X			
B. manic depressive disorder	X			
C. other mental health disorders requiring hospitalization - spec.	X			
10. Muscles/Bones/Joints				
A. muscular dystrophy	X			
B. other chronic muscle disease - specify	X			
C. lupus	X			
D. deformity of spine	X			
E. spina bifida	X			
F. osteoporosis	X			
G. dwarfism	X			
H. hereditary low back disease	X			
I. arthritis			Maternal Grandmother	RA - onset after 70 (age-) → rheumatoid arthritis (related)
J. gout	X			
K. congenital dislocation of hip	X			
11. Sight/Sound/Smell				
A. deafness before age 60	X			
B. deformity of the ear	X			
C. cataracts before age 50	X			
D. blindness	X			
E. color blindness	X			

Not hospitalized?
Misunderstood the statement please ignore

Family Health History continued...

Medical Problem	None affected	Self	Relative(s)/ relationship	Comments - <i>be specific</i> - Indicate age at onset
F. glaucoma	X			
G. deviated septum	X			
H. retinoblastoma	X			
I. congenital word blindness	X			
J. any other sight/sound/smell disorder - specify	X			
12. Skin				
A. acne	X			
B. eczema	X			
C. skin cancer	X			
D. pigmentation disorders	X			
E. Infectious skin disorders	X			
F. other disorders of skin - specify	X			
13. Other				
A. alcoholism	X			
B. drug abuse or addiction	X			
C. breast cancer	X			
D. allergies			Mother Brother (1.)	Severe reaction to penicillin since birth for both.
E. any other cancer not mentioned above - specify	X			
F. any other condition not mentioned above - specify	X			