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Personal and Medical History

Enclosed is the medical history for

PC 1152

Information that we feel would jeopardize the identity of the donor has been omitted. This would include past employment history, institutions of higher learning attended, etc. No medical information has been changed or deleted.

The Management

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 X No If yes, please list: _____

Education

Check all that apply:

X completed high school

X 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 X 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 __X__ No

If yes, what years did these pregnancies occur? _____ _____ _____ _____

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

If yes, when?_____ On what basis? _____

_____

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

Personal Health History

Do you currently have any allergies? ____ Yes __X__ 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? __X__ Yes ____ No ____ Sometimes (specify)_____

Are you: __X__ Nearsighted ____ Farsighted ____Other (specify)_____

Have you ever had a hearing loss diagnosed? ____ Yes __X__ No

If yes, please explain _____

Personal Health History continued...

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

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

Have you ever had any other orthodonture or major dental work? ___ Yes X No

If yes, what and when? _____

Do you have any speech impairment? ___ Yes X No

If yes, please explain _____

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

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

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

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

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

Have you ever received pitultary derived human growth hormone? ___ Yes X No

If yes, when? _____

Have you ever had surgery? ___ Yes X No

If yes, please explain: _____

Have you had any hospitalization other than above? ___ Yes X No

If yes, please explain: _____

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

If yes, please explain: Sprained my ankle in high school, & 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 X No If yes, please explain: _____

Do you have any current or chronic medical problems/conditions? ___ Yes X No

If yes, please explain: _____

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

If yes, please explain: Most recent vaccination was Covid booster Jan 4/2022 I'm fully vaccinated otherwise.

Have you received a hepatitis B immune globulin injection or gamma globulin injection?

___ Yes X No If yes, when? _____

Personal Health: Exposures

Have you ever served in the military? ___ Yes X 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 X No

If yes, which substance(s)? _____

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

If yes, when and where? _____

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

_____

_____

_____

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

If yes, please check:	Frequency/When (years)	How used?
___ Marijuana		
___ Cocaine		
___ Barbituates		
___ Narcotics (heroin, methadone, opium, morphine, codeine)		
___ Amphetamines		
___ Hallucinogens		
___ Tranquilizers		
___ Anti-depressants		
___ PCP		
X Inhalants (amyl or butyl nitrate, aerosol propellants) → Albuterol sulfate inhalation aerosol	For 1 week in 2022	Used to treat minor bronchitis
X Over the counter drugs please list:	Ibuprofen (Advil, Aleve or Tylenol). Use it occasionally when sick or muscular aches or injury (sprain/strain)	Used for when sick or muscular aches from extreme exercise (occasional use). or injury (sprain/strain)

Personal Health: Exposures continued...

Do you currently drink alcoholic beverages? ____ Yes X 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 your ever regularly drank alcoholic beverages?

____ Yes X No If yes, when? _____

Do you currently smoke cigarettes? ____ Yes X 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 X No If yes, when? _____

Do you currently drink coffee? ____ Yes X 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:

		Eye Color	Hair Color	Complexion	Height (1 = under 5'5, 2 = 5'6 to 5'10, 3 = over 5'11)	Bone Type	Vision (1 = good, 2 = glasses or contacts)
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
MGF*		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 X 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) heavy smoker for 40 years, grew up in USSR
living	Grandmother (maternal)	75			
	Father	49			
	Mother	47			
	Brothers	1. 17			
		2. 8			
		3.			
	Sisters	1.			
		2.			
		3.			

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.	____	X	Bones, muscles, joints, limbs
2.	____	X	Gastrointestinal systems
3.	____	X	Nervous system, brain, spinal cord
4.	____	X	Blood/circulatory system
5.	____	X	Respiratory system
6.	____	X	Organ (heart, lung, kidney, etc.)
7.	____	X	Genital/urinary
8.	____	X	Metabolic (hormones, enzymes, etc.)
9.	____	X	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 X No

If yes, please explain: _____

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

If yes, what was the cause? _____

Are there any known genetic diseases or conditions that run in your family? ____ Yes X 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 X 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 Great-father	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 attack lasted a couple hours I passed away in the ER. (Doctor's say age related)

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

Family Health History continued...

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. the cause was that he was a heavy smoker for 40 years.
L. rectal disorder	X			
M. any other cancer/problem of digestive system - specify	X			
5. Metabolic/Endocrine				
A. diabetes mellitus			Paternal Grandfather	Had developed Type II in later years in life (took daily insulin) (age-related) → 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 - ***be specific*** - 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. hypospadiasis	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 - ***be specific*** - 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-related) rheumatoid arthritis
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 - ***be specific*** - 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			