

Date: 3-Feb-09

# DONOR PROFILE

## GENERAL INFORMATION

Year of Birth: 1982

Place of Birth: USA

Racial Group/Color Code:

Caucasian

Black/Black

Asian/Yellow

Other/Red

Ethnic Origin/Ancestry:

Mother: German

Father: American (not native)

Religion Born Into:

Donor: Christian Mother: Christian Father: Christian

If Jewish:  Ashkenazi

Sephardic

Oriental

Height: 5'7" Weight: 150. lbs Eye Color: Blue Hair Color: Blond

Hair:

balding

thin

average

thick

Hair Type:

curly

wavy

straight

Corrective Lenses:

Yes

No

Corrective Eye Surgery

Yes

No

Blood Type:

Bone Structure:

Small

Medium

Large

Very Large

Are you predominately:

right-handed

left-handed

ambidextrous

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

## EDUCATIONAL BACKGROUND

(check highest level attained)

High School

1

2

3

4

GPA: Top 1-2%

College/University

1

2

3

4

GPA: Top 10% in major

B.A.

B.S.

Major Area of Study: Engineering

Post Graduate  1

2

3

4

5+ GPA: \_\_\_\_\_

Major: GPA 3.6; Electrical Engineering

Degrees Attained: M.A. M.S. Ph.D. M.D. J.D. D.D.S. Other: Working on PhD

### **PERSONAL CHARACTERISTICS** (Please describe in some detail)

What is your native language? English

What other languages do you speak? a little Spanish & German

Math Skills/Ability: Engineering = lots of math

Mechanical Skills: Lots - good visualization/conceptualization, have always taken things apart & like working on bikes

Athletic Skills: Good in many sports but committed to none long-term. Example: have run one marathon, qualified for Boston.

What is your favorite sport? Windsurfing.

What are your Hobbies/Interests/Talents: Sports and the outdoors (backpacking etc), brewing beer, cooking, reading, entrepreneurship

Describe your artistic ability: Low. Capable of getting ideas across but more likely to be subject matter than artist.

What are your favorite foods? Sushi and good Mexican food

What is your favorite color? Blue

Do you like animals? If so, which is your favorite? Yes, I grew up with a labrador in the house. In terms of pets, I'm preferential to dogs. In general, I'd have to say I'm fascinated by ants - how organized and resilient they are despite being brainless as individuals.

To where would you like to travel and why? To Southeast Asia, Japan, and China, because they have interesting cultures and are growing so fast that they will become more and more relevant in our daily lives.

How would you describe your personality? Alpha, outgoing with a dry sense of humor, and laid back - no drama!

What is your ultimate ambition or goal in life and how do you see yourself in twenty years? To launch companies that apply engineering solutions to meet the basic needs not being met for many people in the world, such as clean water and energy. In 20 years, hopefully I will have enough experience and success to work as an angel investor.

**ADDITIONAL ACADEMIC INFORMATION**

SAT Scores: Verbal 760 Math 760 Total 1520

LSAT MCAT GRE 610 Verbal, 770 Quant., 5.0 Writing

GMAT Other

Academic and professional societies to which you belong: Tau Beta Pi

**EMPLOYMENT/OCCUPATIONAL HISTORY**

What is your current or most recent occupation? Aerospace Engineer while on-leave from graduate school.

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. Aerospace Engineer	2008	2008	None
2. Student	2004	2008	None
3.	Click	Click	
4.	Click	Click	
5.	Click	Click	
6.	Click	Click	



## 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	1		1	1	1	1	1	2	0	1	0	1	2	0

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		
<b>1. Cardiovascular</b>																			
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 checked="" 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"/>
E. high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input 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. 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"/>
<b>2. Blood</b>																			
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"/>
<b>3. Respiratory (lungs)</b>																			
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 checked="" 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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input 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"/>
<b>4. Skin</b>																			
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 checked="" 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"/>
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 paternal aunts and uncles live in Florida and don't like sunscreen.

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		
<b>5. Gastro-intestinal</b>																			
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"/>
<b>6. Urinary</b>																			
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"/>
<b>7. Genital/Reproductive system</b>																			
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 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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input 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:

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		
<b>8. Metabolic/Endocrine</b>																			
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"/>
<b>9. Neurological</b>																			
A. migraines	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input 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"/>
<b>10. Mental Health</b>																			
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: Father's migraines persisted for a few years, correlated with flying.

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		
<b>11. Muscles/Bones/Joints</b>																			
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 type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input 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. 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"/>
<b>12. Sight/sound/smell</b>																			
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"/>
<b>13. Other</b>																			
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:

**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:

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

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

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?

Dietary supplements (vitamins, etc.)?

How often do you exercise? Regularly Occasionally Rarely  
Type of exercise: Anything but cooped up in a gym! Mostly running & cycling.

Have you ever had surgery? No Yes

If yes, please list all surgeries:

- 1) Arthroscopic wrist surgery.
- 2)
- 3)
- 4)

Year: 2007  
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: I got pneumonia just over a year ago after going sailing with a cold and flying the next day.

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? 4

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.

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# FAMILY HISTORY

## Mother of Donor

Year of Birth 1946

Place of Birth: USA

Racial Group:

Caucasian                       Black                       Asian                       Other

If Jewish:

Ashkenazi                       Sephardic                       Oriental

Height: 5' 4"    Weight: 123lbs    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: Real estate

Education: Master of Science

Special Skills or Characteristics: Problem solver

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

# FAMILY HISTORY

## Father of Donor

Year of Birth 1944

Place of Birth: USA

Racial Group:

Caucasian                       Black                       Asian                       Other

If Jewish:

Ashkenazi                       Sephardic                       Oriental

Height: 5' 7"    Weight: 140lbs    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: Relastate agent

Education: Master of Science

Special Skills or Characteristics: Extremely competitive at all sports & games. Excellent sailor & windsurfer.

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 checked="" type="checkbox"/> 3	<input type="checkbox"/> 4	Pessimistic
Assertive	<input type="checkbox"/> 1	<input checked="" type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	Passive
Leader	<input type="checkbox"/> 1	<input checked="" 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 19

Place of Birth:

Relationship to Donor:

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

Height: Drop-down    Weight:    lbs    Eye Color: Drop-down    Hair Color: Drop-down

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:

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 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 Grandmother of Donor

Year of Birth 1920

Place of Birth: Germany

Racial Group:

Caucasian                       Black                       Asian                       Other

If Jewish:

Ashkenazi                       Sephardic                       Oriental

Height: 5' 4"    Weight: 120lbs    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: Farmer (mostly dairy)

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: Old age, died at 85

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 checked="" 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

## Maternal Grandfather of Donor

Year of Birth 1915

Place of Birth: Germany

Racial Group:

Caucasian                       Black                       Asian                       Other

If Jewish:

Ashkenazi                       Sephardic                       Oriental

Height: 5' 8"    Weight: 160lbs    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: Farmer (mostly dairy)

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: Heart attack, 66

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

# FAMILY HISTORY

## Paternal Grandmother of Donor

Year of Birth 1916

Place of Birth: USA

Racial Group:

Caucasian                       Black                       Asian                       Other

If Jewish:

Ashkenazi                       Sephardic                       Oriental

Height: 5' 5"    Weight: 120lbs    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: Housewife

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: Old age; 87

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 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 type="checkbox"/> 1	<input checked="" type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	Controlling, rigid

# FAMILY HISTORY

## Paternal Grandfather of Donor

Year of Birth 1910

Place of Birth: USA

Racial Group:

Caucasian                       Black                       Asian                       Other

If Jewish:

Ashkenazi                       Sephardic                       Oriental

Height: 5' 11"    Weight: 170lbs    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: CPA

Education: College

Special Skills or Characteristics:

If living, describe his health:                       Excellent                       Good                       Fair                       Poor

If deceased, give cause and age at time of death: Old age/heart failure; 86

What kind of person is/was he?

Optimistic	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input checked="" type="checkbox"/> 3	<input type="checkbox"/> 4	Pessimistic
Assertive	<input type="checkbox"/> 1	<input checked="" 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 Aunt of Donor

Year of Birth 1950

Place of Birth: USA

Racial Group:

Caucasian                       Black                       Asian                       Other

If Jewish:

Ashkenazi                       Sephardic                       Oriental

Height: 5' 5"    Weight: 140lbs    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: School teacher

Education: College

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 type="checkbox"/> 1	<input checked="" 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 type="checkbox"/> 1	<input checked="" type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	Controlling, rigid

# FAMILY HISTORY

## Maternal Uncle of Donor

Year of Birth 19

Place of Birth:

Racial Group:

Caucasian  Black  Asian  Other

If Jewish:

Ashkenazi  Sephardic  Oriental

Height: Drop-down    Weight:    lbs    Eye Color: Drop-down    Hair Color Drop-down

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:

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 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

## Paternal Aunt of Donor

Year of Birth 1938

Place of Birth: USA

Racial Group:

Caucasian                       Black                       Asian                       Other

If Jewish:

Ashkenazi                       Sephardic                       Oriental

Height: 5' 6"    Weight: 125lbs    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: Homemaker/cattle farmer

Education: College

Special Skills or Characteristics:

Does she have any children?

No     Yes

If yes, how many female children? 2

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 type="checkbox"/> 1	<input checked="" 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 type="checkbox"/> 1	<input checked="" type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	Controlling, rigid

# FAMILY HISTORY

## Paternal Aunt of Donor

Year of Birth 1940

Place of Birth: USA

Racial Group:

Caucasian  Black  Asian  Other

If Jewish:

Ashkenazi  Sephardic  Oriental

Height: 5' 3" 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: Housewife

Education: College

Special Skills or Characteristics:

Does she have any children?

No  Yes

If yes, how many female children? 2

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 type="checkbox"/> 1	<input type="checkbox"/> 2	<input checked="" 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

## Paternal Uncle of Donor

Year of Birth 1948

Place of Birth: USA

Racial Group:

Caucasian                       Black                       Asian                       Other

If Jewish:

Ashkenazi                       Sephardic                       Oriental

Height: 5' 10"    Weight: 165lbs    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: Citrus fruit & tree farmer, landscaping

Education: College

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 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

**SUMMARY CONCLUSIONS AND IMPRESSIONS**  
(To be filled out by interviewer)

Intellectual ability: \_\_\_\_\_

Personality: \_\_\_\_\_

Appearance: \_\_\_\_\_

Overall general impression: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Approve \_\_\_\_\_

Signature of Medical Director

Do Not Approve \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Date

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Health: \_\_\_\_\_

Family health history: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Approve \_\_\_\_\_

Signature of interviewer

Do Not Approve \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Date

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**Approved as Donor:**

Approve \_\_\_\_\_

Signature of interviewer

Do Not Approve \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Date

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## **In Your Own Words...**

What did you do immediately after high school? Go to college

Which words describe your personality and character? Alpha personality (taking leadership role), pretty laid back as a person, have a dry sense of humor, honest

Which sports do you like to participate in? Windsurfing, sailing, cycling, rock climbing, skiing, ultimate frisbee, soccer, distance running, tennis

Which sports did you play as a child? Windsurfing, tennis, soccer, swimming

Which sports do you enjoy watching? Tennis, rugby

Do you play any musical instruments? Piano and clarinet, but not with any regularity since high school.

What is your most memorable childhood experience? Flying in a 1943 Stearman (World War II open-cockpit biplane trainer)

To which countries have you traveled? Mexico, Canada, New Zealand, Germany, Vietnam

Describe one of your favorite vacations to another country: Going to Vietnam with my mother to meet up with my sister who had been living there for a year was quite an experience. It was my first time in a non-western country, so it was dizzying to see how different everything was and to enjoy it in the company of my sister who had learned to speak a little Vietnamese. My mother clearly felt much more comfortable doing the many activities she'd planned with us to protect her, especially when it came to crossing the crowded streets where traffic parts around you like a school of fish instead of coming to a stop. A highlight for me was windsurfing at Mui Ne beach; it was my first time windsurfing in such an exotic location outside the US.

Describe things you like the most about your own country: The freedom we have to become anything we'd like, but also to fail trying and be able to pick ourselves up again with a little help from the government.

Describe a few of your strong sides: Leadership, honesty, learning new sports, anything mechanical from fixing things to visualizing how they work, being a good friend, spelling, keeping my feet on the ground in most situations.

Describe a few of your weak sides: Music & artistic abilities/skills, recognizing bad apples quickly, time management, pattern recognition, lying with a straight face, staying awake through something that bores me.

## Donor Essay

Why do you want to be a donor? In short, I want to be a donor because at this point in my life I do not plan on having children of my own, but I consider myself a sufficiently upstanding and productive member of society that it would be good for my genes to be represented in future generations. On a more selfish or personal note, there is something about the legacy of having children which cannot be substituted by any material accomplishments. Being a donor will allow me to focus more of my energy on my life's work, yet still leave a living legacy behind, and make it easier for those passionate about raising children to do so.

Describe your relationship with your family. How has your family shaped your values and who you are today? Today, my relationship with my family is largely that of a mediator and counselor, which sounds bad but has been a rewarding and productive experience. My parents divorced several years ago, and my strong-willed and idealistic sister has had difficulties getting along with my parents during a time in her life when she could most benefit from their guidance and support. I have been there to absorb unproductive emotions and help reach consensus among all three, constrained by my parents' no longer speaking to each other.

Growing up, my parents put a lot of effort into exposing my sister and I to different ideas while at the same time providing clear moral and behavioral role models. I haven't been terribly close to them as a result of a strong desire to live and learn independently, but I've always known that they're there for me and I have taken advantage of them a few times for working through personal problems. I have a sense of personal integrity that only after college did I recognize as being somewhat unusual, and while it must have been instilled by my parents, I can't put my finger on any specific lessons or values of theirs that created it.

What makes you unique? Physically, I have a body that wants to live like a hummingbird – I have to eat at **least** 3 meals a day, I can out-eat friends who substantially outweigh me and still wake up hungry the next morning, and while I never go gyms, I go crazy without getting some kind of exercise every day. I don't feel tired after I eat, and I find it difficult to fall asleep when I haven't been active.

Mentally, I am 'bilingual' in the sense of having an engineering mind but being good at communicating effectively non-engineers, which is an essential but somewhat rare skill for designing things that people will actually want to and be able to use. I also make it a point to question and understand on my own terms everything I am told, rather than take it for granted, no matter who the information comes from.

What are you most proud of and why?

I am most proud of running my first marathon a couple of years ago. A few friends of mine had decided to run their first marathon together, and in combination with my mother's recent foray into marathon running and my sister running college cross-country, I felt compelled to give it a shot simply because everyone around me was running. When

I shared this news with a friend from college and former cross country runner, he chose to enter because it was unpalatable to him that I run a marathon before him. After some brief research and introspection, he and I decided that it was a reasonable goal to qualify for Boston. Having made this decision, I found myself training essentially alone, as my running pace had to be substantially faster than that of my Seattle friends, and my college friend was living in another state.

And so, for 18 weeks I ran at least 5 days a week, topping out at about 50 miles per week as race day approached. I was able to do a single training run with my college friend when he passed through town a few weeks before the race. Even compared to the efforts I've put into school or any other sport to get where I am now, this was by far the most concerted and sustained effort I've put into achieving any kind of goal, and more importantly, I did it largely alone.

On race day, I learned some hard lessons about water and caloric intake, and had to follow through on an agreement made with my friend before the race: that neither of us would slow down to wait for the other in the event of unforeseen difficulties. In the end I had to sprint to be confident about finishing under my goal time of 3:10, and I made it with little time to spare.

The reason this was so important to me is that it allowed me to prove to myself just how far I can go if I choose something and motivate myself to do it on my own. If only a PhD dissertation were as straightforward as running a marathon...

## Handwritten message

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

To the parents:

Given that you have resolved to surmount this difficulty conceiving, I trust that you are passionate about raising children and will be the best parents you can be. For my part, I hope, and am confident, that I am providing you part of a solid foundation on which to build a fine individual.

My understanding of some of the nature vs. nurture questions that have shaped my perspective of what it means to be a genetic donor have been strongly influenced by the work of Dr. Steven Pinker. I would highly recommend reading his books or looking up his recorded talks online if you are wondering about these questions.

To the child(ren):

Best of luck, and I'll be happy to find out who you are and answer your questions when you turn 18, if you so desire.

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