Family Beginnings, P.C.
8435 Clearvista Place #104
Indianapolis, IN 46250

Donor Genetic/Medical History Form

Donor ID # ________________

Date: _____________________ **Completed by**: Donor

Family Ethnic Background: ____

Please indicate all relevant information in the following tables. When requested information is unknown, please say so. If comments are needed, please make them. Remember that we are interested in your genetic background for the health of future generations. If any relevant family member is adopted, please say so.

Relation	Age(s) if Living	Age(s) at Death	Cause of Death
Grandfather(Paternal)			
Grandmother(Paternal)			
Grandfather(Maternal)			
Grandmother(Maternal)			
Father			
Mother			
Brothers			
Sisters			
Sons			
Daughters			

Please take the time to explain any other problems or conditions in your family history that you feel could pertain to the health of future generations.

Donor #

	Self	Children	Father	Mother	Siblings	Paternal Grandparents	Maternal Grandparents	Comments
Familial Conditions								
High Blood Pressure								
Heart Disease								
Juvenile Diabetes								
Diabetes								
Asthma								
Severe Arthritis								
Blindness								
Deafness								
Alcoholism/Substance Abuse								
Schizophrenia or manic depression								
Epilepsy								
Alzheimer’s Disease								
Cancer (specify type)								
Other (specify)								
Malformations								
Cleft Lip or Palate								
Heart Defect								
Clubfoot								
Spina Bifida								
Other (specify)								
Mendelian Disorders								
Color Blindness								
Cystic Fibrosis								
Hemophilia								
Sickle Cell Anemia								
Muscular Dystrophy								
Huntington’s Disease								
Polycystic kidney disease								
Glaucoma								
Tay-Sachs disease								
β- Thalassemia								
α- Thalassemia								
Canavan Disease								
Other (specify)								