CryobankAmerica
3050 S Center St. Suite 100 Arlington, TX 76014
web: www.CryobankAmerica.com **ph**: 817-945-8708 **email**: info@cryobankamerica.com

Donor History of Health: Sample

How would you rate your vision (without use of corrective lenses)?

☐ Excellent ☑ Average ☐ Fair ☐ Poor

Do you require use of corrective lenses?

☑ No ☐ Yes

If yes, are you:

☐ Nearsighted ☐ Farsighted ☐ Other: _____

Have you undergone corrective eye surgery?

☑ No ☐ Yes

How would you rate your hearing?

☐ Excellent ☑ Average ☐ Fair ☐ Poor

Do you have any hearing impairments?

☑ No ☐ Yes

Do you require use of a hearing aid?

☑ No ☐ Yes

How would you rate your teeth health?

☐ Excellent ☑ Good ☐ Fair ☐ Poor

Do you have any allergies?

☐ No ☑ Yes

If yes, type of allergy:

☐ Food ☑ Dust ☐ Drug ☐ Pet

☐ Mold ☑ Sinus ☐ Latex ☐ Chemical

☐ Insect/Sting ☐ Other(s): _____

Allergic Reactions:

Type: Dust/Sinus Reaction: Grass, dust, and pollen cause red eyes, sneezing

Type: _____ Reaction: _____

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Donor History of Health
(continued)

How often do you exercise?

☐ Frequently ☑ Periodically ☐ Infrequently ☐ Never

Do you have any dietary or nutritional restrictions?

☑ No ☐ Yes

If yes, please explain:

Do you use dietary supplements (vitamins, herbals, botanicals, etc.)?

☑ No ☐ Yes

Have you ever had surgery?

☑ No ☐ Yes

If yes, please explain:

Surgery Type: _____ Year: _____

Surgery Type: _____ Year: _____

Surgery Type: _____ Year: _____

Surgery Type: _____ Year: _____

Surgery Type: _____ Year: _____

Have you had any other hospitalizations?

☑ No ☐ Yes

If yes, please explain:

Hospitalization Reason: _____ Year: _____

Hospitalization Reason: _____ Year: _____

Hospitalization Reason: _____ Year: _____

Hospitalization Reason: _____ Year: _____

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Donor History of Health
(continued)

Are you currently taking any prescribed or non-prescribed medications?

☐ No ☑ Yes

If yes, please explain:

Drug Name Allegra Drug Type Antihistamine

For Treatment of Seasonal Allergies Date Started: 03/2010 Date Ended: Present

Drug Name _____ Drug Type _____

For Treatment of _____ Date Started: _____ Date Ended: _____

Drug Name _____ Drug Type _____

For Treatment of _____ Date Started: _____ Date Ended: _____

Drug Name _____ Drug Type _____

For Treatment of _____ Date Started: _____ Date Ended: _____

On average, how many alcoholic beverages do you consume weekly? 1

Do you have, or have you had a drinking problem?

☑ No ☐ Yes

If yes, please explain:

Do you smoke tobacco?

☑ No ☐ Yes

If yes, how long have you been using tobacco? _____ Years _____ Months

If yes, on average how many packs of cigarettes do you smoke per day? _____

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Donor History of Health
(continued)

Have you ever been exposed to an abnormal amount of herbicides or other toxic chemicals?

☑ No ☐ Yes

If yes, please explain:

Have you ever been exposed to an abnormal amount of x-ray or other radiation exposures?

☑ No ☐ Yes

If yes, please explain:

Have you ever served in the military?

☐ No ☑ Yes

If yes, please list branch, occupation(s), and years served:

U.S. Army / Military Intelligence: Signals / 4 Years

Have you ever been treated for any chronic medical problems, conditions, or illnesses?

☑ No ☐ Yes

If yes, please explain:

Have you ever been treated for any sexually transmissible disease?

☑ No ☐ Yes

If yes, please explain:

Type: _____ When: _____ Date last treated: _____

Details: _____

Type: _____ When: _____ Date last treated: _____

Details: _____

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Donor History of Fertility

Do you have any biological children? ☐ No ☑ Yes

If yes, number of male children? 0

If yes, number of female children? 1

Have you been refused as a blood/plasma donor? ☑ No ☐ Yes

If yes, please explain: _____

Do you have a history of multiples (twins, triplets, etc.) in your family? ☑ No ☐ Yes

If yes, please explain: _____

For individual children, please list their age and any health conditions.

Age 3 Sex F Health Conditions None

Age _____ Sex _____ Health Conditions _____

Age _____ Sex _____ Health Conditions _____

Age _____ Sex _____ Health Conditions _____

Age _____ Sex _____ Health Conditions _____