

Data Collection Form

Collection Information

Consent Form Signed Yes No

Date of Collection (MM/DD/YY) ____/____/____

Time of Sample Collection (nearest hour, in 24 hour clock format) _____

Initials of Data Collector _____ Collecting Agency _____

(DO NOT COMPLETE; for data entry only) Sample: _____ intact: _____ lost _____ broken

Patient's Code

Donor Information

Sex: Male Female

Date of Birth (MM/YY): ____/____

In which state do you live? _____

How long have you lived there? _____ Years

What is the highest grade you completed in school?

- Less than 8th grade
 8th, 9th, or 11th grade
 high school graduate of equivalency
 Some college, 2 yr. degree
 college graduate, 4 yr. degree
 post graduate education or degree

To the best of your knowledge, what is the Ethnic Origin of your

Father

Mother

Caucasian (please check specific geographic area below if known)

Northern Europe (Austria, Denmark, Finland, France, Germany, Netherlands, Norway, Sweden, Switzerland, UK)

Southern Europe (Greece, Italy, Spain)

Eastern Europe (Czechoslovakia, Hungary, Poland, Russia, Yugoslavia)

Middle Eastern (Israel, Egypt, Iran, Iraq, Jordan, Syria, Other Arab States)

African-American

Hispanic (please check specific geographic area below if known)

Mexico

Central America, South America

Cuba, Puerto Rico, other Caribbean

Asian (please check specific geographic area below if known)

Japanese

Chinese

Korean

Vietnamese

Other _____

Don't Know

Health Information: Have you or has anyone in your immediate family (parents, brothers, sisters, or your children) had the following? Check all that apply!

Disease

Heart Disease, Stroke, or Arteriosclerosis

You

Mother

Father

Sister

Brother

Child

Cancer (Specify type if known) _____

Alzheimer's Disease of Dementia

Chronic Inflammatory of Autoimmune Disease

Nervous System Disease (e.g., Multiple Sclerosis)

Other (please specify): _____

Additional health information you would like to provide: