

Extended Egg Donor History Form

If you have been instructed by the Infertility and IVF Center to complete the “Extended Egg Donor Application” form, please print off the following detailed form, complete it carefully, and mail it to the Center.

If you have any questions about completing the form, please call and speak with one of the IVF Program Coordinators.

Please **be sure to include this cover page** with the form you mail in.

Thank you-

Contact Information:

Date: _____

Name:

Address:

Phone (home): (_____) _____

Phone (work): (_____) _____

Phone (cell): (_____) _____

e-mail address: _____

NAME: _____

Internal Donor Code # _____

EGG DONOR EXTENDED APPLICATION

Date of Application: _____

Physical Characteristics:

Physical Build: Small Medium Large Athletic

Age _____ Height _____ Weight _____ Eye Color _____

Natural Hair Color _____ Natural Texture of Hair: Fine Thin Thick

Color of Hair at Birth _____ Straight Slightly Curly Curly Very Curly Wavy

Complexion: Fair Fair w/freckles Medium Olive Dark

Ethnicity (i.e. German, Irish, etc.) _____

Do you have birthmarks No Yes

 If yes, describe (what and where) _____

Do you have dimples? No Yes

Are you Right-Handed Left-Handed Ambidextrous

Religious Preference _____ Practicing? No Yes

Are you a smoker? No Yes If Yes, How long? _____ Cigarettes/Packs per day _____

Did you smoke in the past? No Yes If Yes, When did you stop smoking? _____

Does your spouse or other family member in your home smoke? No Yes

 How much do they smoke per day? _____

Do you drink alcohol? No Yes If Yes, _____ (average # drinks per week)

Please list all prescription or nonprescription drugs you are taking: (Include all over-the-counter medicines including vitamins, aspirin, antacids, laxatives, etc. Use the back of this page if you need more space.)

Medication	Frequency	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

How many days in the previous 12 months could you not work due to illness (colds, flu, accidents, surgery, etc.)?
_____ days

NAME: _____

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

Please check all that apply:

Type	Frequency	When (years)	How used
Cocaine			
Narcotics: Heroin, methadone, opium, codeine, morphine (please circle all that apply)			
AmphetaminesHallucinogens			
Tranquilizers			
Anti-depressants			
PCP			
Inhalants: Amyl or butyl nitrate, aerosol propellants			
Others (please identify):			

Are you adopted? No Yes

If yes, do you have knowledge of your medical history? No Yes

Have you every been diagnosed with or treated for a mental illness No Yes

If Yes, please describe the diagnosis and treatment: _____

Is there any member of your family who has had or currently has a learning disorder? No Yes

If yes, please explain: _____

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

If yes, please explain: _____

Are there any known genetic diseases or conditions that run in your family? No Yes

If yes, please explain: _____

NAME: _____

Marital Status:

Marital Status Single Married Separated Divorced Widowed How long married? _____

If married, spouses name: _____

Have you ever been pregnant? No Yes

If yes, how many times were you pregnant? _____

On average, how much weight did you gain during your pregnancy _____

Number of miscarriages (if any)? _____ Number of elective abortions (if any?) _____

Do you have children? No Yes If yes, how many? _____

Age and sex of children _____

Describe any health problems: _____

Are any of your children deceased? No Yes

If yes, please give age and cause of death: _____

Education:

Highest grade completed _____ Diploma? No Yes

Year graduated from High School _____ GPA in High School _____

Trade/Vocational School attended _____ GPA _____

Have you attended college? No Yes If yes, Number of years attended _____

GPA _____ College Major _____ Degree awarded? _____

Currently a college student? Freshman Sophomore Junior Senior Masters Doctorate

SAT or ACT (circle which applies) Scores _____

IQ score (if you have taken one) _____ When taken _____

Do you have learning disabilities? No Yes If Yes, please describe _____

What were your favorite academic classes? _____

What were your least favorite academic classes? _____

Do you have plans to further your education? No Yes If yes, what do you plan to do?

Extra Curricular Activities, Hobbies, Interests, etc. _____

NAME: _____

Sexual History:

Have you or any of your sexual partners had or been in contact with anyone who has had:

Condition	Self		Partner		If yes - When	If yes - How often
	YES	NO	YES	NO		
HIV						
NSU (nonspecific Urethritis)						
Syphilis						
Gonorrhea						
Chlamydia						
Venereal Warts (HPV)						
Herpes						
Viral Hepatitis B or C						
Hemophilia						
Received Human-derived clotting factor concentrates						
IV (Intravenous) drug use						
Other sexually transmitted diseases: Please specify:						

Personal Work History:

List jobs held in the past 5 years:

Employer Name	Duties	Date Started / Ended	Reason for leaving
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you been exposed to any toxic chemicals in your living or work environment? No Yes

NAME: _____

Family Health History

	Eye Color	Hair Color	Complexion	Height	Body Type	Vision
Mother						
Father						
Siblings (indicate gender)						
Maternal Grandmother						
Maternal Grandfather						
Paternal Grandmother						
Paternal Grandfather						

In the chart above, describe *biological* family members using the following terms:

Eye color: use natural eye and hair color

Complexion: use terms like fair / dark / olive

Body type: use small / medium / large frame

Vision: glasses? contacts? 20/20

How many siblings are in your immediate family (including yourself)? _____ Females _____ Males

Have there been any multiple births in your family (twins, triplets, etc.?) No Yes

If Yes, what relation are they to you? _____

List below the ages of *biological* family members (If deceased, please give cause of death)

	Age, if living	Age, at time of death	Cause of death
Mother			
Father			
Siblings: (indicate gender)			
Maternal Grandmother			
Maternal Grandfather			
Fraternal Grandmother			
Fraternal Grandfather			

NAME: _____

Family History (Continued)

Are there any known diseases or conditions that run in your family? No Yes

If Yes, please identify _____

Have you ever been tested as a carrier of:

- | | | | |
|---------------------|----------------------------------|--------------------------------------|----------------------------------|
| Tay-Sach's disease | <input type="checkbox"/> Carrier | <input type="checkbox"/> Non-carrier | <input type="checkbox"/> Unknown |
| Sickle Cell disease | <input type="checkbox"/> Carrier | <input type="checkbox"/> Non-carrier | <input type="checkbox"/> Unknown |
| Thalassemia | <input type="checkbox"/> Carrier | <input type="checkbox"/> Non-carrier | <input type="checkbox"/> Unknown |
| Cystic Fibrosis | <input type="checkbox"/> Carrier | <input type="checkbox"/> Non-carrier | <input type="checkbox"/> Unknown |

Carefully complete the table below for all *biological* family members. Note the following abbreviations:

- | | |
|---|--|
| * MGM= maternal grandmother (your mother's mother) | FGM = fraternal grandmother (your father's mother) |
| MGF = maternal grandfather (your mother's father) | FGF = fraternal grandfather (your father's father) |
| MA = maternal aunts (your mother's sisters) | FA = fraternal aunts (your father's sisters) |
| MU = maternal uncles (your mother's brothers) | FU = fraternal uncles (your father's brothers) |
| MFC = maternal 1 st cousins (your mother's sibling's children) | FFC = fraternal 1 st cousins (your father's siblings' children) |

	You	Mother	Father	Siblings		Grandparents				Aunts		Uncles		1st Cousins	
				brother	sister	MGM	MGF	FGM	FGM	MA	FA	MU	FU	MFC	FFC
Race/Ethnic origin															
Heart:															
Stroke															
Heart Attack															
Heart disease/defect															
>From birth															
>Under 50 years old															
Hardening of the Arteries															
High blood pressure															
High cholesterol															
Blood:															
Blood type															
Anemia															
Sickle-cell anemia															
Hemophilia															
bleeding disorders															
HIV / AIDS															
Leukemia															
Other blood disorders															
Respiratory:															
Asthma															
Emphysema															
Tuberculosis															
Cystic Fibrosis															
Gastro-Intestinal:															
Ulcers															
Hepatitis (all types)															
Cirrhosis/liver disease															
Ulcerative colitis															
Chron's disease															
Pyloric stenosis															
Rectal disorder															

Please indicate any family member who is taking medication for the indicated illness

Name _____

Family Health History (Continued)

	You	Mother	Father	Siblings		Grandparents				Aunts		Uncles		1st Cousins	
				brother	sister	MGM	MGF	FGM	FGM	MA	FA	MU	FU	MFC	FFC
Race/Ethnic origin															
Metabolic / Endocrine:															
Diabetes															
Type I or Type II															
Age of onset															
Thyroid disease															
Goiter															
Hyperactivity															
Phenyl Ketonuria (PKU)															
Dwarfism															
Urinary:															
Kidney disease															
Other disease/defect of urinary tract (urethra, bladder, ureter, etc.)															
Genital / Reproductive:															
Hermaphroditism / ambiguous genitals															
Hypospadias															
Uterine fibroids															
Ovarian cysts															
Endometrioses															
Reproductive outcomes:															
2 or more miscarriages															
Stillborn															
Death of a newborn															
Infertility															
Neurological:															
Migraines															
Mental retardation															
Senility before age 50															
Multiple Sclerosis															
Cerebral Palsy															
Epilepsy / seizures															
Hydrocephalus															
Spina bifida neural tube defect															
Parkinsons Disease															
Creutzfeldt-Jakob disease															
Other neurological disorders															
Mental Health:															
Depression															
Schizophrenia															
Manic Depressive or bipolar disorder															
Huntington's Disease															
Other (suicide, nervous breakdown, etc.)															

NAME: _____

Family Health History (Continued)

	You	Mother	Father	Siblings		Grandparents				Aunts		Uncles		1st Cousins	
				brother	sister	MGM	MGF	FGM	FGM	MA	FA	MU	FU	MFC	FFC
Ethnicity (German, Irish, etc.) <i>write in here or on a separate sheet--></i>															
Muscle / Bone / Joints:															
Scoliosis															
Muscular Dystrophy															
Other chronic muscle disease															
Loss of muscle coordination															
Lupus															
Other autoimmune disease															
Osteoporosis															
Marfan Syndrome															
Arthritis															
Sight / Sound / Smell:															
Deafness before age 60															
Deformity of the ear															
Cataracts before age 50															
Blindness															
Color blindness															
Glaucoma															
Retinitis Pigmentosa															
Other disorders															
Skin:															
Acne															
Eczema															
Pigmentation disorders															
Neurofibromatosis															
Congenital Abnormalities:															
Cleft lip or palate															
Congenital hip problems															
Club feet															
Other (please specify)															
Chromosomal Abnormalities:															
Down Syndrome															
Other (Turner, Fragile X, etc.)															
Cancer:															
Breast															
Ovarian															
Colon															
Skin															
Thyroid															
Cervical															
Uterine															
Lung															
Brain															
Bone															
Other (please specify)															
Other:															
Alcoholism															
Drug abuse, misuse or addiction															

NAME: _____

Personal and Motivational

Reason for wanting to donate eggs:

In your own words, describe your personality:

What are your hobbies, interests and talents?

What do you think is your best physical quality? _____

What do you like most about yourself as a person? _____

The space below is provided for you to share whatever you want about yourself with the recipients. This can be something about you physically, emotionally, spiritually or in any other way that you choose to express yourself. Share what makes YOU special.

This is an opportunity for you to write a message to any recipient parents that may choose you as a donor:

NAME: _____

Certification

I hereby certify that I have answered all the above questions honestly, and to the best of my knowledge and ability. I recognize that the staff of the Infertility & IVF Center and potential recipients shall rely on this information in judging my suitability as a donor candidate.

I also have been informed that this form will be kept on file and data excluding identifiers (name, address, contact information, social security number) will be provided to potential donor egg recipients and/or to children born as a result of the donation cycle. I hereby consent to the delivery of such non-identifying information.

I also promise that, should I receive additional information in future years which indicates that I suffer from an inherited disease or condition, I shall inform the Infertility & IVF Center as soon as possible.

Signature: _____

Witness _____

Date: _____