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DONOR HISTORY FORM INSTRUCTIONS

Instructions:

Donors must complete this entire form, personally. Non-identifying parts of the history may be given to recipients upon request. The recipients may some day give this document to any child(ren) that may result from your donated egg(s). While not every couple will choose to disclose this information to the child(ren), all parents want to be able to provide accurate medical information. If children are told that they are born through your donation, the information contained within this document may be very important to them for medical and psychological reasons. For these reasons answer each question as carefully and thoroughly as possible.

All information requested is voluntary and will remain anonymous. Identifying information such as name, social security number, and address will be omitted from the packet given to the recipients. A copy of pages 2-12 of the Donor History Form will be given to the recipients. Page 1 as well as the supplemental questionnaire on pages 13-15 will not be shared with recipients.

Donating your eggs is a caring and generous act. Those couples who receive eggs feel deep gratitude and respect for the gift you give so willingly. Naturally, most recipients and their children want to know as much as possible about the medical history of the woman who made their family possible. Thank you for letting them get to know you a little better.

Please remember to fill out all questions completely. Your packet will be returned if there is no picture or answers are left blank and incomplete.

Thank you,

Donor Egg Staff

Donor History Form

I certify that the following answers are truthful and accurate to the best of my knowledge and that I have included all pertinent information.

Date: _____ Signature _____

Name: _____

Address: _____

Home Phone: (____) _____ Work Phone: (____) _____

Best Time to call: _____ Can we leave a message? Yes _____ No _____

Social Security #: _____ Date of Birth: _____ Age: _____

Health Insurance Co. (Mandatory for participation): _____

Insurance Policy #: _____

Marital Status: _____ single _____ married _____ separated _____ Divorced _____ widowed

Duration of relationship with partner: Years _____ Months _____

Ancestry/Ethnic Origin example: Caucasian _____ French, German _____

Mother

COUNTRIES

___ African _____

___ Asian _____

___ Caucasian _____

___ Hispanic _____

___ Native American _____

___ Jewish ___ Ashkenazi ___ Sephardic _____

___ Other _____

Father

COUNTRIES

___ African _____

___ Asian _____

___ Caucasian _____

___ Hispanic _____

___ Native American _____

___ Jewish ___ Ashkenazi ___ Sephardic _____

___ Other _____

MANDATORY FOR COMPLETE PROCESSING
Your application will not be processed without photo.

ATTACH CURRENT PHOTOGRAPH HERE

Used for matching purposes only,
Photos are not released to recipients

PHYSICAL CHARACTERISTICS

Height: _____ Current Wt.: _____ Weight at 21 YO? _____

Eye Color: _____

Body Frame: __small __medium __large Natural Hair Color: _____

Hair (check all that apply)

curly/wavy (naturally) _____ curly/wavy (processed) _____
 straight (naturally) _____ straight (processed) _____
 average texture _____ thin texture _____
 premature graying _____ (at what age _____)

Skin Color: fair _____ medium _____ Olive _____ lt. brown _____ dk.brown _____
 ebony _____ freckled _____ rosy _____ birthmarks _____

Right Handed _____ Left Handed _____

REPRODUCTIVE HISTORY

Age at first period: _____ Are periods regular? Yes _____ No _____

Any treatment needed for menstrual problems? _____ Birth Control Pills _____ D- Provera

Method and name of Birth Control used: _____ For how long _____

Did you ever have trouble conceiving? Yes _____ No _____

List # of pregnancies & outcome:

Year	C-Section/Vaginal Delivery Healthy Baby	Miscarriage	Ectopic	Termination
1.				
2.				
3.				
4.				

Any complications: _____

Number of sex partners within the last 6 months: _____

If applicable, my sex partner has had other sex partners in the last 6 months: _____ Yes _____ No

Have you or any of your sexual partners had:

	Self	Partner	When	How Often
NSU (non-specific urethritis)				
Syphilis				
Gonorrhea				
Chlamydia				
Venereal Warts				
Herpes				
Hepatitis				
Use of IV (intravenous drugs)				
Other sexually transmitted diseases				

PERSONAL HEALTH HISTORY

VISION (without corrective lenses):

Poor _____ Fair _____ Good _____ Excellent _____

Do you wear corrective lenses? Yes _____ No _____

For what problems(s)? Nearsighted _____ Farsighted _____

Other (explain) _____

Age first wore glasses _____

HEARING (without corrective aids):

Poor _____ Fair _____ Good _____ Excellent _____

Do you wear corrective aids? Yes _____ No _____

For what problems(?) _____

TEETH: Poor _____ Fair _____ Good _____ Excellent _____

Any abnormalities? _____ Orthodontic work _____ At what age _____

DIET: Vegetarian _____ Non-Vegetarian _____

Diet (nutrition): Poor _____ Average _____ Good _____

Describe your likes & dislikes _____

ALLERGIES: Yes _____ No _____

If yes, are they to: Food(s) _____ Medication(s) _____

Environmental _____ Other _____

For each allergy, describe specific substance and reaction(s), age first noticed & treatment (if any):

Substance	Age	Reaction(s)	Treatment
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List any allergies you have outgrown: _____

List all prescription drugs used within the last six months _____

Have you had any surgery(ies): Yes _____ No _____

List any surgery(ies) you have had & dates of surgery

1. _____

2. _____

3. _____

Have you had any hospitalization(s) not mentioned above? _____

Have you had a blood transfusion? _____ How long ago? _____

PERSONAL FAMILY HISTORY

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

males _____ # females _____

Are you adopted? Yes _____ No _____

If yes, complete the following table based only on you biological (birth) parents, **not** adoptive parents

Please describe your family members by the following characteristics:

**The following abbreviations in the table are:*

MGM = Maternal Grandmother

MGF = Maternal Grandfather

PGM = Paternal Grandmother

PGF = Paternal Grandfather

Relation	Eye Color	Hair Color	Height/ Weight	Complexion	Age if Living	Age at Death	Cause of Death
Mother							
Father							
MGM*							
MGF*							
PGM*							
PGF*							
Brothers	1. 2. 3. 4.	1. 2. 3. 4.	1. 2. 3. 4.	1. 2. 3. 4.	1. 2. 3. 4.	1. 2. 3. 4.	1. 2. 3. 4.
Sisters	1. 2. 3. 4.	1. 2. 3. 4.	1. 2. 3. 4.	1. 2. 3. 4.	1. 2. 3. 4.	1. 2. 3. 4.	1. 2. 3. 4.

YOUR FAMILY:

Describe the following:

	EDUCATION / DEGREE	OCCUPATION	INTELLECTUAL OR ACADEMIC ACHIEVEMENTS	ARTISTIC ACHIEVEMENTS
Mother				
Father				
Siblings Sisters	1. 2. 3. 4.	1. 2. 3. 4.	1. 2. 3. 4.	1. 2. 3. 4.
Brothers	1. 2. 3. 4.	1. 2. 3. 4.	1. 2. 3. 4.	1. 2. 3. 4.

YOUR CHILDREN:

Describe the following:

	PERSONALITY	ARTISTIC ABILITY	INTELLIGENCE	DISTINGUISHING CHARACTERISTIC(S)
1.				
2.				
3.				
4.				

Have twins or multiple births occurred in your family? Yes _____ No _____

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

If yes, please identify: _____

Have you ever been tested as a carrier of:

Tay-Sach's disease: Yes _____ No _____

Sickle cell disease: Yes _____ No _____

Cystic fibrosis: Yes _____ No _____

Thalassemia: Yes _____ No _____

Carefully review the following list of medical problems and identify any which are present in the listed family members (BY BLOOD ONLY). Please be complete, as this may be the only medical history available to children created through donation. **PLEASE LIST WHAT AGE WHEN CONDITION WAS FIRST DIAGNOSED.**

*Please list the appropriate abbreviations in the boxes below:

MGM = Maternal Grandmother / Aunt / Uncle

MGF = Maternal Grandfather /Aunt / Uncle

PGM = Paternal Grandmother /Aunt / Uncle

PGF = Paternal Grandfather /Aunt/ Uncle

	You	Mother	Father	Sibling	MGM/MGF PGM/PGF	Aunt/ Uncle	Cousin
HEART							
Stroke							
Heart attack							
Heart disease							
1. from birth							
2. other							
Hardening of the arteries							
High blood pressure							
High cholesterol level							
BLOOD							
Anemia							
Sickle-cell anemia							
Hemophilia or other Bleeding disorder							
Leukemia							
HIV virus							
Lymphoma							
Other blood disorder							
RESPIRATORY							
hay fever/environmental allergy							
Asthma							
Emphysema							
Tuberculosis							
Lung cancer							
Pneumonia							
Other lung disease							
GASTRO-INTESTINAL							
Ulcer of stomach or duodenum							
Gall stones							
Hepatitis A (infectious)							
Hepatitis B (serum)							
Cirrhosis							
Other liver disease							
Colon cancer							
Ulcerative colitis							
Crohn's disease							
Cystic fibrosis							
Intestinal cancer							

	You	Mother	Father	Sibling	MGM/MGF PGM/PGF	Aunt/ Uncle	Cousin
GASTRO-INTESTINAL							
Developmental disorders of The stomach and intestine							
Pyloric stenosis							
Rectal disorder							
Any other cancer/problem of Digestive system							
METABOLIC/ENDOCRINE							
Diabetes mellitus							
Hypoglycemia							
Thyroid cancer							
Thyroid disease							
Goiter							
Adrenal dysfunction or disorder							
Hyperactivity							
URINARY							
Kidney disease							
Other disease of urinary Tract (urethra, bladder, ureter)							
GENITAL/REPRODUCTIVE							
Undescended testicle							
Hermaphroditism/ Ambiguous genitals							
Hypospadias							
Prostate cancer							
Testicular cancer							
Uterine fibroids							
Ovarian cysts							
Cancer of cervix, Ovaries or uterus							
REPRODUCTIVE OUTCOMES							
2 or more miscarriages							
Stillborn							
Death of a newborn infant							
Neonatal jaundice							
NEUROLOGICAL							
Migraines							
Mental retardation							
Down's syndrome							
Senility before age 50							
Multiple Sclerosis							
Cerebral palsy							
Epilepsy / seizures							
Hydrocephalus							
Spina bifida							
neural tube effect							

	You	Mother	Father	Sibling	MGM/MGF PGM/PGF	Aunt/ Uncle	Cousin
NEUROLOGICAL							
Huntington's disease							
Gaucher's disease							
Wilson's disease							
Parkinson's disease							
Paraplegia							
Tourette's Syndrome							
Scoliosis							
Other diseases of nervous system							
MENTAL HEALTH							
Schizophrenia							
Manic depressive or bipolar disorder							
Depression							
Attention Deficit Disorder							
Autism Spectrum Disorder							
Other mental health disorder Requiring hospitalization							
MUSCLE / BONE / JOINTS							
Muscular dystrophy							
Other chronic muscle disease							
Loss of muscle coordination							
Lupus							
Osteoporosis							
Dwarfism							
Arthritis							
Gout							
Myasthenia Gravis							
SIGHT / SOUND / SMELL							
Deafness before age 60							
Deformity of the ear							
Cataracts before age 50							
Blindness							
Color blindness							
Glaucoma							
Any other sight/sound/smell disorder							
SKIN							
Acne							
Eczema							
Skin cancer							
Pigmentation disorders							
Other disorders of the skin							
CONGENITAL ANOMALIES							
Cleft lip / palate							
Congenital hip problems							
Club feet							
Other							

YOUR TEENAGE YEARS:

Describe yourself as a teenager:

Describe your achievements:

Describe your weaknesses?

Did you have any problems as a teenager (e.g., health, social, educational, etc)?

My favorite subject(s) was: _____

My worst subject(s) was: _____

The activities I was involved in were: _____

The most important influence on me was: _____

In comparison to others I was: _____

I traveled to: _____

I liked to go: _____

I was talented as: _____

My ambition was to: _____

Current:

RELIGION

Religion born into: _____ Religion practiced: _____ Atheist _____

How religious are you now? Very _____ Moderately _____ Occasionally attend _____ Not at all _____

ACTIVITIES

How athletic are you?

Very Athletic _____ Average _____ Not Athletic _____

Do you exercise: Regularly _____ Occasionally _____ Rarely _____

What types of exercise or physical activities do you enjoy?

Do you have musical ability?

What other skills or talents do you have (e.g., painting, writing, reading, ability at games, crossword puzzles, handicraft, etc.)? Please describe in detail.

Describe any special interests you have (e.g., Girl Scout leader, fund raiser, pet owner, etc.).

What physical, artistic, intellectual or social abilities do you feel best about?

What have been your achievements as an adult?

EDUCATIONAL HISTORY

Did you complete high school? Yes ___ No ___ Graduated with class _____ GED _____
Please list all schools (trade, college, university) attended since high school, time at each institution, and major area of study.

Name of school

Years attended

Major

Please list any additional educational goals, and how you plan to achieve those goals.

WORK HISTORY / EXPOSURE

List jobs held in the past five years and exposure as noted:

Job Title	Year Began	Year Ended	Exposure to chemicals, drugs, fumes, pesticides, x-ray, asbestos, gases, lead

SUPPLEMENTARY QUESTIONNAIRE (NOT TO BE GIVEN TO RECIPIENTS)

PSYCHIATRIC AND COUNSELING HISTORY

1. Have you ever been hospitalized for substance abuse, depression, or any other psychological problem?

Yes ___ No ___ (If yes, please list dates and diagnoses):

Dates	Diagnosis	Reason

2. Have you ever been in counseling or psychotherapy?

Yes ___ No ___ (If yes, please list dates and diagnoses):

Dates	Diagnosis	Reason

3. Have you ever taken antidepressants, anti-anxiety, or anti psychotic medications prescribed by any physician?

Yes ___ No ___ (If yes, please list medication and dates)

Dates	Medication	Diagnoses

4. Have you had any personal experience with a traumatic event?

EVENT	YES	NO	EXPLAIN YES ANSWERS
Rape or sexual assault			
Incest, sexual or physical abuse			
Victim of any crime			
Other (death of loved ones, etc.)			

5. What do you think is the biggest stress in your life?

6. Do you, or have you used any of the following?

SUBSTANCE	YES	NO	DATES / FREQUENCY / QUANTITY
Alcohol			
Marijuana			
Cocaine			
Tobacco			
Caffeine			
Prescription Drugs			
Other			

PERSONAL HISTORY AND OPINIONS

1. Have you ever been arrested or convicted of any crimes (other than minor traffic offenses):

Yes ___ (If yes, please explain) No _____

2. Have you ever had children removed from you custody?

Yes ___ (If yes, please explain) No _____

3. Are you currently involved in any lawsuits?

Yes ___ (If yes, please explain) No _____

4. Please list month, year, and location of any body tattoos or piercing:

Date: ___/___/___ Location: _____

Date: ___/___/___ Location: _____

Date: ___/___/___ Location: _____

5. What do you anticipate your feelings and reactions will be to becoming an egg donor?

6. What difficulties do you anticipate on becoming an egg donor?

7. Have you been a donor before? If yes, indicate what type (ovum, blood, bone marrow, etc.)

8. Would you consider donating you eggs on more than one occasion?

Yes ___ No ___

If yes, how many times do you anticipate donating your eggs? _____

9. Would you consider updating your records with any pertinent medical information that might impact the offspring from your donation?

Yes ___ No ___

Is there any additional information that you would like us to know, questions or concerns:

How did you hear about our program?

Print _____ Name of paper or magazine _____

Radio _____ Station Name _____

TV _____ Channel _____

Bus/Billboard _____

Family _____

Friend _____

Other _____

We receive many applications that are incomplete. We are unable to process applications that do not provide ALL requested information. Please take just one more minute to review the questionnaire and make sure that it is complete for review, with photograph on page one.

THANK YOU FOR COMPLETING THIS APPLICATION AND YOUR INTEREST IN THE DONOR PROGRAM!