Date Applied:________________________________ Donor #:________________________________

Donor Services

Egg Donor Application

Please put thought into your responses and write legibly.

Name:_______________________________________ Age:_________ Date of Birth:___________________

Address:____

City:______________________________________ State:______________ Zip Code:___________________

Home Phone:________________ Work Phone:__________________ Cell Phone:______________________

Email Address:____ Marital Status:_____________________

Provide your Social Security or T.I.N. Number :____________________________________

Are you a U.S. Citizen? ☐Yes ☐No Country of Origin?___________________________

Are you a Resident Alien? ☐Yes ☐No If yes, provide your alien number: A___________________________
Please include a copy of your social security card or TIN & green card along with the application

Are you a non-resident Alien? ☐Yes ☐No If yes, what type of VISA?________________________________
Please include a copy of your visa & work permit information with the application

How did you hear about our program?

☐Magazine (name):
☐Friend (name):
☐Newspaper (name):
☐Internet

☐Directed Donor Name of Recipient:____________________________

Although children born of my ovum donation cannot now contact me, should the laws change, I would be willing to be contacted when such children reach maturity (usually age 18-21).
This is not a binding decision, but merely my current inclination.

☐Yes ☐No ☐Undecided Any comments:____

____

Would you be willing to provide a childhood photo of yourself, (between age 6 mos-10 years) for prospective recipients to view?

☐Yes ☐No If yes, please attach a childhood photo of yourself (age 6 mos-10 years)

Why are you interested in becoming an egg donor?________________________________

____

____

____

Personal Information:

Place of Birth:______________________ **Race:**__________________________

Ethnic origin, (i.e.: Italian, Swedish, African, etc.)

Ethnic Origins of your Mother's Family	Ethnic Origins of your Father's Family

Your Religion:________________ Mother's Religion:________________ Father's Religion:________________

If Jewish: ☐Ashkenazi ☐Sephardic

Physical Characteristics

Height:________________ **Weight:**________________ **Build:** ☐**Small** ☐**Medium** ☐**Large**

Eye Color:________________ **Natural Hair Color:**________________

Hair Texture (Check all that apply):

☐Straight ☐Wavy ☐Thick ☐Thin ☐Fine ☐Frizzy ☐Curly ☐Coarse ☐Kinky ☐Shiny

Do you wear glasses or contact lenses? ☐Yes ☐No If yes, at what age were they prescribed?____________

Did you wear braces? ☐Yes ☐No

Do you have any dental abnormalities? ☐Yes ☐No If yes, Please describe:____________________

Complexion:

☐Fair ☐Medium ☐Light Olive ☐Olive ☐Light Brown ☐Medium Brown ☐Dark

Freckles?

☐None ☐Few ☐Numerous

Have you ever had Acne? ☐Yes ☐No

If yes, at what age?________________ Severity of your acne?________________

Are you: ☐Right Handed ☐Left Handed ☐Ambidextrous

Is your hearing normal? ☐Yes ☐No

If no, please describe hearing trouble**:**______________________________________

Family Characteristics

(Please tell us about your family to the best of your ability)

Relative	Alive? Yes/ No	Present age Or age at Death	Height	Weight	Hair Color	Eye Color	Medical Condition or Cause of Death?	Occupation	Birth Place
Mother									
Maternal Grandmother									
Maternal Grandfather									
Father									
Paternal Grandmother									
Paternal Grandfather									
Sibling 1									
Sibling 2									
Sibling 3									
Sibling 4									
Sibling 5									
Sibling 6									
Sibling 7									
Your own Child 1									
Your own Child 2									
Your own Child 3									

If you have additional siblings or children of your own please attach an additional sheet of paper and include their characteristics.

Education

S.A.T. Score:

High School 1 2 3 4 GPA________ (Based upon ☐3 ☐4 point scale) **Math:**

High School G.E.D. ☐

Verbal:

College/University 1 2 3 4 GPA________(Based upon ☐3 ☐4 point scale)

Major of Study:________________________________ Degree Obtained:________________________________

Post Graduate Major:____________________________ Post Graduate Degrees:____________________________

____

Please list any Scholastic achievements or awards received :______________________________________

____

Were you active in School Clubs or Activities?____

Are you or have you been a member of any Honor Societies ?_________________________________

____

In which area(s) of study did you excel?:____

____

Are you fluent in languages other than English? If so, which:_________________________________

Musical Ability

Have you studied music? ☐Yes ☐No If yes, number of years studied?___________________________

Musical Ability: ☐Gifted ☐Above Average ☐Average ☐Fair ☐Tone Deaf

Do you play an instrument? ☐Yes ☐No If yes, what instrument(s) do you play? ____________________

____

Athletic Activity

Are you athletic? ☐Yes ☐No

What is your level of physical activity? ☐Athletic ☐Active ☐Occasionally active ☐Inactive

Have you excelled in physical activities? If so, please describe:_______________________________

____

____

Do you currently participate in sports or physical activities? __________________________________

____

Artistic Ability

Have you studied art or do you have any artistic ability? ☐Yes ☐No

If yes, please describe your artistic ability:____

____

____

Personality Questions:

- Do you like pets or other animals? If yes, what are your favorite types of pets or animals?
- ____
- What is your favorite book?____
- What is your favorite movie? ____
- What is your favorite type of music or musical group? ____
- What is your favorite color?____
- If you could travel any place where would you go and why?____

____

- Do you like to write poetry or short stories or other compositions?____

____

Please list any volunteer activities or community service:

____

Please list your hobbies or any special talent you may have or things you enjoy doing in your spare time:

____

____

____

How would you describe your personality?____

____

Work/Occupation History (check all that currently apply)

☐I am not currently working.
☐I currently work part time.
☐I am currently working full time.
☐I currently work from the home.
☐I am currently a full time student.
☐I am currently a part time student.
☐Other: explain:____

Occupation:____

Please tell us a little bit about your work history

What type of work have you done in the past?____

____

____

____

What are your ambitions for yourself over the next five years?____

____

____

____

- I think my oocyte recipient might like to know these things about me; so they may better understand the type of person I am, my personality, or my interests:

____

____

____

Social History (Check all that currently apply)

Cigarettes/Tobacco

☐ I don't smoke.
☐ I currently smoke______________cigarettes per day.
☐ I used to smoke, but no longer do.

Alcohol

☐ I never drink alcohol. ☐ I drink only occasionally. ☐ I drink regularly.

- What type of alcoholic beverages do you drink?______________________________________

Drug Usage

☐ I have never used illegal drugs.
☐ I have tried drugs at least once in the past.
☐ I used to use drugs regularly but don't anymore.
☐ I currently inject illegal drugs or I have injected illegal drugs within the past 12 months.
☐ Have you ever shared needles? ☐ Yes ☐ No

Have you ever used drugs such as marijuana, heroin, cocaine, LSD, amphetamines, barbiturates, Other? ☐ Yes ☐ No

If yes, please give details and date last used:____

Sexual Orientation

☐ I am a virgin.
☐ I consider myself to be bisexual.
☐ I consider myself to be homosexual.
☐ I consider myself to be heterosexual

Reproductive History

How old were you when you first began to menstruate?__________________________________

How many days between one period to the next?___________ Is your menstrual cycle? ☐ Regular ☐ Irregular

Are you currently taking oral contraceptives? If yes, which brand and for how long?________________________________

Have you donated your eggs before? ☐ Yes ☐ No How many times? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ More

If Yes, where did you donate your eggs?

____

- Have you ever been declined as an Egg Donor? ☐ Yes ☐ No If Yes, Why?_______________________________

____

Pregnancy History

- Have you been pregnant? ☐ Yes ☐ No
- If yes, how many times have you been pregnant?____
- Have you ever carried a pregnancy full term? ☐ Yes ☐ No
- If yes, were there any complications with gestation or delivery? ☐ Yes ☐ No
- What were the complications:____
- How many times have you given birth? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ More
- Has every delivery resulted in a live birth? ☐ Yes ☐ No
- If no, please explain:

____

	Please Answer the following questions:	Yes	No
1	Did your mother take DES while she was pregnant with you?		
2	Have you ever been told you are infertile?		
3	Is there a history of infertility in your family?		
4	Have you ever used intravenous drugs or had a sexual partner that did so?		
5	Have you ever used an injectable drug or had a sexual partner that did so?		
6	Are you currently taking injectable medication or do you have a sexual partner that does so?		
7	Have you engaged in prostitution at any time since 1977?		
8	Have you been involved sexually with anyone during the past six months that has engaged in prostitution at any time since 1977?		
9	Have you been sexually active during the past six months		
10	Are you currently sexually active?		
11	Are you in a monogamous relationship? If no, how many sexual partners have you had during the past six months?		
12	Have you had more than 10 sexual partners?		
13	Have you had sexual relations with a partner that is suspected or known to be HIV positive?		
14	Have you ever had sexual relations with a man that has engaged in anal intercourse or oral sex with another man? If yes, when was the last time?		
15	Have you had sexual relations with a gay or bisexual man? If yes, when?		
16	Have you ever received a blood transfusion? If yes, when?		
17	Have you ever received factor VII or factor IX concentrates (blood transfusion) that was not heat-treated Or otherwise vial inactivated? If yes, when?		
18	Do you have any tattoos or piercings? If yes when did you receive the last one?		
19	Have you been exposed to known or suspected HIV, Hepatitis B or Hepatitis C Virus, infected blood through percutaneous inoculation or through contact with an open wound or mucous membrane? If yes, When?		
20	Have you ever been diagnosed with vCJD or any other form of CJD?		
21	Have you ever had a diagnosis of dementia or any degenerative or demyelinating disease of the central nervous System (CNS) or other neurological disease of unknown etiology?		
22	Have you ever had a blood relative diagnosed with CJD?		
23	Have you ever received a dura mater transplant?		
24	Have you spent three months or more cumulatively in the United Kingdom (U.K.) from the beginning of 1980 through the end of 1996?		
25	Are you a current or former U.S. military member, civilian military employee, or dependent of a military or civilian employee who resided at U.S. military bases in Northern Europe (Germany, U.K., Belgium, Netherlands) for 6 months or more from 1980 through 1990 or elsewhere in Europe (Greece, Turkey, Spain, Portugal, Italy) for 6 months or more from 1980 through 1996?		
26	Have you lived cumulatively for 5 years or more in Europe from 1980 until the present (note this includes time spent in the U.K. from 1980-1996)?		
27	Have you received any transfusion of blood or blood components in the U.K. between 1980 and the present?		
28	Have you injected bovine insulin since 1980, unless you can confirm that the product was not manufactured after 1980 from cattle in the U.K.?		
29	Have you ever been refused as a blood donor? If yes, Why?		
30	Have you ever been immunized against Hepatitis B? If yes, When?		
31	Have you had close contact with someone suspected or known to be positive for Hepatitis B or Hepatitis C? i.e. sexual intimacy, shared a bathroom or a kitchen		
32	Have you been immunized against small pox in the past five years?		
33	Have you had close contact with someone who has had a cell, tissue or organ transplant from an animal?		
34	Have you ever been diagnosed with or treated for West Nile virus? If yes, When?		
35	Have you ever been diagnosed with or treated for Severe Acute Respiratory Syndrome (SARS)? If yes, When?		
36	Have you been exposed to radiation or toxic chemicals in your work or personal life? i.e. lead, mercury and gold		
37	Have you been bitten by an animal suspected of having rabies within the past 12 months?		
38	Have you traveled outside the United States in the past two years? If yes, where and when?		

Have you ever experienced the following conditions? ?	Yes	No
Have you experienced unexplained weight loss?		
Have you ever had a fever of unexplained origin?		
Have you ever had Kaposi Sarcoma?		
Have you ever had Pneumocystic Pneumonia?		
Have you ever had sexual relations with anyone that had the above symptoms/diseases? If Yes, Please specify:		

Medical History

Do you have any medical illnesses (i.e. asthma, diabetes, seizure disorders, tuberculosis, etc.)?

____

List all Surgeries: ____

Do you have any allergies (food, pollen, bee stings, etc.)? Please list:

____

Do you have any allergies to medications? Please list:

____

Describe any childhood allergies you may have outgrown:____________________________

____

List medications including prescription, over the counter, vitamins and herbs that you are currently taking:

____

____

Are there any medications you have taken in the past five years that are not listed above? If so, please list:

____

Have you ever sought psychological counseling? ☐Yes ☐No
Have you, or are you currently taking medication for a psychological condition? ☐Yes ☐No
If yes, what medication have you, or are you currently taking?

____

Have you ever attempted suicide? ______________________________________

Please read through the following list of medical conditions. Indicate which (if any) condition(s) apply to you or your family members. Consider each condition carefully and note the age at which the condition appeared.

Medical Condition	Self	Mother	Father	Siblings	Grandparents	Other Family	Age of Onset
HEART							
Hardening of the Arteries							
Heart Attack							
Heart Disease							
High Blood Pressure							
High Cholesterol							
Mitral Valve Prolapse							
Stroke							

Medical Condition	Self	Mother	Father	Siblings	Grandparents	Other Family	Age of Onset
BLOOD							
Anemia							
Hemophilia or other Bleeding problem							
HIV/AIDS							
Immune Deficiency or disease							
Leukemia							
Other blood disorder							
Prolonged Fever							
Sickle-Cell Anemia							
RESPIRATORY							
Asthma							
Hay Fever							
Emphysema							
Lung Cancer							
Other Lung Disease							
Pneumonia							
Tuberculosis							
GASTROINTESTINAL							
Cancer or Disease of the digestive system							
Colon Cancer							
Crohn’s Disease							
Cystic Fibrosis							
Gall Stones							
Hepatitis A (infectious)							
Hepatitis B (Serum)							
Hepatitis C							
Other Liver Disease							
Ulcerative Colitis							
Ulcer of stomach or duodenum							
METABOLIC /ENDOCRINE							
Adrenal Dysfunction or disorder							
Diabetes mellitus							
Disease of Urinary tract, urethra or bladder							
Goiter							
Human Growth Hormone administration							
Hyperactivity							
Hypoglycemia							
Thyroid Cancer							
Thyroid Disease							
Rectal disorder							
GENITAL REPRODUCTIVE SYSTEM							
Breast Cancer							
Cervical Cancer							
Chlamydia							
Genital Warts							
Gonorrhea							
Hemophilus							
Herpes I or II							
Hypospodiasis							
Ovarian Cysts							
Pelvic Inflammatory Disease							
Prostate Cancer							
Syphilis							

Medical Condition	Self	Mother	Father	Siblings	Grandparents	Other Family	Age of Onset
GENITAL REPRODUCTIVE SYSTEM Continued							
Trichomonas							
Undescended testicle							
Urogenital tuberculosis							
Uterine or Ovarian Cancer							
Uterine Fibroids							
NEUROLOGICAL							
ADD or ADHD							
Autism							
Cerebral Palsy							
Degenerative Neurologic disease							
Disorder of the Spinal Cord							
Epilepsy							
Gaucher's Disease							
Huntington's Disease							
Hydrocephalus							
Learning disabilities/disorders							
Mental Retardation							
Migraines							
Multiple Sclerosis							
Senility before age 50							
Wilson's Disease							
Other disease of the nervous system:							
MENTAL HEALTH							
Alcoholism							
Anxiety Disorder							
Attempted Suicide							
Mania							
Bi-polar Disorder							
Depression							
Drug abuse/misuse or addiction							
Eating Disorders							
Panic Attacks							
Schizophrenia							
MUSCULAR/BONES/JOINTS							
Arthritis							
Cleft Lip or Cleft Palate							
Club Foot							
Deformity of the Spine							
Dwarfism							
Gout							
Hereditary lower back disease							
Lupus							
Muscular Dystrophy							
Osteoporosis							
Spinabifida							
Other Chronic muscle disease							

Medical Condition	Self	Mother	Father	Siblings	Grandparents	Other Family	Age of Onset
SIGHT/ SOUND/ SMELL							
Any disorder of sight, sound or smell							
Cataracts before age 50							
Colorblindness							
Congenital Deafness before age 60							
Deformity of the ear							
Deviated Septum							
Glaucoma							
SKIN							
Acne							
Eczema							
Pigmentation Disorders							
Skin Cancer							
Other skin disorders							
OTHER BIRTH DEFECTS							
Any other birth defects:							
OTHER							
Any Conditions not mentioned:							

Do you have any siblings that died in infancy or childhood? If so, what was the cause?

____

Are there any known genetic diseases or conditions that run in your family? ☐Yes ☐No
If yes, please explain:

____

Have you or anyone in your family experienced recurring and/or chronic physical symptoms that have not yet been evaluated by a physician? Please include symptoms even if you don't consider them serious.

____

- ***I, the undersigned, have read the oocyte donation information. I hereby acknowledge that all the information I have provided on this oocyte donation personal history form has been answered fully and correctly, to the best of my knowledge.***

______________________________ ______________________________
Signature Date

To be completed by the Donor Coordinator or Administrative Coordinator:

______________________________ ______________________________
Name Date application was reviewed

Remember to include: Copies of your photo ID and Social Security Card,

- Current photo as part of Verification of identity and as a matching tool
- Childhood photos
- Signature page for the "information for Potential Egg Donors" document

Physicians Notes regarding Donor Application:

____

____

____

____

____

____

____

Donor Application Approved ☐**Yes** ☐**No**

______________________________________ ________________________

Physician Signature **Date**