

General Information

Name: _____

Address: _____

Telephone #: Home: _____ Cell: _____

Age: _____

Race: _____

Maternal Ethnic Ancestry: _____

Paternal Ethnic Ancestry: _____

Height: _____

Weight: _____

Natural hair color: _____

Natural hair Texture: _____

Eye color: _____

Physical build: _____

Complexion: _____

Teeth: _____

Vision: _____

Hearing: _____

Distinguishing characteristics: _____

Native Tongue: _____

Religion: _____

Birth Date: _____

Blood Type: _____

Sexual orientation: _____

Marital status: _____

Smoker? Yes No

Additional: _____

Education / Intelligence

Education: _____

High School Grade Point average: _____

College grad point average: _____

College major: _____

Highest grade in: _____

Learning Disabilities: _____

(Please explain) _____

Additional educational information: _____

Personal Profile

Have you ever been arrested and/or convicted of a crime/felony? Yes No

If yes, please explain: _____

Have you ever been under the care of a psychiatrist? (Hospitalization, medication, on-going therapy?) Yes No

If yes, please explain: _____

Have you ever received treatment for drug and/or alcohol abuse? Yes No

If yes, please explain: _____

Do you drink alcohol? Yes No

If yes, how much and how often: _____

Do you take any non-prescription drugs? Yes No

If yes, please indicate which ones and the reason? _____

Please list any significant illnesses you have had: _____

Please list any hospitalizations and/or operations you have had and the approximate year they took place:

Please list any prescription drugs you are currently taking and any medical conditions for which you are currently being seen or treated: _____

Were you adopted? Yes No

If yes, what do you know about your biological medical history? _____

Please describe your character (personality): _____

Please list any clubs, organizations, hobbies, interests, sports teams, activities, etc., you are involved in:

Please describe your future personal and career goals: _____

Briefly describe your personal reasons for wanting to be an egg donor:

Is your husband/partner aware of his responsibilities in the medical process and is he willing to cooperate?

Have you ever been an egg donor? _____ If yes, when? _____

Reproductive Health History

Please list any reproductive illnesses or diseases that you have experienced: _____

Please indicate the date(s), complications, outcome, extenuating circumstances, etc.

Have you had children? _____

Please list the age, sex, and general health condition of each of your children?

Were all of your children born healthy? _____

If no, please explain: _____

Were any of them born at an extremely high or low weight? _____

If yes, please explain: _____

Do you have legal and physical custody of all the above children? _____

If no, please explain: _____

Have you ever failed to carry a pregnancy to full term? _____

Which type of birth control are you currently using? _____

Did any of your pregnancies take longer than 6 months to conceive? _____

Did you need any medical assistance to conceive your children? _____

If yes, please explain? _____

Relation: Mother

Age: _____

Height: _____

Eye Color: _____

Natural hair color: _____

Hair type: _____

Complexion: _____

Special skills, talents, abilities _____

Relation: Father

Age: _____

Height: _____

Eye Color: _____

Natural hair color: _____

Hair type: _____

Complexion: _____

Special skills, talents, abilities _____

Relation: Paternal Grandmother

Age: _____

Height: _____

Eye Color: _____

Natural hair color: _____

Hair type: _____

Complexion: _____

Special skills, talents, abilities _____

Relation: Paternal Grandfather

Age: _____

Height: _____

Eye Color: _____

Natural hair color: _____

Hair type: _____

Complexion: _____

Special skills, talents, abilities _____

Relation: Maternal Grandmother

Age: _____

Height: _____

Eye Color: _____

Natural hair color: _____

Hair type: _____

Complexion: _____

Special skills, talents, abilities _____

Relation: Maternal Grandfather

Age: _____

Height: _____

Eye Color: _____

Natural hair color: _____

Hair type: _____

Complexion: _____

Special skills, talents, abilities _____

Relation: Child

Age: _____
Height: _____
Eye Color: _____
Natural hair color: _____
Hair type: _____
Complexion: _____
Special skills, talents, abilities _____

Relation: Child

Age: _____
Height: _____
Eye Color: _____
Natural hair color: _____
Hair type: _____
Complexion: _____
Special skills, talents, abilities _____

Relation: Child

Age: _____
Height: _____
Eye Color: _____
Natural hair color: _____
Hair type: _____
Complexion: _____
Special skills, talents, abilities _____

Relation: Child

Age: _____
Height: _____
Eye Color: _____
Natural hair color: _____
Hair type: _____
Complexion: _____
Special skills, talents, abilities _____

Health History

Has any member of your family, including yourself, had a problem or defect at birth of any of the following body systems?

- | | |
|---------------------------------------|---------------------------------------|
| 1. Bones, muscles, joints, limbs | 6. Organ: heart, lung, kidney, etc. |
| 2. Gastrointestinal system | 7. Genital / urinary |
| 3. Nervous system, brain, spinal cord | 8. Metabolic: hormones, enzymes, etc. |
| 4. Blood, circulatory system | 9. Eye, ear |
| 5. Respiratory system | |

If "YES", please list below the specific defect in each case.

Birth Defect	Who?	When observed?	Relevant Circumstances

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

If YES, please explain: _____

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

If YES, what was the cause? _____

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

If YES, what are they? _____

Has anyone in your family, including yourself, experience recurring and/or chronic physical symptoms that have not been evaluated by a physician? (Please include those symptoms that you may not consider serious). Yes No

If YES, please explain: _____

Medical Problem	Don't know	No	Yes	You	Mother	Father	Sibling	GP	Aunt/ Uncle	Cousin
SIGHT/SOUND/SMELL										
Deafness before age 60										
Deformity of the ear										
Cataracts before age 50										
Blindness										
Color blindness										
Glaucoma										
Deviated septum										
Retinoblastoma										
Congenital word blindness										
Other disorder										
OTHER										
Alcoholism										
Drug abuse or addiction										
Breast cancer										
Any other cancer not mentioned above										
Any other condition not mentioned above										
Please explain:										

Risk Factor Assessment

According to the guidelines governing Assisted Reproductive Technology, we are required to obtain information regarding any risk factors that may impact your diagnosis and treatment. Please mark the appropriate box to answer the following questions.

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever injected drugs for a non-medical reason? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you performed a sexual act in exchange for money or drugs? |
| <input type="checkbox"/> | <input type="checkbox"/> | In the past twelve months, have you participated in a sexual act with any person described in the items above or with any person suspected of having HIV or hepatitis infection? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you been exposed, through percutaneous inoculation, contact with an open wound, non-intact skin, or mucous membrane within the past twelve months, to blood this is know to be infected with HIV. Hepatitis B and/or hepatitis C virus? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been imprisoned or participated in a sexual act with someone in prison? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had close contact with another person having viral hepatitis within the past twelve months? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you been treated for syphilis or gonorrhea within the past twelve months? |
| <input type="checkbox"/> | <input type="checkbox"/> | Within the past year, have you undergone any form of acupuncture, body piercing, and/or tattooing procedures in which sterile technique was not used? |
| <input type="checkbox"/> | <input type="checkbox"/> | Is any indication found in your family history of transmissible spongiform encephalopathy (TSE) such as Creutzfeldt-Jakob disease (CJD); or a history of changes in cognition, speech, or gait; or exposure to tissue of harboring TSEs? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been a recipient of human organs, human extracts, or tissue transplants? |