



Center for Reproductive Medicine and Surgery

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Egg Donor Application

Please take the time to accurately complete this application in order to best assure your success in becoming a qualified donor. Please notify us immediately should there be a change in your health, medications or any other information that you shared in this form.

Date: _____

First Name: _____ Last Name: _____

Date of Birth: ____/____/____ (month/day/year)

Address 1: _____
Street Address City State Zip Code

Address 2: _____
Street Address City State Zip Code

Home Phone: (____) _____
Area

Daytime Phone: (____) _____
Area

Alternate Phone: (____) _____
Area

I heard about egg donation through:

- a friend or another donor name of referring person: _____
- a patient at our Center name of referring patient: _____
- advertisement where: _____
- online website or search engine which one: _____

If accepted as an egg donor, I would be available to serve beginning:

- immediately
- starting as of ____/____/____ (month/day/year)

Personal Characteristics

Marital Status: married single committed relationship
 divorced/separated widowed how long? _____

Place of Birth: _____
City State/Province Country

Ethnicity: Paternal _____
 Maternal _____

Religion born into:

- Buddhist Christian Hindu Islamic
 Judaic none other: _____
enter

Physical Characteristics

Height: ___ ft. ___ in. Weight: _____ lbs.

Build: extra-small small medium large

Bust: extra-small small medium large

Eye Color: blue gray brown green hazel
 other: _____
enter

Natural Hair Color: auburn ash blonde strawberry blonde red
 blonde light Brown dark Brown black

Hair Type (check all that apply):

- straight wavy curly frizzy kinky
 coarse thick fine thinning

Male Balding in Family? yes no

Skin Tone: fair medium olive ruddy
 light brown medium brown dark brown

Freckles: none few numerous

Do you wear corrective lenses (contacts or glasses)? yes no

Are you predominantly: right-handed left-handed ambidextrous

Additional Characteristics (Check all that apply):

- large eyes cleft chin dimples high cheek bones full lips
 thin lips other: _____
please describe

Education/Work/Interests

Academic Background (check all that apply):

- some high school high school graduate: GPA _____ G.E.D.
 tech/trade school some college
 bachelor's degree: GPA _____ degree achieved: _____ major: _____
 some graduate study major area of study: _____
 graduate degree: Masters MBA Ph.D. M.D. D.O. J.D.
major area of study: _____

(if you took any college entrance exams, please answer)

S.A.T. scores: total score: _____ Verbal: _____ Math: _____
A.C.T composite score: _____ Verbal: _____ Math: _____

Work History: I am currently working in the home. a full-time student.
 unemployed working part-time. working full-time.
 occupation, if working: _____
enter

Past Work History:

Occupation	Date of Employment	Exposed to toxins/radiation?

Career Goals: _____

Talents/Hobbies:

How would you describe your personality?

What is you greatest ambition in life?

Social History

Tobacco (Check all that apply):

- I currently smoke I am a heavy smoker
- I used to smoke but no longer do I have never smoked cigarettes

Alcohol (Check all that apply):

- I never drink alcohol
- I drink _____ times per week
- I rarely drink alcohol (less than twice a year)
- I think I had an alcohol abuse problem in the past

Drug Usage (Check all that apply):

- I have never used illegal drugs
- I have tried illegal drugs at least once in the past
- I used to use illegal drugs regularly, but don't use them anymore
- I am currently using one or more of the following illegal drugs:

Enter drugs used: _____

Have you ever used injectable illegal drugs? no yes

If yes, when did you last use illegal injectable drugs? _____

Criminal History (Check all that currently apply):

Have you had legal trouble in the past? no yes
If yes, please explain:

Have you ever been convicted of a crime? no yes
If yes, have you spent time in prison? no yes
If yes, to either please explain:

Psychological History

Have you ever sought counseling for depression or emotional problems? no yes

Have you ever taken antidepressants for more than 3 months at a time? no yes

Have you ever been diagnosed as having one of the following? no yes

If yes, please check any that apply:

- depression
- schizophrenia
- manic-depressive disorder
- mania
- obsessive-compulsive disorder
- anorexia/bulimia
- suicidal behavior
- self-mutilation
- substance abuse/addiction disorder
- personality disorder
- attention deficit disorder (ADD)
- autism or Asbergers syndrome

Personal Health History

Your blood type: _____ Rh positive or negative

Are you aware of any allergies you may have? no yes
If yes, to what are you allergic (and please describe the reaction)?

Are you allergic to any medications? no yes
If yes, what medications and reactions?

Were you or any relatives born with genetic disorders that led to hearing impairment? no yes

Do you have any dietary restrictions? no yes
If yes, what are the dietary restrictions and reasons for the restrictions?

Do you take any supplemental vitamins or herbal remedies on a continual basis? no yes
If yes, please list the supplements you are taking:

Do you take any prescription or over-the-counter medication on a regular basis?
 no yes If yes, please list the medications you are currently taking:

Do you have both ovaries? no yes

Have you had any surgeries in the past? no yes If yes, please list what surgeries you have had:

Have you ever had any adverse reaction to general anesthesia? no yes
If yes, please describe what happened and the severity of your reaction:

Have you ever been hospitalized for any condition other than the above listed surgeries?
 no yes If yes, please list why you were hospitalized:

Menstrual History (Please answer the following questions about your menstrual cycle)

How old were you when you had your first menstrual period? _____ years old.

How many days are there from the first day of one period to the first day of the your next period (when you are not taking hormonal contraception such as birth control pills, patch or injections)?

Usually _____ days with a range of as few as ____ days to as many as ____ days.

How many days do your periods usually last? _____ days.

Would you describe your menstrual periods as regular or irregular (when you are not taking hormonal contraception such as birth control pills, patch or injections)?

Have you ever been evaluated or treated for a menstrual disorder? no yes
If yes, please explain: _____

Have you ever taken, or are you currently taking, hormonal contraceptives (pill, patch, vaginal ring, injections)? no yes

If currently yes, what brand and for how long? _____

And

If yes in the past, what methods of contraception did you use and when?

Method	Date(s) Used	Any Problems

Sexual Activity History

Sexual orientation and behavior (Check all that currently apply):

- I consider myself to be heterosexual.
- I consider myself to be homosexual.
- I consider myself to be bisexual.
- If sexually active, my relationship is mutually monogamous.
- I engage in sexual activities with more than one partner on a regular basis.
- I engaged in sexual activities with a male prostitute in the previous 6 months.
- I have worked as a prostitute in the past.

How many sexual partners have you had in the past year?

- 1 2 3 4 or more

Have you ever been with a sexual partner who is a known user of drugs? no yes

Have you had intercourse without use of a condom in the last year? no yes

Have any of your past or present sexual partners shown evidence of having:

- HIV, Hepatitis B Hepatitis C? no yes

If yes, please check which viral infections above were known to be present and explain:-

_____.

Have you ever been with a sexual partner who tested positive for a sexually transmitted disease? no yes If yes, please indicate when this occurred, which disease, and if you acquired the disease:

Have you ever tested positive for the following communicable diseases? no yes

If yes, please indicate which one(s) below, if there was treatment and for some, a test to show you are cured.

- HIV Hepatitis B Hepatitis C Gonorrhea
 Chlamydia Syphilis Human Papilloma Virus (genital warts)

Have you had a pap smear within the past 6 months? no yes

Was the result of the pap smear normal? no yes If no, what care has been provided to you to resolve this problem? _____

Have you ever had a blood transfusion? no yes

Within the past 6 months? no yes

If yes, when and why did this happen? _____

Have you had any tattoos within the past year? no yes

If yes, when did you get your most recent tattoo? _____

Have you ever been excluded from blood donation? no yes

If yes, why? _____

Have you ever received pituitary derived growth hormone? no yes

Pregnancy History

Have you ever been pregnant? no yes If yes, then list all previous pregnancies (including abortions and miscarriages) in the table below:

Year	Type of Delivery	Outcome	Complications

Have you ever been told, in the past, that you have had any of the following: (check all that apply):

<input type="radio"/> Sexually Transmitted Disease	<input type="radio"/> Autoimmune disorder	<input type="radio"/> Multiple Sclerosis	<input type="radio"/> Herpes Simplex Virus 1 or 2
<input type="radio"/> Tuberculosis	<input type="radio"/> Alzheimer's Disease	<input type="radio"/> Pelvic Inflammatory Disease	<input type="radio"/> Abnormal Pap Smear
<input type="radio"/> Cancer	<input type="radio"/> Endometriosis	<input type="radio"/> Uterine Fibroids	<input type="radio"/> Ovarian cysts
<input type="radio"/> Endocrine Disease	<input type="radio"/> Hypertension	<input type="radio"/> Blood Clots	<input type="radio"/> Heart Disease
<input type="radio"/> Seizure Disorder	<input type="radio"/> Birth Defects	<input type="radio"/> Eating Disorder	<input type="radio"/> Diabetes
<input type="radio"/> Thyroid Disease	<input type="radio"/> Sexually Transmitted Diseases	<input type="radio"/> Other:	

Family History

Relative	Alive?	Present age or age of death	Medical Problems	Cause of Death	Birth Defects
Father	<input type="radio"/> yes <input type="radio"/> no				
Paternal Grandmother	<input type="radio"/> yes <input type="radio"/> no				
Paternal Grandfather	<input type="radio"/> yes <input type="radio"/> no				
Mother	<input type="radio"/> yes <input type="radio"/> no				
Maternal Grandmother	<input type="radio"/> yes <input type="radio"/> no				
Maternal Grandfather	<input type="radio"/> yes <input type="radio"/> no				
Sibling 1 Male/Female	<input type="radio"/> yes <input type="radio"/> no				
Sibling 2 Male/Female	<input type="radio"/> yes <input type="radio"/> no				
your 1 st biological child M or F (circle)	<input type="radio"/> yes <input type="radio"/> no				
your 2 nd biological child M or F (circle)	<input type="radio"/> yes <input type="radio"/> no				

Please indicate to us if you or any member of your family has any of the conditions listed below. Check all that apply and indicate who in your family has the condition.

Condition	Self	Family	Who in the family?
Cleft Palate	<input type="radio"/>	<input type="radio"/>	
Spina Bifida	<input type="radio"/>	<input type="radio"/>	
Thyroid Disease	<input type="radio"/>	<input type="radio"/>	
Club Foot	<input type="radio"/>	<input type="radio"/>	
Mental Retardation	<input type="radio"/>	<input type="radio"/>	
Down's Syndrome	<input type="radio"/>	<input type="radio"/>	
Cystic Fibrosis	<input type="radio"/>	<input type="radio"/>	
Marfan Syndrome	<input type="radio"/>	<input type="radio"/>	
Albinism	<input type="radio"/>	<input type="radio"/>	
Muscular Dystrophy	<input type="radio"/>	<input type="radio"/>	

Cancer (type):	<input type="radio"/>	<input type="radio"/>	
Schizophrenia	<input type="radio"/>	<input type="radio"/>	
Clinical Depression	<input type="radio"/>	<input type="radio"/>	
Obsessive/Compulsive Disorder	<input type="radio"/>	<input type="radio"/>	
Mania	<input type="radio"/>	<input type="radio"/>	
Tay Sachs Disease	<input type="radio"/>	<input type="radio"/>	
Canavan's Disease	<input type="radio"/>	<input type="radio"/>	
Hemolytic anemia	<input type="radio"/>	<input type="radio"/>	
Blindness	<input type="radio"/>	<input type="radio"/>	
Hearing Impairment	<input type="radio"/>	<input type="radio"/>	
Color Blindness	<input type="radio"/>	<input type="radio"/>	
Heart disease	<input type="radio"/>	<input type="radio"/>	
Parkinson's disease	<input type="radio"/>	<input type="radio"/>	
Hemochromatosis	<input type="radio"/>	<input type="radio"/>	
High Cholesterol	<input type="radio"/>	<input type="radio"/>	
Sickle Cell Anemia	<input type="radio"/>	<input type="radio"/>	
Hemophilia	<input type="radio"/>	<input type="radio"/>	
Huntington's Disease	<input type="radio"/>	<input type="radio"/>	
Diabetes	<input type="radio"/>	<input type="radio"/>	
Multiple Sclerosis	<input type="radio"/>	<input type="radio"/>	
Alzheimer's Disease	<input type="radio"/>	<input type="radio"/>	
Infertility	<input type="radio"/>	<input type="radio"/>	
Recurrent Miscarriage	<input type="radio"/>	<input type="radio"/>	
Liver Disease	<input type="radio"/>	<input type="radio"/>	
High Blood Pressure	<input type="radio"/>	<input type="radio"/>	
Asthma	<input type="radio"/>	<input type="radio"/>	
Epilepsy	<input type="radio"/>	<input type="radio"/>	
Tourette's Syndrome	<input type="radio"/>	<input type="radio"/>	
Still born babies	<input type="radio"/>	<input type="radio"/>	
Sudden Infant Death	<input type="radio"/>	<input type="radio"/>	
Death before age 40 years old	<input type="radio"/>	<input type="radio"/>	
Addiction (type):	<input type="radio"/>	<input type="radio"/>	
Clinical osteoporosis	<input type="radio"/>	<input type="radio"/>	

Your Interest and Commitment to voluntarily serve as an egg donor:

I am interested in voluntarily becoming an egg donor because:

Are you currently in an egg donor program elsewhere? no yes

Have you ever donated your eggs before? no yes

If yes, when did you donate? _____.

How many eggs were retrieved? _____.

Are you willing to share a photo of yourself as a child with the egg recipient?

no yes

If you are chosen as an egg donor, what would you like the recipient to know about your characteristics/personality and/or areas of talent?

Do you certify that your answers and explanations were voluntarily given and are correct to the best of your knowledge?

yes no

Are you aware of any health problems in yourself, family or previous sexual partners that you have not already disclosed?

yes no If yes, please explain below:

I hereby certify that my answers and explanations, which were voluntarily given in this questionnaire, are correct. I understand that the answers used in this questionnaire will be used to determine my appropriateness as an egg donor and to help match me with a prospective recipient. I allow the Center for Reproductive Medicine and Surgery (CRMAS) to share any of the information in this questionnaire with potential recipient couples, except my identifying information. I am not aware of any problems in myself, my family or my current or previous sexual partners that were not disclosed in the above questions.

Oocyte Donor Applicant Signature

Date

Please Print Name

Witness Signature

Date

Please Print Name