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?

☐Flyer/Mailer
☐Friend (name):
☐Newspaper (name):
☐Internet
☐Website

☐Directed Donor Name of Recipient:_____

Although children born of your ovum donation cannot now contact you, should the laws change, would you be willing to be contacted when such children reach maturity (usually age 18-21). This is not a binding decision, but merely your current inclination. ☐Yes ☐No ☐Undecided

Are you willing to share your photo with the Oocyte Recipient so we can find a match for you? ☐Yes ☐No
Will you allow us to post your photos and brief anonymous profile on our password protected donor database website? ☐Yes ☐No

Are you willing to travel to a recipient clinic out of state at no expense to you? ☐Yes ☐No

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 or 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:**

G.E.D. ☐ **Verbal:**

College/University 1☐ 2☐ 3☐ 4☐ GPA_____(Based upon ☐3 ☐4 point scale) **ACT:**

Major of Study:_____ **Degree Obtained:**_____

Post Graduate Major:_____ **Post Graduate Degrees:**_____

Please list any Scholastic achievements or awards received :_____

_____

In which School Clubs or Activities were you active?_____

_____

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

Did you take any AP or Honors Classes in High School?_____

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 like to sing? ☐Yes ☐No Have you sung in a Choir? ☐Yes ☐No If yes, For how long?_____

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

_____

Athletic Ability

Are you athletic? ☐Yes ☐No Are you active in sports, fitness or dance? Yes☐ No☐

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

What teams or sports have you taken part in (from early childood to present)? Please list :_____

_____

_____

Do you currently participate in sports or physical activities? (describe)

_____

Do you like to go camping or spend time outdoors? _____

Artistic Ability

Are you talented in the area of Visual Arts? Yes☐ No☐

What is your level of Artistic ability? ☐Gifted ☐Above Average ☐Average ☐Fair

Have you studied art? ☐Yes ☐No If yes, for how long?_____

What are your favorite mediums for creating art?_____

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?_____

_____

In your opinion what is the most important thing to know about you/ your interests?

_____

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 (Be detailed)

What type of work have you done in the past?

_____

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

_____

Please tell us what personal accomplishement you are most proud of and why (be detailed):

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: ☐I drink more than 4 drinks a week.

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 12 months of today. When:_____
☐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 and frequency of usage:

Sexual Orientation

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

Have you been treated for Syphilis, Gonorrhea or Chlamydia within the past 12 months? ☐Yes ☐No

If yes, when were you treated?_____

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?_____

Do you have an Implant or IUD for Contraceptive treatment? ☐Yes ☐No Which one?_____

Have you donated your eggs before? ☐Yes ☐No How many times? ☐1 ☐2 ☐3 ☐4 ☐5 ☐More
If Yes, where and when did you donate your eggs?

And how many eggs were retrieved?_____
Are you currently in a donor program elsewhere? ☐Yes ☐No
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 in prison for more than 72 hours consecutively in the past 12 months?		
10	Have you been sexually active during the past six months		
11	Are you currently sexually active?		
12	Are you in a monogamous relationship? If no, how many sexual partners have you had during the past six months?		
13	Have you had more than 10 sexual partners?		
14	Have you had sexual relations with a partner that is suspected or known to be HIV positive?		
15	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?		
16	Have you had sexual relations with a gay or bisexual man? If yes, when?		
17	Have you ever received a blood transfusion? If yes, when?		
18	Have you ever received factor VII or factor IX concentrates (blood transfusion) that was not heat-treated Or otherwise vial inactivated? If yes, when?		
19	Do you have any tattoos or piercings? If yes when did you receive the last one?		
20	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?		
21	Have you ever been diagnosed with vCJD or any other form of CJD?		
22	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?		
23	Have you ever had a blood relative diagnosed with CJD?		
24	Have you ever received a dura mater transplant?		
25	Have you spent three months or more cumulatively in the United Kingdom (U.K.) from the beginning of 1980 through the end of 1996?		
26	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?		
27	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)?		

	Continued: Please Answer the following questions:	Yes	No
28	Were you born in Cameroon, Central African Republic, Chad, Congo, Guinea, Gabon, or Niger? Or have you ever had sexual intercourse with a man who has lived in the above countries?		
29	Have you received any transfusion of blood or blood components in the U.K. or France between 1980 and the present?		
30	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.?		
31	Have you ever been refused as a blood donor? If yes, Why?		
32	Have you ever been immunized against Hepatitis B? If yes, When?		
33	Have you had close contact with someone suspected or known to be positive for Hepatitis B or Hepatitis or HIV? i.e. sexual intimacy, shared a bathroom or a kitchen		
34	Have you been immunized against small pox in the past 21 days?		
35	Have you been diagnosed with West Nile virus within the past 120 days?		
36	Have you ever received human organ or tissue transplants? Have you been exposed to people who have received human organ or tissue transplants?		
37	Have you had close contact with someone who has had a cell, tissue or organ transplant from an animal?		
38	Have you ever been diagnosed with or treated for West Nile virus? If yes, When?		
39	Have you ever been diagnosed with or treated for Severe Acute Respiratory Syndrome (SARS)? If yes, When?		
40	Have you been exposed to radiation or toxic chemicals in your work or personal life? i.e. lead, mercury and gold		
41	Have you been bitten by an animal suspected of having rabies within the past 12 months?		
42	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 experienced any significant respiratory symptoms within the last year?		
	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:		

Have you Traveled to any Zika environments in the past 6 months? ☐ **Yes** ☐ **No**

If yes, Where and What date did you travel?_____

Personal Medical History Information

Do you know your blood type? If so please tell us what it is:_____

List complications to anesthesia that you or a family member have experienced:

_____

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 or allergies to latex? 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:

_____

Mental Health

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

						Family	Onset
GENITAL REPRODUCTIVE SYSTEM Continued							
Trichomonas							
Undescended testicle							
Urogenital tuberculosis							
Uterine or Ovarian Cancer							
Uterine Fibroids							
Menopause or Ovarian Failure before the age of 40							
NEUROLOGICAL							
ADD or ADHD							
Autism							
Degenerative Neurologic disease							
Degenerative disease of the Brain or Spinal Chord							
Epilepsy							
Gaucher's Disease							
Huntington's Disease							
Hydrocephalus							
Learning disabilities/disorders							
Mental Retardation							
Migraines							
Multiple Sclerosis							
Senility before age 50							
Wilson's Disease							
Parkinson's Disease							
MENTAL HEALTH							
Alcoholism							
Anxiety Disorder							
Attempted Suicide							
Mania							
Bi-polar Disorder							
Chronic Depression							
Drug abuse/misuse or addiction							
Eating Disorders							
Chronic 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							

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 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 not already mentioned 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 and that my answers and explanations were voluntarily given.***

_____ _____
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**