

Donor Application

Name: _____ Date of Birth: _____

Address: _____ Med. Ins. Co. _____

Phone #: _____ Employer: _____

Soc. Sec. #: _____ Highest Level of Education: _____

Please complete the enclosed questionnaire, and please be completely candid. The accuracy of the information you will be giving will have a great impact on future generations you are about to create. The information on this form will be provided to the intended recipient so that she may have any relevant questions answered and obtain genetic counseling if she wishes. If you do not wish the information on this form to be made available to the intended recipient, you will not be considered to donate.

Are you a citizen of the United States? Yes _____ No _____

1. Some people cannot provide a complete family history (including grandparents). For example, if you are adopted, or do not know one side of your family, your ability to provide a complete family history may be compromised. Is there any reason you cannot complete a family history? Yes _____ No _____

If yes, please explain: _____

Have you ever been an egg donor before? Yes _____ No _____

If yes, Where and how many times? _____

All information provided by me on this application is true, correct and complete to the best of my knowledge.

Signature

Date

MD reviewed & deemed acceptable _____

Date _____

Please list the members of your immediate family (mother, father, brothers, sisters), their age (or age at death) and any medical problems they may have (and/or their cause of death). Be sure to list any siblings who may have died in infancy.

Age	Medical Problems	Age of Death (if applicable)	Cause of Death (if applicable)
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Mother _____
 Father _____
 Maternal
 Grandmother _____
 Maternal
 Grandfather _____
 Paternal
 Grandmother _____
 Paternal
 Grandfather _____
 Siblings and
 Cousins _____

What is your ethnic background? (Check where applies, add in any specifics please.)

<input type="checkbox"/> Caucasian	<input type="checkbox"/> Caribbean
<input type="checkbox"/> Northern European	<input type="checkbox"/> Mexican
<input type="checkbox"/> African	<input type="checkbox"/> South American
<input type="checkbox"/> Southeast Asian (Cambodia, Viet Nam)	<input type="checkbox"/> Middle Eastern (Iran, Israel)
<input type="checkbox"/> Far Eastern (China, India, Philippines, Japan)	<input type="checkbox"/> Spanish
<input type="checkbox"/> Ashkenazi Jewish	<input type="checkbox"/> Portuguese
<input type="checkbox"/> Sephardic Jewish	<input type="checkbox"/> Native American
<input type="checkbox"/> West Indies	<input type="checkbox"/> Other _____
<input type="checkbox"/> Hindu/Guyana/India	_____

Have you ever been convicted of a crime or at present, have any pending legal action?

Yes _____ No _____

Have you ever been pregnant? Yes _____ No _____

If yes, how many times? _____ If yes, how many stillbirths? _____

How many live births? _____ How many miscarriages? _____

How many abortions? _____

YOUR REPRODUCTIVE HISTORY

Menstrual History: Age of first menses? _____

Cycle length: _____ Regular _____ Irregular _____

Describe any menstrual related difficulties since puberty: _____

How bad were your menstrual cramps as a teenager? _____ Now? _____

Premenstrual syndrome? _____ Describe symptoms, duration and severity: _____

Describe any medical treatment for menstrual problems: _____

Is there a history of infertility in your family? Explain: _____

Describe any complications: _____

Current Allergies? _____ To what? _____

How long? _____ Any treatment given? _____

Describe any weight problems you may have had: _____

Diet: Describe your preferences and dislikes: _____

Do you drink alcoholic beverages? _____ What kind? _____

How many drinks (beer, wine, liquor) do you consume per day? ____ week? ____ month? ____

Have you ever sought help for an alcohol problem? If yes please explain: _____

If you do not drink at all, what is your reason (if any)? _____

OOCYTE DONOR PERSONAL HISTORY

Date: _____

Age: _____ Year of Birth: _____

Height: _____ Weight: _____

Race: _____ Ethnic Origin: _____

Place of Birth: _____ Religion born into: _____

I grew up in _____

PHYSICAL CHARACTERISTICS (please circle appropriate response)

BODY TYPE / BONE STRUCTURE:

Small Medium Large

HANDS:

Right-handed Left-handed Ambidextrous

EYES:

Color	brown	hazel	green	blue
Set	narrow	average	wide	
Size	small	average	large	
Shape	round	oval	almond	
Shade	light	medium	dark	

HAIR:

Color as a young Child	blonde	brown	black	red	other _____
Natural Color	blonde	brown	black	red	other _____
Shade	light	medium	dark		
Type	straight	wavy	curly		
Fullness	thin	medium	thick		
Texture	fine	medium	coarse		

NOSE:

Size	small	medium	large
Width	narrow	average	wide
Length	short	average	long
Nostril Flare	small	average	wide

CHEEKBONES:

Set	low	average	high
Prominence	slight	medium	strong

MOUTH:

Size	small	average	large
Lips	thin	average	full

CHIN:

Shape square oval round
Prominence slight average strong
Cleft none slight medium strong

SKIN:

Tone light med-light medium med-dark dark
Tan ability none slight medium easy
Condition oily medium dry combination
Acne none slight medium severe
At what age? _____

OTHER FACIAL FEATURES:

Moles none one several numerous
Freckles none several moderate numerous
Dimples none slight medium deep

PHYSICAL AIDS:

EYES:

Vision normal far-sighted near-sighted
Glasses none single bifocal trifocal
Age diagnosed _____ yrs

DENTAL:

Device none braces retainer other _____
Reason cosmetic accident disease other _____
Age during use _____ to _____ years of age

OTHER:

List _____
Reason (Cause) _____

Describe your parents by the following physical characteristics:

	Eye color	Hair color	Complexion	Height	Body type
Father					
Mother					

PERSONAL CHARACTERISTICS:

Level of Education:

Completed Grade school _____ Completed High school: _____
Currently in college, pursuing a degree in: _____
Completed college degree in : _____
Currently pursuing an advanced degree in: _____
Completed an advanced degree in: _____
SAT score Math: _____ Verbal: _____

LANGUAGES:

Speak _____
Read _____
Write _____

ATHLETIC ACTIVITY: (circle appropriate choice)

Athletic active average inactive

What physical activities do you engage in? _____

Have you excelled in any physical activities? _____

MANUAL DEXTERITY:

Dextrous average clumsy

What manual skills do you have? _____

What other skills or talents do you have? (e.g., painting, writing, reading, ability to do games, crossword puzzles, handcrafts, etc.) Please describe: _____

MUSICAL ABILITY:

Musical average tone deaf

WORK/OCCUPATIONAL HISTORY:

What were your strengths in school? _____

What were your weaknesses in school? _____

Were you ever diagnosed with any learning disabilities? _____

What is your current or most recent occupation? _____
What other types of employment have you had? _____

Describe yourself as a child: (e.g. personality, health, interests, activities, etc.) _____

PERSONAL CHARACTERISTICS

What are your favorite foods? _____

What is your favorite color? _____

Do you like pets? If so, which is your favorite? _____

To where would you most like to travel and why? _____

How would you describe your personality? _____

What is your ultimate ambition or goal in life? _____

What were your reasons for becoming a donor? _____

What would you especially like your genetic offspring to know about you? _____

Would you be willing to be an “identified donor” if your genetic offspring needed further genetic or medical information? Yes _____ No _____

RELIGION:

Are you atheist _____ agnostic _____

What religion did you belong to as a child? _____

As an adult? _____

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

FAMILY HISTORY

MOTHER: Place of birth: _____

Racial group: _____

Religion: _____

Height: _____ Weight: _____ Eye Color: _____

Natural hair color: _____

Bone structure: _____
Other distinguishing features: _____

Occupation: _____
Education: _____
Special skills, characteristics, achievements: _____

Describe her personality: _____

FATHER: Place of birth: _____
Racial group: _____
Religion: _____

Height: _____ Weight: _____ Eye Color: _____
Natural hair color: _____
Bone structure: _____
Other distinguishing features: _____

Occupation: _____
Education: _____
Special skills, characteristics, achievements: _____

Describe his personality: _____

SIBLING: Brother _____ Sister _____
Place of birth: _____
Racial group: _____
Religion: _____

Height: _____ Weight: _____ Eye Color: _____
Natural hair color: _____
Bone structure: _____
Other distinguishing features: _____

Occupation: _____
Education: _____
Special skills, characteristics, achievements: _____

Describe his/her personality: _____

SIBLING: Brother _____ Sister _____
Place of birth: _____

Racial group: _____
 Religion: _____
 Height: _____ Weight: _____ Eye Color: _____
 Natural hair color: _____
 Bone structure: _____
 Other distinguishing features: _____

 Occupation: _____
 Education: _____
 Special skills, characteristics, achievements: _____

 Describe his/her personality: _____

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

1. Organ (heart, lung, kidney, etc.) Yes _____ No _____
2. Blood circulation Yes _____ No _____
3. Respiratory system Yes _____ No _____
4. Gastrointestinal system Yes _____ No _____
5. Genital/Urinary Yes _____ No _____
6. Metabolic (hormones, enzymes, etc.) Yes _____ No _____
7. Nervous system (brain, spinal cord) Yes _____ No _____
8. Bones, muscles, joints, limbs Yes _____ No _____
9. Other: _____ Yes _____ No _____

If yes to any of the above, please list below the specific defect in each case.

Type of defect	Affected family member	When did this happen?	Relevant circumstances
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are there any diseases, abnormalities or conditions that appear to run in your family?

Yes _____ No _____

If yes, please indicate the disease(s) and the family members affected: _____

Has anyone in your family, including yourself, experienced 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: _____

Have you ever been screened for:

- | | | |
|--------------------|-----------|----------|
| 1. Tay Sachs | Yes _____ | No _____ |
| 2. Sickle Cell | Yes _____ | No _____ |
| 3. Thalassomia | Yes _____ | No _____ |
| 4. G6DP Deficiency | Yes _____ | No _____ |
| 5. Cystic Fibrosis | Yes _____ | No _____ |

