Please return this application to:
ATT: Roxann Taylor, RN
IVF & Oocyte Donor Program Coordinator
Strong Fertility and Reproductive Science Center
601 Elmwood Avenue / BOX 685
Rochester, New York 14642

STRONG FERTILITY AND REPRODUCTIVE SCIENCE CENTER
EGG DONOR APPLICATION

Date: _____/_____/_____

Name:_____ Social Security #: _____

Address: _____ City/State _____ Zip: _____

Birth date: _____/_____/_____ Age: _____ Birthplace:_____

Home phone: _____ Best time to reach:_____ OK to leave message ☐ Yes ☐ No

Occupation: _____ Work Hours: _____

Number of years at present job: _____

Business phone: _____ OK to call at work? ☐ Yes ☐ No OK to leave message? ☐ Yes ☐ No

Husband/Partner's name: _____

How many pregnancies have you had? (Include live born plus miscarriages, ectopic pregnancies, stillborn, etc) _____

How many living children? _____

Do you wish to donate anonymously? ☐ Yes ☐ No (OR) Do you have a recipient? ☐ Yes ☐ No
If donating for a known recipient please list:

Recipient's name: _____

Recipient's address: _____

Relationship to you: _____

Are you adopted? ☐ Yes ☐ No

Do you have any allergies? ☐ Yes ☐ No

If yes, please check all that apply ☐ Food ☐ Drugs ☐ Environmental ☐ Other: _____

Please list any medication allergies and the reaction if known: _____

How did you hear about the Egg Donor Program? _____

Education:

_____ Completed High School
_____ Associates Degree/Field:________________________________
_____ Trade School /Trade studied: ____________________________
_____ Some College
_____ College Degree/Major:_________________________________
_____ Masters Degree/Field:__________________________________
_____ Doctorate Degree/Field: ________________________________

Please list any talents or skills:____

Hobbies/special interests: ____

How would you describe yourself physically? _____________________________________

What is your biggest stress in life? ____

Why did you decide to become an egg donor? _____________________________________

Body build (describe, for example, small or large boned, slight, strong, etc): ________________________

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Confidential Egg Donor History Form

Please fill out as accurately and truthfully as possible. Please complete all questions.

Marital and Family History

Marital Status: ____

If ever married, date or dates of previous marriages: _____________________________

Physical Characteristics

Race: ____________ Blood type, if known: __________ Height: __________ Weight: __________ Weight at age 21: ________

Natural Eye Color ____________________________ Natural Hair Color __________________________

Hair (check all that apply): ☐ Thin ☐ Thick ☐ Curly ☐ Straight ☐ Average ☐ Wavy

Complexion (check one): ☐ Light ☐ Medium ☐ Olive ☐ Rosy ☐ Freckled ☐ Asian

For African Americans: ☐ Light ☐ Medium ☐ Dark

Any birthmarks? ____________________________ Ethnic background of your parents: ______________________

Jewish/Eastern European Ancestry? ____
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Reproductive History

Menstrual history:

Age of first menses: _____ How many days is it from the first day of a period to the start of the next period?: _____

Do you have irregular cycles (shorter than 25 days or longer than 42 days)? _____

If yes, please explain: _____

Describe any medical or surgical treatment for menstrual problems: _____

Pregnancy:

Please list **all** pregnancies, the outcome and date. (Example: vaginal birth 1999, miscarriage 2002 , termination 2005, etc).

_____
_____
_____

Have you ever been diagnosed with a sexually transmitted disease? □ Yes □ No
If yes, please list dates and diagnosis:

_____
_____

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

Breasts:
Have you ever had lumps or cysts in your breasts? □Yes □No If yes, please explain: _____
_____
Have you ever had breast surgery: □ Yes □ No If yes, please explain: _____
_____

Health Questionnaire

Have you ever been rejected as a blood donor? _____ If so, when? _____
Have you ever been treated for substance abuse, depression, or any other psychiatric disorder? _____ If yes, please list dates and diagnosis: _____
Were you ever hospitalized as part of the treatment for your condition? _____
Have you experienced any personal traumatic event?

□ Serious accident □ Sexual assault □ Physical abuse □ Other (please explain): _____
□ Rape □ Incest □ Sexual abuse _____

Have you ever been in counseling or psychotherapy? □Yes □No
If yes, please give reason, start date and stop date if applicable: _____
_____

Have you ever been tested for: Tay-Sachs, Sickle Cell Anemia, or Thalassemia? □Yes □No
If yes, which one and what was the result? _____

Have you ever been arrested or convicted of a felony? (Other than minor traffic offenses) □Yes □No
If yes, please describe circumstances: _____

Please list the frequency you use or have you used any of the following? (Circle NLU if you no longer use)

- Caffeine _____ NLU
- Tobacco _____ NLU
- Alcohol _____ NLU
- Marijuana _____ NLU
- Cocaine _____ NLU
- Other recreational drugs: _____ NLU

Have you ever been a tissue donor before? □Yes □No
What type (egg, bone marrow, blood, etc)? _____
How many times do you anticipate you will donate your eggs? _____
Have you or **any** of your partners [either past or present] had any of the following? (Circle yourself and/or partner if yes)

- Herpes You/Partner
- Gonorrhea You/Partner
- Venereal Warts You/Partner
- Syphilis You/Partner
- Chlamydia You/Partner
- Non-specific Urethritis You/Partner
- Other sexually transmitted diseases You/Partner

Have you been exposed to chemicals, drugs, or gases in any jobs, activities, or hobbies over the past five years? □Yes □No
If yes, please list: _____

Job/Activity	Date of employment	Drug/Chemical/Gases

Do you have any health problems? □ Yes □ No
If yes, please describe:_____
_____

Have you ever had surgery? □ Yes □ No
Please explain and provide dates: _____
Have you ever been hospitalized? □ Yes □ No
Please explain and provide dates: _____
Have you ever had any major illness? (pneumonia, mononucleosis, hepatitis, etc.) □ Yes □ No
Please explain: _____

List any medications you are currently taking:_____

If you had any childhood allergies you have outgrown, please list:_____

Diet: (Check one)

□ Non-vegetarian □ Vegetarian □ Poor diet □ Average diet □ Excellent diet
Do you exercise: □ No □ Occasionally □ Regularly

Vision:

Do you wear glasses/contacts? □ Yes □No Age you first wore glasses: _____ □ Nearsighted □ Farsighted □ Glaucoma

Hearing: □ Normal □ Describe any problems: _____

Teeth (check one): □ Poor □ Fair □ Good. Orthodontic work (braces) in the past? _____

Please circle the correct answer: (Please answer all questions)

Have you injected drugs (includes intravenous, intramuscular or subcutaneous injections) for a non-medical reason in the past 5 years? Yes No

Do you have hemophilia or a related clotting disorder? Yes No
If yes, have you received human-derived clotting factor concentrates? Yes No

Have you engaged in sex in exchange for drugs or money in the past five years? Yes No

In the past year, have you:
1. had sex with a person known or suspected to have HIV, hepatitis B, or hepatitis C? Yes No
2. been exposed to blood (via needle stick, or contact with an open wound, non-intact skin, or mucous membranes) that is known or suspected to be infected with HIV, Hepatitis B, or C ? Yes No

Have you ever been diagnosed with viral hepatitis or had a reactive test for hepatitis? Yes No
If yes, was it Hepatitis A, B, or C? _____
If yes, how old were you? _____

In the past year, have you been in close contact with another person who has clinically active hepatitis? Yes No
Have you ever had liver enlargement or unexplained jaundice? Yes No

Have you ever had bacteremia, septicemia, sepsis syndrome, or septic shock? Yes No

Have you had smallpox vaccination within the past 2 months? Yes No

Have you developed skin lesions as a result of close contact with another individual who received the small pox vaccine? Yes No
If yes, did this happen in the last two months? Yes No

In the past year, have you had sex with:
1. a needle drug user? Yes No
2. a person with hemophilia or related clotting disorder? Yes No
3. a man who has had sex with another man in the past five years? Yes No
4. a person who has engaged in sex in exchange for drugs or money in the past five years? Yes No

Have you or any of your sexual partners been incarcerated for more than 72 hours during the past 12 months? Yes No

Have you received a tattoo, ear or body piercing within the past 6 months? Yes No
Have you received a tattoo, ear or body piercing within the past 12 months? Yes No

Have you ever been evaluated, diagnosed or treated for the West Nile Virus? Yes No
If yes, was this within the last month? Yes No

Have you had a simultaneous fever and headache within the past 7 days? Yes No
Have you been in close contact with someone known or suspected to have SARS in the past 14 days? Yes No
Have you traveled to areas affected by SARS in the past 14 days? Yes No
Have you been evaluated, diagnosed or treated for SARS in the past month? Yes No
Have you or your sexual partner or any member of your household ever had a transplant or other medical procedure that involved being exposed to live cells, tissues, or organs from an animal? Yes No

Have you had or been treated for syphilis or gonorrhea in the past 12 months? Yes No

The following questions are about transmissible spongiform encephalopathy (TSE), such as Creutzfeld-Jakob disease (CJD). These are neurologic diseases that can cause a change in cognition, gait, or speech:

Do you or a blood relative have a history of CJD or any other form or variant of CJD? Yes No

Have you been diagnosed with dementia or any degenerative/demyelinating disease of the central nervous system? Yes No

Have you traveled or resided in the U.K. for a total of 3 or more months between 1980-1996? Yes No

Have you received any transfusion of blood or blood products in the U.K. from 1980 until the present? Yes No

Have you resided in Europe outside of the U.K. for 5 or more years between 1980 and the present? Yes No

Have you resided at a U.S. Military base in Germany, Turkey, Spain, Belgium, U.K., Portugal, Italy, Netherlands, or Greece for 6 months or more since 1980? Yes No

Have you received injections of human-derived pituitary growth hormone? Yes No

Have you ever injected bovine insulin since 1980? Yes No

Have you received a transplant of dura mater? Yes No

Family History

Including yourself, how many blood siblings are in your immediate family? _____

- Number of males _____
- Number of females _____

Do you have any brothers or sisters that died in infancy or childhood?

□Yes □No

If yes, please explain: _____

Are there any genetic diseases or conditions that run in your family?

□Yes □No

If yes, please explain:

_____

_____

Please describe the following characteristics of your family members:

Relation	Natural Hair Color	Eye Color	Height	Ethnic Origin	Age if living	Age at death	Cause of death
Father							
Mother							
Paternal Grandmother							
Paternal Grandfather							
Maternal Grandmother							
Maternal Grandfather							

Genetic/Family History

Were you born with any birth defects? □Yes □No Please list if yes: _____

Has anyone in your family had any of the following conditions?		**Yes**	**No**	
1.	Down's Syndrome	____	____	
2.	Mental Retardation		____	____
3.	Seizure Disorder		____	____
4.	Loss of Muscle Coordination		____	____
5.	Premature Senility (before 50)		____	____
6.	Alzheimer's disease		____	____
7.	Deafness (before 60)		____	____
8.	Blindness		____	____
9.	Cataracts (before 40)		____	____
10.	Any mental health problems--mild depression, anxiety	____	____	
11.	Schizophrenia or manic-depressive Disorder		____	____
12.	Serious Birth Defects		____	____
13.	Cleft Lip and/or Cleft Palate		____	____
14.	Club Feet		____	____
15.	"Open Spine" or "Water on the Brain"		____	____

16.	Congenital Heart Defects		____	____
17.	Congenital Hip Problems		____	____
18.	Two or More Miscarriages or Stillborn		____	____
19.	Crib death (neonatal death)	____	____	
20.	Diabetes Mellitus		____	____
21.	Thyroid Disease		____	____
22.	Progressive Kidney Disease		____	____
23.	Skin Disease		____	____
24.	Coffee-Colored Spots on the Skin (the size of a quarter or larger) or Lumps Under the Skin		____	____
25.	Early Death (less than 50)		____	____
26.	Cystic Fibrosis		____	____
27.	Emphysema		____	____
28.	Tuberculosis		____	____
29.	Lung disease		____	____
30.	Rheumatoid Arthritis		____	____
31.	Blood diseases:			
	Hemophilia		____	____
	Anemia		____	____
	Sickle Cell Anemia		____	____
	Leukemia/Lymphoma		____	____
	Thalassemia		____	____
32.	Reproductive Problems:			
	Ovarian Malignancy (Cancer)		____	____
	Endometriosis		____	____
	Undescended Testicles		____	____
	Hypospadias		____	____
33.	Alcoholism		____	____
34.	Drug Abuse		____	____
35.	Cancer (type and location)		____	____
36.	Heart Disease		____	____

If yes to any of above genetic/family history conditions, please give details below:

Condition Number	Specific Relation	Specific Condition	Age Affected

Genetic/Family History

Mother's Family

A. Is your Mother: □ Living □ Deceased

Age (or age at death) _____

If dead, cause of death _____

Any Health Problems	Age Diagnosed

B. Aunts and Uncles (on your mother's side), **who have died** (include stillborns, infant deaths, and childhood deaths)

	Sex	Age at Death	Cause of Death	Age Diagnosed
1.				
2.				
3.				
4.				
5.				

C. Aunts and Uncles (your mother's brothers and sisters), **who are living**:

	Sex	Age	Health Problems	Age Diagnosed
1.				
2.				
3.				
4.				
5.				

D. Grandfather (your mother's father) □ Living □ Deceased

Age (or age at death) _____ If dead, cause of death _____

Any Health Problems	Age Diagnosed

E. Grandmother (your mother's mother) □ Living □Deceased
Age (or age at death)_____ If dead, cause of death_____

Any Health Problems Age Diagnosed

_____
_____

Father's Family

A. Is your Father: □ Living □ Deceased

Age (or age at death) _____

If dead, cause of death _____

Any Health Problems Age Diagnosed

_____
_____

B. Aunts and Uncles (your father's brothers and sisters), **who are deceased** (include stillborn, infant and childhood deaths)

Sex Age at Death Cause of Death Age Diagnosed

1. _____
2. _____
3. _____
4. _____
5. _____

C. Aunts and Uncles (your father's brothers and sisters), **who are living**

Sex Age Health Problems Age Diagnosed

1. _____
2. _____
3. _____
4. _____
5. _____

D. Grandfather (your father's father) □ Living □ Deceased

Age (or age at death)_____ If deceased, cause of death_____

Any Health Problems Age Diagnosed

_____
_____

E. Grandmother (your father's mother): ☐ Living ☐ Deceased

Age (or age at death)__________ If deceased, cause of death______________________

Any Health Problems Age Diagnosed

____

____

Siblings

A. Your brothers and sisters, living

Sex	Age	Health Problems	Age Diagnosed
1.			
2.			
3.			
4.			
5.			

B. Your brothers and sisters, deceased

Sex	Age at Death	Cause of Death	Other Health Problems
1.			
2.			
3.			

Children

A. Your children, Living

Sex	Age	Health Problems	Age Diagnosed
1.			
2.			
3.			

B. Your children, Deceased

Sex	Age	Health Problems	Age Diagnosed
1.			
2.			
3.			

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Reviewed by ____M.D. Date: _______/_______/_______

- Discussed at IVF Team meeting Date: _______/_______/_______
- Further information needed ☐ Yes ☐ No

____

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- Approved to proceed with screening and testing by: ______________________________MD Date:_____/_____/_____
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