Please return this application to:
ATT: Roxann Taylor, RN
Oocyte Donor Program Coordinator
Strong Fertility and Reproductive Science Center
500 Red Creek Dr, STE # 220
Rochester, New York 14623

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: ______________________________

____

Personal Health Questionnaire

Please describe any major illness, chronic medical condition or disease (such as asthma, diabetes, seizures, high blood pressure, pneumonia, blood clots etc. Include dates:

____
____
____
____

Please list any surgical procedures and their dates:

____
____

Did you have any concerns or complications with anesthesia? If yes, please describe:

____

Please list any prescription medications that you have taken in the last year. Include dose, frequency and reason:

____
____

List any over the counter medications (such as vitamins, herbals, antacids, laxatives, pain relievers etc):

____

____

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? (Select 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

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: (You are required to 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 received a blood transfusion within the preceding 12 months? 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

Question		
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 received a bite from an animal suspect of rabies in the preceding 6 months?	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:

Question		
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

Genetic/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

We would like to know about your genetic and family health history. We will ask about you, and your first degree relatives (your parents, your siblings and your children) and second degree relatives (grandparents, aunts/uncles, cousins and nieces/nephews)

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

Have you or any of your first degree or second degree relatives 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	____	____

		Yes	No
9.	Cataracts (before 40)	____	____
10.	Any mental health problems--mild depression, anxiety	____	____
11.	Schizophrenia or manic-depressive Disorder	____	____
12.	Malformations, Serious Birth Defects or other genetic disorders	____	____
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	____	____

		Yes	No
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

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. Nieces and Nephews, Cousins, 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.				
6				

C. Nieces and Nephews, Cousins, Aunts and Uncles (your mother's brothers and sisters), **living with health problems**:

	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. Nieces and Nephews, Cousins, 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. Nieces and Nephews, Cousins, Aunts and Uncles (your father's brothers and sisters), **living, with health problems**

	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

  ____
  ____

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