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www.reproendo.com

Diplomate American Board of Obstetrics & Gynecology
Board Certified Reproductive Endocrinology & Infertility

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Please provide complete and accurate information to these questions. Your responses, and any other information you provide during the egg donation process, remain completely confidential. Information from this questionnaire may be made available *anonymously* to the recipient couple.

I, the undersigned, acknowledge that the following answers are accurate and truthful to the best of my knowledge and include all relevant information.

Signature: _____ **Date:** _____

Personal Information (For Internal Use)

Name:

Address:

Telephone 1st Choice:

2nd Choice:

Email:

Date of Birth:

Marital Status (Choose one: Single, In A Relationship or Divorced or Separated):

Are you eligible to work in the United States?
(The money received from donation is taxable.)

Do you have a SSN?

Do you work full or part time?

Do you attend school (where)?

Would you be available for morning appointments for 10-14 days if you were chosen to be an egg donor?

Are your family, boyfriend/husband and friends supportive of your decision to donate your eggs?

Where did you see our advertisement?

Please answer the following questions honestly, as your opinion is important in this process.

Would you be comfortable donating to a single parent?

Would you be comfortable donating to a gay or lesbian couple?

Would you like to know the results of any abnormal test results we receive on you?

Would you like to know of any genetic abnormalities of the offspring resulting from your donation?

We display baby photos of our egg donors alongside their profiles in our egg donor book. Would you be comfortable submitting a baby photo of yourself to be seen by the prospective recipient?

We keep current adult photos of our egg donors in a separate file, accessible only by our staff. The egg donor coordinator will usually show this adult photo to a prospective profile. Are you comfortable with the prospective recipient seeing your adult photo in this manner?

REPRODUCTIVE HISTORY

Age at first menstrual period:

Are your menstrual cycles regular (yes/no)?

What is the interval (#days) between your periods, in days, from the start of one to the start of the next?

Have you ever been diagnosed with infertility?

Do you have a history of gynecological problems (endometriosis, fibroids, ovarian cysts, abnormal Pap, etc)?

Have you or a partner ever tested positive for a sexually transmitted disease?

Have you been sexually active during the past six months?

Are you currently sexually active?

Are you in a monogamous relationship?
you have had in the past six months:

What type of birth control are you using, if any?

What other types of birth control have you used?

Have you *ever*

PREGNANCY HISTORY (Including terminations and miscarriages)

Year	Outcome	Any Complications

PHYSICAL CHARACTERISTICS

Age: _____ **Year of Birth:** _____

Height: _____ *feet* _____ *inches* **Weight:** _____ *pounds*

Place of Birth: _____

Date moved to this country (if applicable): _____

Race (Please indicate all that apply - Asian, Black, Caucasian, Hispanic and/or Other):

(Expand on the information provided above. For example, if mother is of Hispanic descent, then indicate country (ies) of ancestry such as Portugal, Mexico, Brazil, etc.):

(Expand on the information provided above. For example, if mother is of Hispanic descent, then indicate country (ies) of ancestry such as Portugal, Mexico, Brazil, etc.):

Religious Background (if applicable):

BODY TYPE/BONE STRUCTURE (small, medium or large):

EYE COLOR:

HAIR:

- **Natural color:**
- **Color as a child:**
- **Shade (light, medium or dark):**
- **Type (straight, wavy or curly):**
- **Fullness (thin, medium or thick):**
- **Texture (fine, medium or coarse):**

SKIN:

- **Tone (fair, medium, olive, dark, other):**
- **Describe your ability to tan (tan easily, tend to sunburn, etc.):**
- **Condition (oily, medium, dry, combination):**
- **Acne (none, slight, medium, severe):**

At what age?: _____

PERSONAL CHARACTERISTICS

LEVEL OF EDUCATION:

COMPLETED HIGH SCHOOL: Yes No

COLLEGE EDUCATION (If you are in/have attended college, list your major and/or any degrees received):

FOREIGN LANGUAGES (Indicate what languages you can speak, read or write):

ATHLETIC ACTIVITY (athletic, average or inactive):

- What physical activities do you engage in?

- Have you received awards for your participation in any physical activities?

MUSICAL ABILITY (musical, average or non-musical):

- Voice (soprano or alto):
- Instrument: _____ years experience
- Other: _____ years experience

OTHER SKILLS OR TALENTS (e.g., painting, writing, ability to do games, crossword puzzles, handcrafts, etc.):

MEDICAL HISTORY

Please list any allergies you have (food, pollen, bee strings, medications, etc.):

Describe any childhood allergies you have outgrown:

Do you have any history of medical illness (asthma, diabetes, seizures, disorders, etc.)?

Do you have excessive hair growth that requires regular removal?

Do you have frequent nose bleeds, bleeding gums when you brush your teeth, and/or menstrual periods with blood clots?

List *all* vitamins, herbs, over the counter *and* prescription medications that you take on a regular basis:

List any other Medicines taken in the last 5 years:

Do you smoke cigarettes? How much?

What types of alcoholic beverage (beer, wine, alcohol) do you drink?

How many alcoholic drinks do you consume in a week?

Have you ever used any kind of recreational drugs such as marijuana, LSD, heroin, ecstasy or cocaine? If yes, please give details and state last date used:

Have you ever used neuroleptic agents (tranquilizers, valium, thorazine, etc.) or anti-depressants? If yes, please give details and state date last used:

Have you ever been refused as a blood donor? If yes, why?

Have you been exposed to radiation or toxic chemicals in your work or home environment?

Have you ever had surgery? If so, describe:

FAMILY HEALTH HISTORY

Please read the following list of medical problems carefully and indicate which ones you or one of your relatives has had. Please consider each condition carefully for each family member.

Medical Problems	Y O U R S E L F	M O T H E R	F A T H E R	S I B L I N G S	G R A N D P A R E N T	O T H E R F A M I L Y	Describe
<i>HEART</i>							
Stroke							
Heart attack							
Heart disease							
From birth							
Other							
High cholesterol							
High blood pressure							
<i>BLOOD</i>							
Anemia							
Sickle-cell anemia							

Hemophilia or other bleeding problem							
Leukemia							
Immune Deficiency							
Clotting disorder							
Thalessemia							
RESPIRATORY (LUNGS)							
hay fever							
Asthma							
Emphysema							
tuberculosis							
Lung cancer							
Pneumonia							
Cystic fibrosis							
Other lung disease							
GASTRO-INTESTINAL							
Ulcer of stomach or duodenum							
Gall stones							
Hepatitis A (infectious)							
Hepatitis B (serum)							
Hepatitis C							
Colon cancer							
Ulcerative colitis							
Crohn's disease							
Intestinal cancer							
Any other cancer/problem of digestive system							

Medical Problems	Y O U R S E L F	M O T H E R	F A T H E R	S I B L I N G S	G R A N D P A R E N T	O T H E R F A M I L Y	Describe
METABOLIC/ENDOCRINE							
Diabetes – Type I (Juvenile onset)							
Diabetes – Type II (Adult onset)							
Hypoglycemia							
Thyroid cancer							
Thyroid disease or nodules							
Goiter							

Adrenal dysfunction or disorder									
Hyperactivity									
URINARY									
Kidney disease									
Other disease of urinary tract (urethra, bladder, ureter)									
Rectal disorder									
GENITAL/REPRODUCTIVE									
Undescended testicles									
Birth defects of genitals									
Breast cancer									
Prostate cancer									
Testicular cancer									
Uterine fibroids									
Ovarian cysts									
Cancer of cervix, ovaries, uterus									
Recurrent miscarriage									
Stillbirth									
Infertility									
NEUROLOGICAL									
Migraines									
Mental retardation									
Senility before age 50									
Multiple sclerosis									
Cerebral palsy									
Epilepsy									
Hydrocephalus									
Disorder of the spinal cord (Spina bifida/neural tube defects)									
Huntington' chorea									
Parkinson's disease									
Gaucher's disease									
Wilson's disease									
Tourette's Syndrome									
Creutzfeldt-Jacob's disease									
Alzheimer's disease									
Other diseases of the nervous system									

Medical Problems	Y O U R S E L F	M O T H E R	F A T H E R	S I B L I N G S	G R A N D P A R E N T	O T H E R F A M I L Y	Describe
<i>MENTAL HEALTH</i>							
Schizophrenia							
Clinical Depression							
Bipolar Disorder							
Other mental health disorders requiring Hospitalization							
<i>MUSCULAR/BONES/JOINTS</i>							
Muscular dystrophy							
Other chronic muscle disease							
Lupus							
Deformity of the spine							
Osteoporosis							
Dwarfism							
Hereditary low back disease							
Arthritis (indicate rheumatoid or degenerative/osteo)							
Gout							
<i>SIGHT/SOUND/SMELL</i>							
Deafness before age 60							
Deformity of the ear							
Cataracts before age 50							
Blindness							
Color blind							
Glaucoma							
Deviated septum							
Any other sight/sound/smell disorder							
<i>SKIN</i>							
Acne							
Eczema							
Skin cancer							
Pigmentation disorder							
Neurofibromatosis							
Any other disorders of the skin							
<i>CONGENITAL ANOMALIES</i>							

Cleft palate							
Congenital hip problems							
Down Syndrome							
Trisomy 13 or 18							
Fragile X syndrome							
Turner's syndrome							
Any other defects or problems at birth							
<i>OTHER</i>							
Alcoholism							
Drug abuse, misuse or addiction							
Any other cancer not mentioned above							
Any other condition not mentioned above							

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

If yes, what was the cause?

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

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.)

PERSONAL AND MOTIVATIONAL

WHEN I WAS A CHILD:

My favorite thing to do was:

My parents taught me to value:

What I loved most about my father was:

What I loved most about my mother was:

My favorite relatives were:

I loved to visit:

My parents would have described me as:

WHEN I WAS A TEENAGER:

My favorite subject(s) was:

My least favorite subject(s) was:

I liked to:

I hated to:

I traveled to:

My talents/achievements were:

I had problems with (health, acne, friends, school, parents, etc.):

My friends would have described me as:

WHO I AM TODAY:

Today my goal for my life is:

Some of the things that I like about myself are:

The most influential person in my life has been:

I would like to donate my eggs, because:

I want to tell the recipient of my eggs:

