EGG DONOR PROFILE FORM

Date _____

Initials _____

Height _____ Weight _____ Eye color _____ Hair color _____

Special Talents / Skills _____

Ethnic Background _____ Mother _____ Father _____

Religion born into _____ Mother _____ Father _____

Blood Type _____

Picture goes here

Year of Birth _____ Place of Birth _____

Racial Group: __Caucasian __African American __Asian __Other

Hair Type: ___Curly ___Wavy ___Straight

Corrective Lenses: __Yes__No

Bone Structure: ___Small ___Medium ___Large ___Very Large

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Are you predominantly: __Right-handed __Left-handed __Ambidextrous

Other distinguishing features (dimples, cleft chin, Roman nose, etc):

_____

Skin Characteristics:

__Freckles: __None __Few __Numerous

__Very Fair (little to no ability to tan on sun exposure)

__Fair (skin will tan lightly on sun exposure)

__Medium (Light color but will tan moderate to dark)

__Olive (pigmentation of unexposed skin) __light __moderate __dark

__Dark (pigmentation of unexposed skin)

Educational Background

(Circle highest level attained)

High school 1 2 3 4

College/University 1 2 3 4 B.A._____ B.S._____

Major area of study: _____

Post Graduate 1 2 3 4 5+ Major:_____

Degrees Attained M.A. M.S. Ph.D. M.D. J.D. D.D.S. Other:_____

Personal Characteristics

Why do you want to be a donor? _____

_____

What is your ultimate ambition or goal in life? _____

_____

Math Skills_____

Mechanical Skills_____

Athletic Skills_____

Music Skills_____

Artistic Abilities_____

Favorite Sport_____

What languages do you speak?_____

Hobbies_____

Special Talents_____

Favorite Foods_____

Favorite Color_____

Describe your personality_____

_____

Do you have any children? _____Yes _____No

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If yes, please give their age and any health problems they might have:

Age	Health Problems
_____	_____
_____	_____
_____	_____
_____	_____

Have you ever been refused as a blood donor? _____Yes _____No

If yes, explain:_____

Has anyone in your family had difficulty achieving a pregnancy?_____

_____

Work / Occupational History

Please list all the jobs you had in the past five years, starting with your present position. Include all exposures to drugs, chemicals, and toxins.

Job / Duties (Do Not name employer)	Start Date	End Date	Drugs, Chemicals and Toxins exposed to

Personal Health History

Menstrual History: Regular Periods _____Yes _No

Birth Control ___Yes _No What Brand_____

Allergies:	Reaction
_____	_____
_____	_____
_____	_____

Do you wear corrective lenses? _____Yes _____No

Vision uncorrected: ___ / 20

Do you exercise regularly?_Yes _____No

List all surgeries:

1.	Date:
2.	Date:
3.	Date:
4.	Date:

Have you ever been hospitalized?_____

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Have you ever been treated for sexually transmitted disease? _____Yes No___
If yes, please explain. What type?_____
When?_____Details:_____
When you were last treated?_____
Have you or your sexual partners ever had:
Chlamydia ___ Yes ___No myself / Partner When_____
Venereal Warts ___Yes ___No myself / Partner When_____
Herpes ___Yes ___No myself / Partner When_____
Syphilis ___Yes ___No myself / Partner When_____

Do you have any chronic medical problems or conditions? If yes, please describe:

_____

Please list all prescription drugs you have used or are currently using.

Name of drug Date started Frequency of use

_____

_____

_____

How many alcoholic beverages, on average, do you consume in an entire week?__
On a weekend night?_____On a week night? _____
Have you ever experimented with drugs? Yes No Please list: _____

_____

When was the last time you used drugs?_____
Do you know or suspect you have been sexually abused? Yes No
Have you ever considered suicide? Yes No
Have you ever attempted to commit suicide? Yes No
Have you ever been arrested or convicted of a crime / felony? Yes No
If yes, please explain:_____
Have you ever been under the care of a psychiatrist? Yes No
If yes, please explain: _____
Do you need any medical assistance to conceive your children? Yes No
Do you have legal and physical custody of all your children? Yes No
If no, please explain: _____

Number of miscarriages: _____ Number of abortions:_____

Family History - Please fill in completely

Look through the following list of medical problems and mark in the applicable boxes to indicate problems you or one of your relatives has had. Please consider each condition carefully for each family member.

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Date _____

Initials _____

Do you know about your mother and father's sides of the family? If not, why not?_____

_____

Medical Problem	You	Mother	Father	Sibling	MGM	MGF	PGM	PGF
Heart Disease								
Heart Attack								
High Blood Pressure								
Anemia								
Hemophilia								
Sickle Cell Disease								
Leukemia								
Immune Deficiency								
Asthma								
Lung Cancer								
Skin Cancer								
Stomach Ulcer								
Gallstones								
Hepatitis								
Ulcerative Colitis								
Chron's Disease								
Cystic Fibrosis								
Colon Cancer								
Kidney Disease								
Undescended Testicle								
Hypostasis								
Prostate Cancer								
Cancer of Ovary, Uterus, Cervix								
Diabetes								
Thyroid Cancer								
Mental Retardation								
Alzheimer's Disease								
Multiple Sclerosis								
Epilepsy or Seizures								
Disorders of Spinal Cord								
Huntington's Disease								
Gaucher's Disease								
Wilson's Disease								
Schizophrenia								
Other Psychiatric								
Muscular Dystrophy								

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Lupus								
Arthritis								
Gout								
Deafness								
Blindness								
Cataracts before age 50								
Color Blindness								
Breast Cancer								
Other Cancer								
Any other condition								

Please circle all relatives you suspect or know have experienced any of the following:
M=mother F=father B=brother S=sister MGM,MGF=maternal grandmother grandfather
PGM, PGF=paternal grandmother grandfather MA, MU= maternal aunt maternal uncle
PA, PU paternal aunt uncle MC, PC= maternal, paternal FIRST cousin.

Alcohol problem self M F S B MGM MGF PGM PGF MA MU PA PU MC PC
Drug problem self M F S B MGM MGF PGM PGF MA MU PA PU MC PC
Depression self M F S B MGM MGF PGM PGF MA MU PA PU MC PC
Anxiety self M F S B MGM MGF PGM PGF MA MU PA PU MC PC
Panic Attacks self M F S B MGM MGF PGM PGF MA MU PA PU MC PC
Meds for depression self M F S B MGM MGF PGM PGF MA MU PA PU MC PC
Or anxiety
Suicide self M F S B MGM MGF PGM PGF MA MU PA PU MC PC
Mental Retardation self M F S B MGM MGF PGM PGF MA MU PA PU MC PC
Manic depressive or Bipolar self M F S B MGM MGF PGM PGF MA MU PA PU MC PC
Schizophrenia self M F S B MGM MGF PGM PGF MA MU PA PU MC PC
OCD's self M F S B MGM MGF PGM PGF MA MU PA PU MC PC
Violence self M F S B MGM MGF PGM PGF MA MU PA PU MC PC
Learning disability self M F S B MGM MGF PGM PGF MA MU PA PU MC PC
Attention Deficit self M F S B MGM MGF PGM PGF MA MU PA PU MC PC
Hyperactivity self M F S B MGM MGF PGM PGF MA MU PA PU MC PC

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Initials _____

Nervous breakdowns self M F S B MGM MGF PGM PGF MA MU PA PU MC PC

Seizures self M F S B MGM MGF PGM PGF MA MU PA PU MC PC

Do you have any brothers or sisters who died in infancy or childhood? Yes No

If yes, what was the cause? _____

Are there any known genetic disease or conditions that run in your family? Yes No

If yes, what are they? _____

Has anyone in your family including yourself and your first cousins, experienced recurring and or chronic physical symptoms that have not been evaluated by a physician? Yes No

_____

Has any member of your family, including yourself, had a problem or defect at birth of any of the following body systems (please include first cousins and great-grandparents)?_____

_____

Birth Defect	Yes	No	Who	When	seriousness
Bones, muscles, Joints, limbs					
Gastrointestinal System					
Nervous system, Brain, spinal cord					
Blood circulation					
Respiratory system					
Organ(hearing,lung,kidney)					
Genital/ urinary					
Metabolic(hormones,enzymes,etc)					

Do you have any Jewish ancestors? Yes____ No____ Unknown

If yes, have you been tested as a carrier of: Tay Sachs, cystic fibrosis or Gaucher's disease? _____

_____

Do you have any African ancestors? Yes____ No____ Unknown

If yes, have you been tested as a carrier of sickle cell disease? Yes____ No____

If yes, result: _____

Do you have any Mediterranean (Greek or Italian) ancestors? Yes____ No____

If yes, have you been tested as a carrier of Talasemia? Yes____ No____

If yes, result: _____

Do you have Oriental ancestors? Yes____ No____

If yes, have you been tested as a carrier of Thalassemia? Yes____ No____

If yes, result: _____

What level of schooling did your mother reach? _____

What is her current occupation? _____

What level of schooling did your father reach? _____

What is his current occupation? _____

Are you adopted? Yes_____ No_____ If yes, do you know any of your biological parents medical history? _____

EGG DONOR PROFILE FORM

Date _____

Initials _____

Physical characteristics of the family

Please describe your family members by the following characteristics:

	Age	Eye color	Hair color	Complexion	Height	Body type	Ethnic Origin
Mother							
Father							
Brothers 1.							
2. 3.							
Sisters 1. 2. 3.							
MGF PGF							
MGM PGM							

Mother's health _____ Age of death _____
Father's health _____ Age of death _____

MGM's health _____ Age of death _____
MGF's health _____ Age of death _____

PGM's health _____ Age of death _____
PGF's health _____ Age of death _____

Brothers health _____ Age of death _____
Sisters health _____ Age of death _____

Comments: _____

Donor General Health

Please mark if you are now or have recently experienced any of the following:

Problem	Yes	No
Problems with vision		
Double vision		
Blurred vision		
Loss of vision		
Problems with hearing		
Ringing in ears		

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Earache		
Loss of balance		
Problems with your sense of smell		
Frequent sinus pain, congestion or drainage		
Frequent or severe headaches		
Difficulty swallowing		
Sores in your mouth or gums		
Pain in any of your teeth		
Lumps or bumps in your neck		
Chest pain		
Any pain with exertion		
Shortness of breath		
Difficulty sleeping at night		
A need to be propped up on pillows when sleeping		
Waking up in the middle of the night with shortness of breath		
Fevers or chills		
Waking up at night soaked in sweat		
Hot flashes		
Rapid heart beat		
Breast pain		
Persistent lump in your breast		
Discharge of any kind from your breast		
Heartburn		
Stomach pain		
Pelvic pain		
Bloating		
Back pain		
Joint pain		
Swelling of your feet		
Painful or enlarged veins in your legs		
Nervousness		
Irritability		
Persistent unexplained fatigue		
Constipation or diarrhea		
Urinating more frequently than every 2 hours		
Waking up in middle of night to urinate		

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A MESSAGE TO EGG DONORS

Congratulations on making such a generous decision. Being an egg donor may help a couple fulfill the wonderful dream of having a child. At the same time, your very kina decision brings with it a great deal of responsibility. You may possibly influence generations to come with your genetic history. It is crucial you are only honest concerning all aspects of yourself and your family history. It is understood that there is no perfect person and no perfect family history. It is extremely rare a person and/ or her family does not exhibit some sort of problem, be alcoholism, drug abuse, learning problems, depression, anxiety, or other mental health problems. It is best to be open on the interview form and in the interview. The information you provide Hill help the potential parents be prepared for any special needs their child might have.

Thanks again for your generosity and thoughtfulness, as they are very much appreciated.

By signing below, I, _____, certify I have read and understand the above information.

_____

Print name

_____

Signature