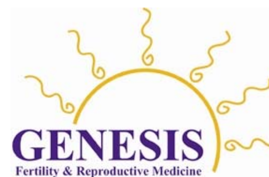
OOCYTE DONOR SCREENING FORM



For Office Use Only
Donor No.

Date: _____/_____/_____

Age: _______ Date of Birth: ________ Marital Status: ________

Race: ______________________ Ethnic Background: ________________ Religion: ________

Physical Characteristics:

Height: ______ Weight: ______ Body Type/Bone Structure: ( ) Small ( ) Medium ( ) Large

Eye Color: ______ Do you wear glasses or contacts? ( ) Yes ( ) No Age they were prescribed

Natural Hair Color: ______________________ Hair Type: ________________________

Skin Complexion: ( ) Fair ( ) Light ( ) Olive ( ) Dark Brown ( ) Light Brown ( ) Medium ( ) Ebony ( ) Rose ( ) Freckled

Have you ever had acne? ________ At what age: _______ Severity? ____________________

Are you: ( ) Right Handed ( ) Left Handed ( ) Ambidextrous

Is your hearing normal? ______________ If not, please describe any problems: __________
____

Do you have any dental abnormalities? Please describe: ______________________________
____

Orthodontia (Braces)? ____

	Mother	Father
Ethnic Origin		
Place of Birth		
Religion Born Into		
Religion Practiced		

Describe Your Family's Physical Characteristics

	Eye Color	Hair Color	Skin Complexion	Height	Weight	Body Type	Education Level	Occupation
Father								
Mother								
Brother 1								
2								
3								
4								
Sister 1								
2								
3								
4								
Children1								
2								
3								
4								

Education:

Completed grade school ( ) Yes ( ) No Completed High School ( ) Yes ( ) No

Currently in college, pursuing a degree in:

____

Number of Credits: ___________ Completed Undergrad college ( ) AAS ( ) BA ( ) BS

Degree in: _________________________ Currently pursuing an advance degree: ( ) Yes ( ) No

Completed an advanced degree in: ____

Please list all educational awards or acknowledgements received: _________________________________

Please any volunteer activities or community service: ____

Current Occupation: ____

Athletic Activity: ( ) Athletic ( ) Active ( ) Average ( ) Inactive

What physical activities do you engage in? Have you excelled in any physical activities? _______________

Manual Dexterity: ( ) Dexterous ( ) Average ( ) Clumsy

What manual skills do you have? Please describe: ____

Musical Ability ( ) Musical ( ) Average ( ) Tone Deaf

Please describe: ____

____

Do you play any musical instruments? Please describe:

____

What other skills, talents, or hobbies do you have? Please describe: _________________________________

____

REPRODUCTIVE HISTORY

Age of first period ________ ( ) Regular ( ) Irregular Interval between periods: _____ days

How many days does the bleeding occur? _________ Date of last pap smear? ________________________

Results of last pap smear ( ) normal ( ) abnormal Treatment: _______________________________________

PREGNANCY HISTORY		
Year/Age	Outcome	Complications

Please answer the following questions	Yes	No
Did your mother take DES while she was pregnant with you?		
Have you ever been told you are infertile?		
Is there a history of infertility in your family?		
Have you ever used intravenous drugs or had a sexual partner who did so?		
Have you ever used an injectable drug or had a sexual partner who did so? When?		
Are you currently taking injectable medication or do you have a sexual partner who does so?		
Have you engage in prostitution at any time since 1977?		
Have you been involved sexually with anyone during the past six months who has engaged in prostitution at any time after 1977?		
Have you been sexually active during the past six months?		
Are you currently sexually active?		
Are you currently in a monogamous relationship? How many sexual partners have you had in the past six months ______		
How many sexual partners have you had in the past six months?		
Are you currently or have you taken birth control? If yes what brand ____________ when______		
Do you use other forms of birth control and, if yes, what type(s)____________________		
Have you had more than 10 sexual partners?		
Have you ever had a sexual partner who was gay or bisexual?		
Have you ever had sexual relations with anyone suspected or known to be HIV positive?		
Have you ever had relations with a man who has engaged in anal intercourse or oral sex with another man?		
Have you ever had a blood transfusion?		
Have you ever been refused as a blood donor? If yes, why?		
Have you ever been incarcerated?		
Have you ever received factor VII or factor IX concentrates (blood transfusion) that was not heat-treated or otherwise vial inactivated? Within the past year?		
Have you ever had any tattoos or body piercing within the last twelve months?		
Have you been exposed to radiation or toxic chemicals in your work or personal life (i.e., lead, mercury, and gold)?		

Have you had any of the following?			
Unexplained weight loss	( ) yes ( ) no	Kaposi Sarcoma	( ) yes ( ) no
Fever of unknown origin	( ) yes ( ) no	Pneumocystic Pneumonia	( ) yes ( ) no

Have you ever had sexual relations with anyone with the above symptoms/diseases? Please specify:______________________________

____

____

Have you donated oocytes before ( ) yes ( ) no; If yes, how many times?_______________

Where was your donation(s)? ______________________________

When was your last donation?______________________________

Do you know how many eggs where retrieved ( ) yes ( ) no; If yes how many?

____

Do you know the outcome of your donation? ______________________________

Medical History

Do you have any medical illnesses (i.e., asthma, diabetes, seizure disorders, tuberculosis, etc)?

____

____

____

List all surgeries you have had and when: ______________________________

____

List current allergies (food, pollen, bee stings, medications, etc.) ____________________

____

Describe any childhood allergies you have outgrown: _________________________

____

List any allergies to medicine: ______________________________

____

List all drugs, including physician prescribed and non-prescription (please include vitamins and herbs) that

you are currently taking: ____
Any other medications taken in the last five years? ____

Do you smoke cigarettes? ( ) yes ( ) no; If yes, how many per day? _____ per week? _________
Do you drink alcoholic beverages ( ) yes ( ) no, if yes what type of drinks __________________
___________________, how many per day? _________ per week ________ per month _______
Have you ever used any kind of mind-altering drugs such as marijuana, LSD, heroin, or cocaine? If yes, please give details and state date last used: ____
Have you ever been treated for depression? If yes, please describe: ______________________________

Have you ever attempted suicide? ____

	Age	Age at Death	Medical problems or cause of death
Mother			
Father			
Brother 1			
2			
3			
4			
Sister 1			
2			
3			
4			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Your children 1			
2			
3			
4			

Please read the following list of medical problems carefully and indicate which ones you or a relative has had. Please consider each condition carefully for each family member by noting the age at which the condition appeared:

Medical Problem	**You**	**Mother**	**Father**	**Siblings**	**Grand-parents**	**Other family**	**Describe**
Heart							
Stroke							
Heart attack							
Heart Disease							
Hardening of Arteries							
High Blood Pressure							
Mitral Valve Prolapse							
BLOOD							
Anemia							
Sickle-cell anemia							
Hemophilia or other bleeding problem							
Leukemia							
Immune deficiency/disease							
HIV/AIDS							
Other blood disorder							
Prolonged fever							
RESPIRATORY							
Hay fever							
Asthma							
Emphysema							
Tuberculosis							
Lung cancer							
Pneumonia							
Other lung disease							
Gastrointestinal							
Ulcer of stomach/duodenum							
Gall stones							
Hepatitis A (infectious)							
Hepatitis B (serum)							
Hepatitis C							
Other liver disease							
Colon cancer							
Ulcerative colitis							
Crohn's disease							
Cystic fibrosis							
Intestinal cancer							
Any other cancer or problem of digestive system							
METABOLIC OR ENDOCRINE							
Diabetes Mellitus							
Hypoglycemia							
Thyroid Cancer							
Thyroid disease							
Goiter							
Adrenal dysfunction or							

disorder							
Hyperactivity							
Urinary disease							
Kidney disease							
Other disease of urinary tract (urethra, bladder, ureter)							
GENITAL REPRODUCTIVE SYSTEM							
Undescended testicle							
Hypospadias							
Prostate cancer							
Uterine fibroids							
Ovarian cysts							
Cancer of cervix, ovaries or uterus							
Gonorrhea							
Syphilis							
Chlamydia							
Mycoplasma							
Trichomonas							
Pelvic inflammatory disease							
Hemophilus							
Herpes							
Genital warts							
Urogenital tuberculosis							
NEUROLOGICAL							
Migraines							
Mental retardation							
Senility before age 50							
Multiple scierosis							
Cerebral palsy							
Epilepsy							
Hydrocephalus							
Disorfer of the spinal cord							
Huntington’s disease							
Gaucher’s disease							
Wilson’s disease							
Other diseases of the nervous system							
Degenerative neurologic disease							
MENTAL HEALTH							
Mania							
Depression							
Schizophrenia							
Bi-polar disorder							
Anxiety disorder							
Panic attacks							
MUSCULAR/BONES/JOINTS							
Muscular dystrophy							
Other chronic muscle disease							
Lupus							
Deformity of the spine							

Osteoporosis							
Dwarfism							
Hereditary low back disease							
Arthritis							
Gout							
Human growth hormone administration							
SIGHT/SOUND/SMELL							
Deafness before age 60							
Deformity of the ear							
Cataracts before age 50							
Blindness							
Color blindness							
Glaucoma							
Deviated septum							
Any sight/sound/smell disorder							
SKIN							
Acne							
Eczema							
Skin cancer							
Pigmentation disorders							
Other disorders of the skin							
OTHER							
Alcoholism							
Drug abuse, misuse or addiction							
Breast cancer							
Eating disorders							
Malignant disease							
Any other condition not mentioned above							
Learning Disorders (Please specify)							
Attempted Suicide							

Has any member of your family, including yourself, had a birth defect or problem at birth in any of the following body systems? If yes, please list the specific defect below.

- Bones, muscles, joints, limbs
- Gastrointestinal system
- Nervous system, brain, spinal cord
- Blood or circulatory system
- Respiratory system
- Organ (heart, lung, kidney, etc)
- Genital/Urinary tract
- Metabolic (hormones, enzymes, etc)

____

____

____

Birth Defect	Who	When did this happen?	Relevant Circumstances

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

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

Has anyone in your family, including you, 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. Please explain ____

____

What is your motivation to becoming an Oocyte Donor? ____

____

____

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____

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____

Personal Information

Name: ____

Address: ____

City: ____________________________ **State:** __________ **Zip Code:** ____________

Phone; (Home)____________________ **Work:** ______________________________

Cell Phone: __________________________

Date of Birth: __________________ **Do you have medical insurance ( ) Yes ( ) No**

Insurance Company Name: ____

Are you a US Citizen ( ) Yes ( ) No Country of Birth: ____________________________

Social Security of Tax ID Number: ____

Are you a resident Alien with a Green Card? ( ) Yes ( ) No If yes please provide you alien #

Are you a non-resident alien? ( ) Yes ( ) No, If yes what type of visa? _________________

Visa Number ____________________________ **Expiration Date** __________________

Work Permit # if applicable ____

- **To process your application you must send a copy a valid state id, social security/tax ID**
- **For non US citizens you must send a copy of resident alien card or valid visa**
- **A current photograph**

How did you learn about our program?: ______________________________________

I, ___________________________________ **have read the Oocyte Donation information. I hereby acknowledge that all information provided on this Oocyte Donation Personal History Form has been answered truthfully and to the best of my knowledge.**

Date:__________________________ **Signature:** ______________________________

Office use only:

Date Received: _________________________ **By:** __________________________________

Thank you very much for your time and for your interest in being an egg donor. If you have any questions, please call Jill Jabbour at 718-283-6588. or mail information to Genesis Fertility 1355 84th street Brooklyn, NY 11228 Attention Jill Jabbour