

WEST VALLEY FERTILITY CENTER

**EGG DONOR
INITIAL SCREENING QUESTIONNAIRE**

Name: _____ Date of Birth: _____ Age: _____

Address: _____ State: _____

City: _____ Zip code: _____

Home Phone: () _____ Work: () _____ Cell () _____

Height: _____ Weight: _____ Eye Color: _____ Natural hair color: _____

Skin Complexion: _____ Light _____ Medium _____ Dark _____

Do you have freckles?

No _____ Few _____ Moderate _____ Many _____

Body Type: _____ Small _____ Medium _____ Large _____

Do you smoke or use tobacco? _____ If so, for how long? _____ How many per day? _____

Mother's ethnic origin (please be specific, do not use Caucasian): _____

Father's ethnic origin: _____

Do you have any current or prior medical problems, surgeries, etc? _____

Do you have any recent tattoos or piercings? If so, when was the latest? _____

Do you have any allergies (food, animals, hay fever, drugs, etc.):

Your occupation: _____

Years of education (high school=12) _____ High School GPA: _____

College degrees and/or major: _____ College GPA: _____

Do you have children? Yes _____ No _____ How many? _____ Ages? _____

Reason for wanting to become a donor: _____

Have you ever been an egg donor before? _____

How did you hear about our donor program? _____

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PERSONAL MEDICAL HISTORY

Please list medications you take regularly, including any birth control you are using:

Name of Medication	Reason
1. _____	_____
2. _____	_____
3. _____	_____

Have you ever used or do you currently use any of the following:

Marijuana	Ever Used ___	Currently ___	Never Used ___
Barbiturates	Ever Used ___	Currently ___	Never Used ___
Amphetamines	Ever Used ___	Currently ___	Never Used ___
Hallucinogens	Ever Used ___	Currently ___	Never Used ___
Tranquilizers	Ever Used ___	Currently ___	Never Used ___
Anti-depressants	Ever Used ___	Currently ___	Never Used ___
PCP	Ever Used ___	Currently ___	Never Used ___
Inhalants (exclude Asthma medications)	Ever Used ___	Currently ___	Never Used ___

When was the last time you used any of the above? _____

Have you ever used IV drugs (not prescribed a physician)? ___ Yes ___ No

Please enclose a current full length and up close picture

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FAMILY MEDICAL HISTORY

Please indicate if you or a family member (siblings, parents, grandparents, cousins, aunts and uncles) have a history of the following and please state the relation to you. All information is kept confidential.

History of:	Yes/No	Relationship to You
Blindness/Deafness		
Mental Retardation		
Severe learning Disabilities		
Autism		
Attention Deficit Disorder (ADD)		
Miscarriages-(How many)		
Stillbirth		
Infant Death (0-1 year)		
Childhood Death		
Birth Defects:		
Cleft lip/palate		
Spina Bifida		
Heart Defects		
Other: _____		
Chromosome Abnormality		
Down Syndrome		
Other: _____		
Muscular Dystrophy		
Cystic Fibrosis		
Sickle Cell Anemia		
Tay Sachs		
Diabetes (prior to age 40)		
Cancer (prior to age 40)		
Hypertension (prior to age 40)		
Kidney Disease/Failure/Transplant		
Epilepsy/Seizures		
Dementia/Alzheimer's		
Blood Disorders/Anemia		
Thalassemia		
Obesity		
Alcoholism (formally diagnosed)		
Mental Illness		
Bipolar		
Schizophrenia		
Psychosis		
Unusual Behavior Problems		
Uncontrolled Movements		
Parkinson's Disease		
Substance Abuse		