

WVFC EGG DONOR QUESTIONNAIRE

Name (First & Last): _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

PHYSICAL CHARACTERISTICS

Date of Birth: _____ Present Age: _____ Height: _____ Weight: _____

Blood Type _____ Eye Color: _____ Natural Hair Color: _____

Is your hair (check all that apply):
 Fine/thin _____ Straight _____ Average _____
 Wavy _____ Thick _____ Curly _____

Body Frame: Small _____ Medium _____ Large _____ Very Large _____

Skin Complexion:
 _____ Very fair (little or no ability to tan with sun exposure)
 _____ Fair (skin will tan lightly with sun exposure)
 _____ Medium (light color but will tan moderate to dark with sun exposure)
 _____ Olive (pigmentation of unexposed skin) Slight _____ Moderate _____ Dark _____
 _____ Dark (unexposed skin) Light tan _____ Dark tan _____ Black _____
 _____ Freckles None _____ Few _____ Numerous _____

Are you predominately: Right Handed _____ Left handed _____ Ambidextrous _____

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

ETHNIC ORIGIN / ANCESTRY

Racial group: Caucasian _____ Black _____ Hispanic _____ Asian _____ Other _____

Ethnic Origin/Ancstry: Mother: _____ Father: _____

Religion born into: Donor: _____ Mother: _____ Father: _____

Do you have any ancestors who are/were?

| | | | | | |
|----------------------------------|-------|---|-------|---|---------|
| Jewish: | _____ | Y | _____ | N | Unknown |
| African | _____ | Y | _____ | N | Unknown |
| Mediterranean (Greek or Italian) | _____ | Y | _____ | N | Unknown |
| Asian | _____ | Y | _____ | N | Unknown |

If so have you been tested as a carrier for: Sickle Cell _____ Tay Sachs _____ Thalassemia _____
 Cystic Fibrosis _____ Gaucher's Disease _____

EDUCATIONAL BACKGROUND

(Circle highest level attained)

High School High School GPA _____ (based on __ 3 or __ 4 scale)

Currently attending trade school for _____ GPA _____

Trade School GPA _____ Area of study: _____

College / University 1 2 3 4 GPA _____ BA ___ BS ___

Major Area of Study _____

SAT Scores: Verbal _____ Math _____ Total: _____

Academic or Professional Societies to which you belong: _____

Any honors programs or specialty training in which you participated: _____

Level of schooling of Mother: _____

Level of Schooling of Father: _____

OCCUPATIONAL/WORK HISTORY

What is your present occupation: _____

Mother's Occupation: _____

Father's Occupation: _____

In the past year have you been exposed to any of the following either through work or in association with

hobbies: ___ Radiation ___ Toxic Chemicals ___ Sprays/Pesticides

___ Lead or lead products ___ Cleaning solutions/solvents

Please include dates and frequency of exposure _____

What are your long term career or personal goals? _____

GENERAL HEALTH HISTORY

What is your general health condition? _____

Do you have allergies? Y N If yes, to: Food Medications Environment Other _____

Please list substance you are allergic to and the type of reaction you have: _____

Have you ever had any surgeries or been hospitalized for any reason? _____

Do you smoke cigarettes? Y N Packs per day: _____ Length of time smoking? _____

Do you drink alcoholic beverages? Y N Type: Beer Wine Liquor

How often (No. of times per day, week)? per day _____ per week _____

Would you be willing to abstain from smoking and/or drinking alcohol during the donation cycle? Y N

Do you drink coffee/caffeinated sodas? Y N How many cups per day _____.

Do you exercise? Y N Type and frequency _____

Do you have normal vision? Y N If no, are you: Nearsighted Farsighted Other

Do you have normal hearing? Y N If no, please specify condition _____

Your diet is: Vegetarian Non-vegetarian

Medications you take regularly, please include any over the counter medicines:

_____ Reason: _____

_____ Reason: _____

_____ Reason: _____

Have you ever used or do you currently use:

- | | | | | | | | | | |
|---------------|--------------------------|---|--------------------------|---|------------------|--------------------------|---|--------------------------|-----------------------|
| Marijuana | <input type="checkbox"/> | Y | <input type="checkbox"/> | N | Tranquilizers | <input type="checkbox"/> | Y | <input type="checkbox"/> | N |
| Barbiturates | <input type="checkbox"/> | Y | <input type="checkbox"/> | N | Anti-depressants | <input type="checkbox"/> | Y | <input type="checkbox"/> | N |
| Amphetamines | <input type="checkbox"/> | Y | <input type="checkbox"/> | N | PCP | <input type="checkbox"/> | Y | <input type="checkbox"/> | N |
| Hallucinogens | <input type="checkbox"/> | Y | <input type="checkbox"/> | N | Inhalants | <input type="checkbox"/> | Y | <input type="checkbox"/> | N (excl. asthma meds) |

Would you explain the circumstances of any drug use listed above: _____

Have you ever used IV drugs (not prescribed by a physician)?: Y N

PERSONAL MEDICAL HISTORY

Have you ever had any of the following:

- | | | |
|---------|---------|---|
| Y _____ | N _____ | High blood pressure |
| Y _____ | N _____ | Heart disease/rheumatic fever |
| Y _____ | N _____ | Hyperlipidemia |
| Y _____ | N _____ | Stroke |
| Y _____ | N _____ | Phlebitis/clots in the vein |
| Y _____ | N _____ | Varicose veins |
| Y _____ | N _____ | Blood problems/anemia, (Sickle cell, Thalassemia, Hemophilia) |
| Y _____ | N _____ | Frequent headaches |
| Y _____ | N _____ | Diagnosed migraines |
| Y _____ | N _____ | Epilepsy/convulsions |
| Y _____ | N _____ | Liver disease/Hepatitis |
| Y _____ | N _____ | Diabetes |
| Y _____ | N _____ | Gall bladder disease |
| Y _____ | N _____ | Thyroid disease |
| Y _____ | N _____ | Cancer |
| Y _____ | N _____ | Lung problems/Bronchitis, Tuberculosis |
| Y _____ | N _____ | Asthma |
| Y _____ | N _____ | Breast lumps/discharge |
| Y _____ | N _____ | Kidney/Bladder Problems |
| Y _____ | N _____ | German measles/Rubella vaccine |
| Y _____ | N _____ | Blood transfusion |

Were you adopted? ___Y ___ N

Are you a twin? ___Y ___N

Age when periods began: _____

Date of last menstrual period: _____

When not using birth control, like the pill or patch, your periods come every _____ days.

Last Pap smear: _____

Results: _____

Date of last physical: _____

Date & result of last mammogram: _____

Check if you have ever had: Herpes _____ Gonorrhea _____ Syphilis _____ Chlamydia _____
 Non-Specific Urethritis (NSU) _____ Venereal warts _____ Other _____

Have you ever donated eggs before? ___Y ___N If yes, when? _____

Where? _____ How many times have you donated? _____

How many births resulted from your donations? _____

Why do you want to become an egg donor? _____

Is there any history of infertility (trouble conceiving) in your family? ___Y ___ N

If yes, please explain _____

Have you ever been pregnant? ___Y ___N

Please list your pregnancy information below:

| Year | Miscarriage | Abortion | Length of Pregnancy | Type of Delivery | Birth Weight | Complications |
|------|-------------|----------|---------------------|------------------|--------------|---------------|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

Please provide the following information on your child (ren) (if any):

| Age | Sex | Health Problems |
|-----|-----|-----------------|
| | | |
| | | |
| | | |

PERSONAL CHARACTERISTICS

What classes did you excel at in school? _____

What was your favorite extra curricular activity in school? _____

Do you speak any other languages? ___ Y ___N Please list: _____

What is your favorite sport? _____

What is your favorite type of music? _____

Do you have any musical skills? _____

Any special hobbies or talents? _____

Any artistic abilities? _____

Do you enjoy animals/pets? ___ Y ___ N; Which is your favorite? _____

How would you describe your personality? _____

Are you (Select the number closest to your characteristic):

| | | | | | |
|------------|---|---|---|---|-------------|
| Optimistic | 1 | 2 | 3 | 4 | Pessimistic |
| Assertive | 1 | 2 | 3 | 4 | Passive |
| Leader | 1 | 2 | 3 | 4 | Follower |
| Easy going | 1 | 2 | 3 | 4 | Controlling |

FAMILY CHARACTERISTICS

| Relation | Age | Height | Eye Color | Hair Color | Complexion |
|------------------|-----|--------|-----------|------------|------------|
| Mother | | | | | |
| Father | | | | | |
| Mat. Grandmother | | | | | |
| Mat. Grandfather | | | | | |
| Pat. Grandmother | | | | | |
| Pat. Grandfather | | | | | |
| Sibling #1 | | | | | |
| Sibling #2 | | | | | |
| Sibling #3 | | | | | |
| Sibling #4 | | | | | |

FAMILY HISTORY

Please list the cause of death and age of death of the following family members:

| Relation | Age at Death | Cause of Death |
|----------------------|--------------|----------------|
| Mother | | |
| Father | | |
| Maternal Grandmother | | |
| Maternal Grandfather | | |
| Paternal Grandmother | | |
| Paternal Grandfather | | |
| Sibling | | |
| Sibling | | |

Do you know of any genetic diseases or conditions that run in your family? Y N

If so, please explain: _____

GENERAL QUESTIONS

What reassurances can we give the prospective parents that you will not try to gain custody of any child or children that result from your donation?

If you could pass a message to the recipients of your eggs, what would that message be?

Would you like to meet the prospective parents? Y N

What kind of support do you expect for being an Egg Donor from the following people in your life:

Parents?

Husband/boyfriend?

Friends/co-workers

Have you ever been in bankruptcy? Y N

Have you been arrested (including drunk driving arrests)? Y N

Have you ever placed a child for adoption? Y N

Have you ever consulted a psychologist, psychiatrist, or social worker? Y N

Aside from minor illnesses, have you lost time from work or school in the past for any reason? Y N

If married, have you filed for divorce, dissolution, legal separation or annulment of this marriage? Y N

Are you past due on any court ordered installments of child support? Y N

Do you have any legal cases or claims pending at the present time? Y N

Have you been in a substance abuse program? Y N

Do you have a car or other reliable method of transportation to get to the appointments? Y N

If you have children, do you have childcare? Y N

Will you be able to adjust your work schedule to accommodate your appointments if accepted as an egg donor? Y N

AUTHORIZATION AND RELEASE

I authorize investigations of all statements contained in this application. I understand that misrepresentations or omission of facts called for is cause for rejection as an Egg Donor. Further, I understand that signing this form is not an acceptance, but a preliminary information form.

Donor Code _____

I further authorize release of the information (medical and other information) contained in this application to West Valley Fertility Center, its agents, and employees, including physicians, psychotherapists, and prospective parents.

Date: _____

Applicant _____

Husband (if any) _____