

Arkansas Fertility and Gynecology Associates

Egg Donor Screening Form

Name: _____ Date: _____

DOB: _____ Age Today: _____

Address: _____

City/State/Zip: _____

Phone Numbers-

Home: _____ Cell: _____ Work: _____

E-mail address: _____

Occupation: _____

Highest Level of education completed: _____

College major/minor: _____ GPA: _____

Social Security Number: ____ - ____ - ____

Drivers License Number: ____ - ____ - ____ State: _____

Do you have private health insurance? _____

If yes, name the policy: _____

Height: _____ ft _____ inches

Weight: _____ pounds

Hair color: _____

Hair type: straight, curly, wavy, coarse

Eye color: _____

Complexion: fair, olive, dark, light

Freckles: none, few, numerous

Build: small, medium, large, obese

Race: Caucasian, African American, Hispanic, Chinese, Japanese, American Indian,

Other Race: _____

Which BEST describes your MOTHER's ethnic background:

British, Irish, Chinese, Japanese, Jewish, German, Spanish, Mexican,

Mediterranean (i.e. Greek, Italian), African, Pacific Islander,

Other: _____

Which BEST describes your FATHER's ethnic background:

British, Irish, Chinese, Japanese, Jewish, German, Spanish, Mexican,

Mediterranean (i.e. Greek, Italian), African, Pacific Islander,

Other: _____

Marital Status: Single, Married, Divorced, Widowed, In a relationship

Husband/Partner's name: _____

Husband/Partner's occupation: _____ Age: _____

How long have you been with your current partner/husband? _____

Religious Preference: _____

Musical Skills: _____

Athletic Skills: _____

Artistic Skills/ Hobbies: _____

Name	MRN		DOB	
FDA Screening Question	Y	N	Don't Know	Comments
1. Have you ever had a sexually transmitted disease? If yes, please list all that apply: syphilis, gonorrhea, herpes, Chlamydia, genital warts				
2. In the past 5 years, have you or your male partner ever had sexual relations with a male homosexual, male bisexual, or IV drug user?				
3. Has your current male partner ever been in prison?				
4. In the past 12 months, have you been in jail for more than 3 days in a row?				
5. In the past 5 years, have you received or given money or drugs in exchange for any sexual act?				
6. Have you had sex in the past 12 months with anyone who would answer yes to question 4?				
7. In the past 12 months, have you had sex with a person known or suspected to have HIV, or active hepatitis B or C?				
8. In the past 12 months, have you been in close contact (i.e. sharing kitchen or bathroom) with a person having active viral hepatitis?				
9. Have you had sexual contact with anyone who was born in or lived in any African country since 1977?				
10. Were you born in, have you lived in, or have you traveled to any African country since 1977?				
11. After age 11, have you ever had viral hepatitis: Hep B or Hep C?				
12. Have you ever been told you cannot donate blood?				
13. Have you or your current partner received a blood transfusion? If yes, year of transfusion:				
14. When traveling abroad, did you receive a blood transfusion or any other medical treatment with a product made from blood?				

FDA Screening Questions	Y	N	Don't Know	Comments
15. Have you received growth hormone made from human pituitary glands?				
16. Have you received or had intimate contact (exchange of bodily fluids, sharing toothbrush or razors) with someone who has received organs or cells from non-human sources?				
17. Do you have a clotting disorder for which you have received human-derived clotting factor concentration?				
18. Have you injected drugs for a non-medical reason in the last 5 years, including intravenous, intramuscular, or subcutaneous injections?				
19. Have you ever used marijuana?				
20. Are you currently using marijuana?				
21. Have you ever used cocaine?				
22. Are you currently using cocaine?				
23. Have you ever used methamphetamines?				
24. Are you currently using methamphetamines?				
25. Have you ever used LSD?				
26. Are you currently using LSD?				
27. Have you ever used any illicit drugs not listed above? List drug:				
28. During work, are you exposed to toxic or radioactive substances?				
29. Have you ever had a needle stick injury?				
30. Have you ever been tested for the AIDS virus (HIV testing)? If yes, list result and year of test:				
31. Have you recently received any vaccinations? If yes, please list: Have you received a small pox vaccination? If yes, please list date of injection:				
32. In the past 2 weeks have you had any of the following symptoms:				
Fever >101 degrees				
Flu-like symptoms				
Swollen glands				
Fatigue				
33. Have you or your partner been diagnosed with West Nile Virus?				

FDA Screening Questions	Y	N	Don't Know	Comments
34. Have you had a headache and fever within the last 7 days?				
35. Have you received a dura mater (brain covering) graft?				
36. Have you or your partner ever had Creutzfeldt-Jakob disease (CJD)?				
37. From 1980 through 1996, were you a member of the US military, a civilian military employee or a dependent of a member of the US military?				
38. In the past three years have you been outside the US or Canada?				
39. Since 1980, have you ever lived in or traveled to Europe? Includes: England, Ireland, Scotland, Wales, the Isle of Man, the Channel Islands, Gibraltar, or the Falkland Islands				
40. Have you spent a total of 6 months or more associated with a military base in any of the following countries: Belgium, the Netherlands, Germany, Spain, Portugal, Turkey, Italy, or Greece?				
41. Have you traveled to a country affected by SARS (severe acute respiratory syndrome) or been with an affected individual in the last 14 days?				
42. Have you been treated for SARS in the last 28 days?				
43. Within the past year, have you undergone acupuncture, body piercing, or received a tattoo?				
The following relate to your past medical history. Have you ever had, or been treated for, any of the following conditions:				
Condition	Yes	No	Don't Know	Comment
Drug Allergies				
Seasonal Allergies				
Birth Defects				
Epilepsy (seizure, convulsions)				
High blood Pressure				
Diabetes (high blood sugar)				
Kidney problems				
Asthma				
Arthritis or joint pain				

Condition	Yes	No	Don't Know	Comment
Vision problems				
Skin problems or rashes				
Received human organ or tissue transplant				
Hearing problems				
Bleeding Disorders				
Cancer				
Migraine Headaches				
Psychiatric Problems :				
Depression				
Anxiety				
Schizophrenia				
Mania/ Bipolar disorder				
Gastrointestinal disorder				
Thyroid Disease				
Anemia or low blood count				
High cholesterol				
Clubfeet				
Congenital hip dislocation				
Congenital heart disease				
Neurofibromatosis				
Sickle cell disease				
Thalassemia				
Tuberous sclerosis				
Alcohol abuse				
Chromosomal abnormality				
Hydrocephalus (water on the brain)				
The following questions are related to your Family History : grandparents, parents, siblings, aunts/uncles, first cousins				
Condition	Yes	No	Don't Know	Comment Relation
Childhood blindness				
Color blindness				
Childhood deafness				
Albinism				
Hemachromatosis				
Breast Cancer				
Ovarian Cancer				
Hemophilia/Bleeding disorder				
Neurofibromatosis				
Mental retardation				
Adrenoleukodysrophy				
Down syndrome (mongoloid, trisomy 21)				
Cystic Fibrosis				

Condition	Yes	No	Don't Know	Comment Relation
Muscular dystrophy				
Huntington's disease				
Hydrocephalus (water on the brain)				
Galactosemia				
Phenylketonuria (PKU)				
Dwarfism				
Polycystic Kidney disease				
Alcoholism				
Alzheimer's disease				
Premature heart attack (before age 50)				
Thyroid Disease				
Diabetes				
Unexplained infant or childhood death				
Early death (before age 35)				
Psychiatric problems (depression, mania, Schizophrenia, anxiety)				
Suicide				
Multiple Sclerosis				
Cleft lip Cleft palate				
Tay-Sachs disease				
Sickle Cell disease				
Thalassemia				
Neural tube defect (open spinal column, Spina bifida)				
Congenital heart problems				
Marfan's syndrome				
Multiple colon polyps, or colon cancer				
Cancer				
Congenital hip dislocation				
Clubfoot				
Hypospadias				
Retinitis pigmentosa				
Retinoblastoma				
Alport disease				
High cholesterol requiring treatment				
Fragile X syndrome				
Creutzfeld-Jakob disease (CJD)				

The following is related to your gynecology and obstetrical history:				
Question	Yes	No	Don't Know	Comment
1. How old were you when you started your first menstrual period?	→	→	→	Age:
2. How many days from the start on period until the start of the next period?	→	→	→	Days:
3. How long do your period last?	→	→	→	Days:
4. Do you have pain with your periods?				
5. Do you have bleeding between periods?				
6. Have you ever missed a period?				
7. Do you have bleeding after intercourse?				
8. Do you have pain with intercourse?				
9. Have you had an abnormal pap smear?				
10. Have you ever had a colposcopy, LEETZ, or Cone procedure?				
11. Have you ever had the diagnosis of Pelvic inflammatory disease (PID)?				
12. Have you ever had discharge from your breasts other than during pregnancy or breast feeding?				
13. Do you have problems with excessive hair growth (hirsutism)?				
14. Have you ever had endometriosis?				
15. Are you currently sexually active? Please list the number of partner's you have had in the last 2 years (male and female):				
16. Have you completed your child bearing?				
17. Have you ever been treated for infertility?				
18. Have you ever had a mammogram?				

What are you currently using for contraception? _____

Will you be able to discontinue your form of contraception during the stimulation cycle, estimated time frame of 6 to 8 weeks? _____

Please list all of your pregnancies, including live births, stillbirths, miscarriages, elective abortions, and tubal (ectopic) pregnancies:

<u>Date of Outcome</u>	<u>Duration of Pregnancy</u>	<u>Outcome</u>	<u>Complications</u>
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What led you to seek egg donation?

Do you have a support person to assist you with the donation process, i.e. provide your transportation after the egg retrieval? _____

Have you donated eggs previously? _____

Do you have knowledge of the following details related to the egg donation process:

- Self-injection of medication
- Frequent blood testing, requiring blood draw
- Frequent vaginal ultrasound
- Early morning availability
- Use of alternate form of contraception in the cycle (i.e. condoms)
- Committed time frame once in cycle
- Psychological evaluation requirement of screening process

I hereby attest that the information I have provided is true to the best of my knowledge.

Donor Signature

Date

Donor Oocyte Program
Family History of Donor

Brothers and Sisters

	<u>Sex</u>	<u>Age</u>	<u>Health Problems</u>	<u>Height</u>	<u>Living</u>	<u>Full/Half</u>
1.	_____	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____	_____
6.	_____	_____	_____	_____	_____	_____

Donor's Mother

Name _____ Birthdate ___/___/___ Education _____
Alive _____ Dead _____ Age at Death _____ Cause of Death _____
Height _____ Health Problems _____

Mother's Brothers and Sisters

	<u>Sex</u>	<u>Age</u>	<u>Health Problems</u>	<u>Height</u>	<u>Living</u>	<u>Full/Half</u>
1.	_____	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____	_____
6.	_____	_____	_____	_____	_____	_____

Maternal Grandmother

Name _____ Date of Birth ___/___/___
Alive _____ Dead _____ Age at death _____ Cause of Death _____
Height _____ Health Problems _____

Maternal Grandfather

Name _____ Date of Birth ___/___/___
Alive _____ Dead _____ Age at death _____ Cause of Death _____
Height _____ Health Problems _____

Donor's Father

Name _____ Date of Birth ___/___/___
Alive _____ Dead _____ Age at death _____ Cause of Death _____
Height _____ Health Problems _____

Father's Brothers and Sisters

	<u>Sex</u>	<u>Age</u>	<u>Health Problems</u>	<u>Height</u>	<u>Living</u>	<u>Full/Half</u>
1.	_____	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____	_____
6.	_____	_____	_____	_____	_____	_____

Paternal Grandmother

Name _____ Date of Birth / /
Alive Dead Age at Death Cause of Death _____
Height _____ Health Problems _____

Paternal Grandfather

Name _____ Date of Birth / /
Alive Dead Age at Death Cause of Death _____
Height _____ Health Problems _____

Are any of your parents blood relatives? yes no
Ancestor's country of origin: your mother _____ your father _____

Additional Family History Information:

