Arkansas Fertility & Gynecology Associates
Egg Donor Screening Form

Date: _____ Referred by (person/advertisement): _____

Name: _____ DOB: _____ Age Today: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

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

Email Address(es): _____

Occupation: _____ Employer: _____

Highest Level of Education Completed: _____ GPA: _____

College Major / Minor: _____

SSN: _____ Driver's License #: _____ State: _____

Race: Caucasian African American Hispanic Other: _____

Height: _____ Feet _____ Inches Weight: _____pounds BMI: _____(for clinic use only)

Build: Small Medium Large Obese Complexion: Fair Olive Dark Light

Hair Color: _____ Hair Type: Straight Curly Wavy Course

Eye Color: _____ Freckles: None Few Many

Which BEST describes your MOTHER'S ethnic background:

British Irish Chinese Japanese Jewish German Spanish Mexican African Pacific Islander

Mediterranean (Greek, Italian) Other: _____

Which BEST describes your FATHER'S ethnic background:

British Irish Chinese Japanese Jewish German Spanish Mexican African Pacific Islander

Mediterranean (Greek, Italian) Other: _____

Marital Status: Single Married Divorced Widowed In a relationship

Husband/Partner's Name: _____ DOB: _____ Age Today: _____

Husband/Partner's Occupation: _____

How long have you been with your husband/partner: _____

Do you SMOKE: YES NO If YES, how much/often: _____

Do you DRINK ALCOHOL: YES NO If YES, how much/often: _____

Please list all of your current medications and dosages: _____

_____

FDA Screening Questions	YES	NO	UNSURE	COMMENTS
Have you ever had a sexually transmitted disease? If YES, please list all that apply: Syphillis, Gonorrhea, Herpes, Chlamydia, Genital Warts				
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?				
Has your current male partner ever been in prison?				
In the past 12 months, have you been in jail for more than 3 days in a row?				
In the past 5 years, have you received or given money or drugs in exchange for any sexual act?				
Have you had sex in the past 12 months with anyone who has been in jail for more than 3 days in a row?				
In the past 12 months, have you had sex with a person known or suspected to have HIV, active Hepatitis B or C?				
In the past 12 months, have you been in contact (i.e.- sharing kitchen or bathroom) with a person having active viral Hepatitis?				
Have you had sexual contact with anyone who was born in or lived in any African country since 1977?				
Were you born in, or have you lived in, or traveled to any African country since 1977?				
After age 11, have you ever had viral Hepatitis: Hepatitis B or C?				
Have you ever been told that you cannot donate blood?				
Have you or your current partner received a blood transfusion? If YES, what year?				
When traveling abroad, did you receive a blood transfusion or any other medical treatment with a product made from blood?				
Have you received growth hormones made from human pituitary glands?				
Have you received or had intimate contact (exchange of bodily fluids, sharing razor or tooth-brush) with someone who has received organs or cells from non-human sources?				

FDA Screening Questions	YES	NO	UNSURE	COMMENTS
Do you have a clotting disorder for which you have received human derived clotting factor concentration?				
Have you injected drugs for a non-medical reason in the past 5 years, including intravenous, intramuscular, or subcutaneous injections?				
Have you ever used marijuana?				
Are you currently using marijuana?				
Have you ever used cocaine?				
Are you currently using cocaine?				
Have you ever used methamphetamines				
Are you currently using methamphetamines?				
Have you ever used LSD?				
Are you currently using LSD?				
Have you ever used any illicit drugs not listed above? Please list all.				
During work, are you exposed to toxic or radioactive substances?				
Have you ever had a needle stick injury?				
Have you ever been tested for AIDS? If YES, please list year and result.				
Have you recently received any vaccinations? If YES, please list.				
In the past 2 weeks have you had any of the following symptoms:				
Fever >101 degrees				
Flu like symptoms				
Swollen glands				
Fatigue				
Have you or your partner been diagnosed with West Nile Virus?				
Have you had a headache and fever within the past 7 days?				
Have you received a dura mater (brain covering) graft?				
Have you or your partner ever had CJD?				
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?				

FDA Screening Questions	YES	NO	UNSURE	COMMENTS
In the past 3 years, have you even been outside the US or Canada? If YES, where?				
Since 1980, have you lived in or traveled to Europe? This includes: England, Scotland, Ireland, Wales, the Isle of Man, the Channel Islands, Gibraltar, or the Falkland Islands. Please list length of time spent in each area.				
Have you spend a total of 6 months of more associated with a military base in any of the following countries: Belgium, the Netherlands, Germany, Spain, Portugal, Turkey, Italy, or Greece? Please list where.				
Have you traveled to a country affected by SARS (severe acute respiratory syndrome) or been with affected individuals in the past 14 days?				
Have you been treated for SARS within the last 28 days?				
Within the past year have you had any tattoos or body piercings, or had any type of acupuncture? If YES, what business did you use?				

The following are related to YOUR PAST medical history. Have you ever had, or been treated for, any of the following conditions:

CONDITION	YES	NO	UNSURE	COMMENTS
Drug Allergies				
Seasonal Allergies				
Birth Defects				
Epilepsy (seizure, convulsion)				
High Blood Pressure				
Diabetes (high blood sugar)				
Kidney Problems				
Asthma				
Arthritis or joint pain				
Vision Problems				
Skin Problems / Rashes				
Received human organ or tissue transplant				
Hearing Problems				
Bleeding Disorders				
Cancer (type)				
Migraine Headaches				
Psychiatric Problems (type)				
Depression				
Anxiety				
Schizophrenia				
Mania/Bipolar Disorder				
Gastrointestinal Disorder				
Thyroid Disease				
Anemia (low blood count)				
High Cholesterol				
Clubfeet				
Congenital Hip Location				
Congenital Heart Disease				
Neurofibromatosis				
Sickle Cell Disease				
Thalassemia				
Tuberous Sclerosis				
Alcohol Abuse				
Chromosomal Abnormality				
Hydrocephalus				

The following are related to your FAMILY HISTORY: (grandparents, parents, siblings, aunts, uncles, cousins, etc.):

CONDITION	YES	NO	UNSURE	COMMENT / RELATION
Childhood blindness				
Color blindness				
Childhood deafness				
Albinism				
Hemacromatosis				

CONDITION	YES	NO	UNSURE	COMMENT / RELATION
Breast cancer				
Ovarian cancer				
Hemophilia/Bleeding disorder				
Neurofibromatosis				
Mental retardation				
Adrenoleukodystrophy				
Down Syndrome				
Cystic fibrosis				
Muscular dystrophy				
Huntington's disease				
Hydrocephalus				
Galactosemia				
Phenylketonuria (PKU)				
Dwarfism				
Polycystic Kidney Disease				
Alcoholism				
Alzheimer's disease				
Premature Heart Attack (before age 50)				
Thyroid disease				
Diabetes				
Unexplained infant/child death				
Early death (before age 35)				
Psychiatric problems (depression, mania, anxiety)				
Suicide				
Multiple Sclerosis				
Cleft lip/Cleft palate				
Tay-Sachs disease				
Sickle Cell disease				
Thalassemia				
Neural tube defect (open spinal column)				
Congenital heart problems				
Marfan's Syndrome				
Multiple colon polyps				
Colon cancer				
Other cancer (type)				
Congenital hip dislocation				
Clubfeet				
Hypospadias				
Retinitis pigmentosis				
Retinoblastoma				
Alport disease				
High cholesterol (requiring treatment)				
Fragile X Syndrome				
Creutzfeld-Jakob Disease (CJD)				

The following is related to YOUR GYNECOLOGICAL & OBSTETRICAL history:

QUESTION	YES	NO	UNSURE	COMMENT
How old were you when you started your first menstrual period?				Age:
How many days from the start of one period until the start of the next period?				Days:
How long do your periods last?				Days:
Do you have pain with your periods?				
Do you have bleeding between periods?				
Have you ever missed a period?				
Do you have bleeding after intercourse?				
Have you had an abnormal Pap smear? (When?)				
Have you ever had a Colposcopy, LEETZ, or Cone procedure? (When?)				
Have you ever been diagnosed with PID? (Pelvic Inflammatory Disease)				
Have you ever had a discharge from your breast other than during pregnancy or breast feeding?				
Do you have a problem with excessive hair growth?				
Have you ever had endometriosis?				
Are you sexually active? Please list the number of partners that you have had in the last 2 years (male and female)				
Have you completed your child bearing?				
Have you ever been treated for infertility?				
Have you ever had a mammogram?				

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

Date of Outcome	Length of Pregnancy	Outcome	Gender	Weight	Complications

What led you to seek egg donation?

_____

_____

_____

Have you previously been an egg donor? YES NO

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 YES NO

Do you have a support person to assist you with the donation process, i.e. – provide you with transportation after the retrieval process? YES NO

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

Self injection of medication	YES	NO
Frequent blood testing	YES	NO
Frequent vaginal ultrasounds	YES	NO
Early morning appointments	YES	NO
Use of an alternate form of contraception (condoms)	YES	NO
Committed time frame once in a cycle	YES	NO
Required psychological evaluation	YES	NO

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

_____ _____

Donor Signature Date

Family History of Donor

Brothers and Sisters

Sex	Age	Health Problems	Height	Living	Full/Half

Donor's Mother

Name: _____ DOB: _____ Age Today: _____

Alive Dead Age at Death: _____ Cause of Death: _____

Height: _____ Health Problems: _____

Mother's Brothers and Sisters

Sex	Age	Health Problems	Height	Living	Full/Half

Maternal Grandmother

Name: _____ DOB: _____ Age Today: _____

Alive Dead Age at Death: _____ Cause of Death: _____

Height: _____ Health Problems: _____

Maternal Grandfather

Name: _____ DOB: _____ Age Today: _____

Alive Dead Age at Death: _____ Cause of Death: _____

Height: _____ Health Problems: _____

Donor's Father

Name: _____ DOB: _____ Age Today: _____

Alive Dead Age at Death: _____ Cause of Death: _____

Height: _____ Health Problems: _____

Father's Brothers and Sisters

Sex	Age	Health Problems	Height	Living	Full/Half

Paternal Grandmother

Name: _____ DOB: _____ Age Today: _____

Alive Dead Age at Death: _____ Cause of Death: _____

Height: _____ Health Problems: _____

Paternal Grandfather

Name: _____ DOB: _____ Age Today: _____

Alive Dead Age at Death: _____ Cause of Death: _____

Height: _____ Health Problems: _____

Are your parents blood relatives? YES NO

Ancestor's country of origin:
Mother: _____
Father: _____

Additional Family History Information:

_____
_____
_____
_____

Additional information about yourself that you would like to share (hobbies, special skills, sports, etc):

_____
_____
_____
_____

IF POSSIBLE, PLEASE INCLUDE A BABY PICTURE AND A CURRENT PICTURE OF YOURSELF WITH THIS APPLICATION