Egg Donation Screening Form

Arkansas Fertility & Gynecology
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Thank you for choosing to become an egg donor. This is one of the most fulfilling and honorable decisions that a woman can make. Egg donors like you help couples to create their families that would otherwise only remain a dream.

In order to qualify for the program, the two most basic requirements are that you are between the ages of 21 and 32 years and you must also have a Body Mass Index (BMI) of less than or equal to 30. Click here to figure your BMI

If you meet these two basic requirements please continue to fill out the screening form. Fill the entire form out completely and include detailed information about any personal or family illnesses and diseases. If the form is incomplete it could cause you to be denied or cause the review process to be much longer so that additional information can be obtained. Once the form has been submitted the review process will begin. You will be notified via e-mail of the approval or denial of your submission.

First name | Last name | Date of birth | Age today | SSN

Street address | City | State | Zip code

Phone number | E-mail address | Best way to contact | Best time to contact

Occupation | Employer | Location (city)

Marital status | Maiden name | Partner's full name

Highest level of education | Major / Area of interest / Future plans

Personal Characteristics

Race **Height** **Weight** **BMI** **Click here to calculate BMI**

Body build **Complexion** **Eye color** **Hair color** **Hair type**

Mother's ethnic background *(please be as specific as possible)*

African	Asian	European	Hispanic/Latino	Middle Eastern
Botswana	Asian Indian	Belgium	Brazil	Arabia
Chad	Chinese	Germany	Caribbean	Armenia
Ghana	Filipino	Greece	Central America	Cyprus
Guinea	Japanese	Ireland	Columbia	Egypt
Kenya	Korean	Italy	Costa Rica	Israel
Malawi	Thai	Norway	Cuba	Jordan
Namibia	Vietnamese	Russia	Mexico	Syria
Nigeria	Polynesia	Spain	Panama	Turkey
Sudan	Melanesia	Switzerland	Puerto Rico	JEWISH
Zimbabwe	Micronesia	United Kingdom	Venezuela	HEBREW

Father's ethnic background *(please be as specific as possible)*

African	Asian	European	Hispanic/Latino	Middle Eastern
Botswana	Asian Indian	Belgium	Brazil	Arabia
Chad	Chinese	Germany	Caribbean	Armenia
Ghana	Filipino	Greece	Central America	Cyprus
Guinea	Japanese	Ireland	Columbia	Egypt
Kenya	Korean	Italy	Costa Rica	Israel
Malawi	Thai	Norway	Cuba	Jordan
Namibia	Vietnamese	Russia	Mexico	Syria
Nigeria	Polynesia	Spain	Panama	Turkey
Sudan	Melanesia	Switzerland	Puerto Rico	JEWISH
Zimbabwe	Micronesia	United Kingdom	Venezuela	HEBREW

Additional information that you would like to share about your heritage:

Clinical Information

Do you SMOKE? YES NO
(This includes e-cigs)

Have you ever smoked? YES NO

If YES, what type of product did you smoke?

If YES, when was the last time you smoked?

Do you DRINK alcohol? YES NO

If YES, how often?

Are you currently using a method of birth control? YES NO

If YES, which method are you using?

Are you currently taking ANY medications? YES NO
(This includes over the counter medications)

If YES, please complete the information below.

Name of Medication	Daily dose	Reason for medication	Any additional notes

Have you ever had SURGERY? YES NO
(This includes c-sections)

If YES, please complete the information below.

Year	Procedure	Reason for surgery	Outcome/Complications

Gynecological History

How old were you when you started your first period? __________

How many days from the start of one period until the start of the next? __________

How many days does your flow usually last? __________

Do any of the following apply to you? Check all that apply.

Irregular cycles	Pain with periods	Bleeding between periods	Missed periods
Excessive acne	Excessive hair growth	Bleeding after intercourse	Breast discharge

Have you ever been diagnosed with any of the following? Check all that apply.

Endometriosis	Polycystic ovaries	Pelvic adhesions	Infertility
Hydrosalpinx*	PID (Pelvic Inflammatory Disease)		

Have you ever had a mammogram? YES NO

If YES, please explain why, when, and the results: ____

When was your most recent pap smear? Results? Have you ever had an abnormal pap smear?
YES NO

Are you currently sexually active? YES NO Number of partners in the last 2 years: ________

Pregnancy Information

Have you ever been pregnant? YES NO Number of pregnancies: ________

Have you completed your childbearing? YES NO

Would you ever consider being a surrogate? YES NO Maybe

Pregnancy #1

Year Outcome # weeks gestation Complications

Pregnancy #2

Year Outcome # weeks gestation Complications

Pregnancy #3

Year Outcome # weeks gestation Complications

FDA REQUIRED SCREENING

Please check YES or NO for each question and include the additional information where it is necessary.

Have you ever had a sexually transmitted disease or infection (STD/STI)? YES NO

If YES, complete the information below.

- What infection did you have? Check all that apply.

  HPV Chlamydia Gonorrhea Syphilis Herpes Genital warts
- When did you have the infection? ______ / ______
- Were you treated? YES NO
- What treatment did you receive? ____________________

In the past 5 years have you had sexual relations with a male homosexual, bisexual, or IV drug user? YES NO

Have you had a partner who had sexual relations with a male homosexual, bisexual, or IV drug user? YES NO

Has your current partner ever been in prison? YES NO

If YES, please complete the information below.

- What dates was your partner incarcerated? ____________________
- What prison(s) was your partner incarcerated? ____________________

In the past 12 months have you:

- Been in jail for more than 3 days in a row? YES NO
- Had sexual relations with anyone who has been in jail for more than 3 days in a row? YES NO
- Had sex with a person known or suspected to have HIV, Hepatitis B or Hepatitis C? YES NO
- Been in contact with a person known or suspected to have active viral Hepatitis? YES NO
- Had sexual relations with anyone who would answer YES to any of the above questions? YES NO

Have you ever given or received money or drugs in exchange for any sexual act? YES NO

Were you born in or did you live in or travel to Africa between 1977 and today? YES NO

Have you had sexual contact with anyone born in or lived in Africa between 1977 and today? YES NO

After age 11, have you had viral Hepatitis, Hepatitis B, or Hepatitis C? YES NO

Have you ever been told that you could not donate blood? YES NO If YES - Why? __________

Have you ever received a blood transfusion? YES NO If YES - Why? __________

If YES, what date(s) and where was the transfusion performed?____________________

Has your partner ever received a blood transfusion? YES NO

If YES, what date(s) and where was the transfusion performed?____________________

Do you have a blood clotting disorder and receive human derived clotting factor concentration? YES NO

Have you ever received growth hormones made from human pituitary glands (HGH)? YES NO

Have you ever taken part in the following behaviors and if so, use the space provided to answer when and how often:

- Injected any type of drug for non-medical reasons YES NO __________
- Used marijuana (including medical marijuana) YES NO __________
- Used cocaine in any form YES NO __________
- Used LSD (Angel Dust) YES NO __________
- Used methamphetamine YES NO __________
- Used any illicit drug not listed YES NO __________

Have you ever used prescription medications for reasons other than their intended use? YES NO

Are you currently using ANY illicit drugs or prescription drugs for non-medical reasons? YES NO

During work are you exposed to toxic or radioactive substances? YES NO

Have you ever had a needle stick injury? YES NO If YES - When: ___________ Where: _________

Have you ever been tested for HIV/AIDS? YES NO If YES - When: ___________ Results: ________

Have you recently received any vaccinations? YES NO If YES - When: ___________ Type: __________

In the past 7 days have you had any of the following symptoms? YES NO If YES, check all that apply.

Fever of 101° or more | Flu like symptoms | Swollen glands | Fatigue | Headache

Have you or your partner ever been diagnosed with West Nile Virus (WNV)? YES NO

Have you ever received a dura-mater (brain covering tissue) graft? YES NO

Have you or your partner ever been diagnosed with CJD? YES NO

Between 1980 and 1996 were you a member of the US Military or civilian employee? YES NO

Between 1980 and 1996 were you a dependent of a member of the US Military? YES NO

Have you traveled to a country affected by or treated for SARS in the past 14 days? YES NO

Have you been with an individual affected by SARS in the past 14 days? YES NO

In the past 12 months have you received any of the following

Tattoos | Permanent make-up | Body piercing | Acupuncture | None

If YES to the above 3 questions - When: ____________________ What business: ___________________________________

TRAVEL

Please answer each of the following questions and provide additional information where it is necessary.

❖ Between 1980 and today, have you traveled to any of the following European countries? Check all that apply.

NONE	England	Wales	Gibraltar
France	Scotland	The Isle of Man	The United Kingdom
The Channel Islands	The Falkland Islands		

❖ Have you spent a total of 6 months or more associated with a military base in any of the following countries? Check all that apply.

NONE	Belgium	Italy or Greece	Portugal
Turkey	Germany	Spain	The Neatherlands

❖ During the last 6 months have you or any sexual partner that you've had in the last 6 months resided in or traveled to any of the locations listed below for ANY amount of time?
***** This includes cruise ship travel, regardless of whether or not you disembarked from the ship at that port of call*****

Mexican Riviera

NONE | Mexico (ANY part of the country)

Travel questions continue on the next page.

The Caribbean

NONE, Anguilla, Antigua & Barbuda, Aruba, The Bahamas
Barbados, Bonaire, British Virgin Islands, Cuba, Curaco
Dominica, Dominican Republic, Grenada, Haiti, Jamaica
Montserrat, Puerto Rico, Saba, St. Kitts & Nevis, St. Lucia
St. Vincent, The Grenadines, St. Eustatius, St. Maarten, Trinidad & Tobago
Turks & Caicos Islands, US Virgin Islands

NONE	Anguilla	Antigua & Barbuda	Aruba	The Bahamas
Barbados	Bonaire	British Virgin Islands	Cuba	Curaco
Dominica	Dominican Republic	Grenada	Haiti	Jamaica
Montserrat	Puerto Rico	Saba	St. Kitts & Nevis	St. Lucia
St. Vincent	The Grenadines	St. Eustatius	St. Maarten	Trinidad & Tobago
Turks & Caicos Islands	US Virgin Islands			

Central America

NONE Belize Costa Rica El Salvador Guatemala Honduras Nicaragua Panama

Pacific Islands

NONE Fiji Marshall Islands Papua New Guinea Samoa Solomon Islands Tonga

South America

NONE	Argentina	Bolivia	Brazil	Columbia	Ecuador	French Guiana
Guyana	Paraguay	Peru	Suriname	Venezuela		

Asia

NONE	Bangadesh	Burma	Cambodia	India	Indonesia	Laos	Malaysia
Maldives	Pakistan	Philippines	Singapore	Thailand	Timo Leste	Vietnam	

Africa

NONE	Angola	Benin	Burkina-Faso	Cameroon	Cape Verde	Chad
Congo	Cote d'Ivoire	Guinea	Gabon	Gambia	Ghana	Guinea
Guinea-Bissau	Kenya	Liberia	Mali	Niger	Nigeria	Rwanda
Senegal	Sierra Leone	Sudan	Tanzania	Togo	Uganda	

Central African Republic Democratic Republic of the Congo Equatorial Guinea

United States

Brownsville, Texas Lower Rio Grande Valley , Texas
Miami-Dade County, Florida Southern Florida (includes Miami Beach)

- ❖ If you marked any of the travel locations on the previous pages, please give more details in the area below.

Location	**Traveler**	**Arrival Date**	**Departure Date**	**For clinic use only**

Medical History

The following information is related to your own personal medical history.

Have you ever been diagnosed with or treated for any of the following conditions? Check ALL that apply.

Any disease/disorder marked with an asterisk (*) indicates that there is a definition on the following page.

Cardiac (Heart)	Respiratory (Lungs)	Urinary (Kidneys, Bladder)
High blood pressure	Allergies (seasonal)	Kidney stones
Mitral valve prolapse	Asthma (childhood)	Recurring UTIs
Congenital heart disease	Asthma (current)	Other kidney problem
Other heart disease: ______	Other breathing problem: ______	Other bladder problem: ______
Gastrointestinal (Stomach)	**Musculoskeletal (Muscles, Bones)**	**Endocrine (Hormones)**
Crohn's disease	Arthritis	Diabetes (Type I)
GERD*	Clubfeet	Diabetes (Type II)
IBS*	Congenital hip dislocation	Thyroid disorder
Ulcers	Joint pain/pressure	High cholesterol
Other GI disease: ______	Other disease: ______	Other disease: ______
Reproductive (Uterus, Ovaries)	**Hematological (Blood)**	**Eyes, Ears, and Skin**
Endometriosis	Anemia	Eczema or Psoriasis
PID	Sickle Cell Anemia	Skin rashes
Ovarian cysts	Thalassemia*	Vision problems
Ectopic pregnancy	Other bleeding disorder	Hearing problems
Other reproductive disease: ______	Other blood disease: ______	Other disease: ______
Neurological (Brain, Nerves)	**Psychological (Mental)**	**Other**
Epilepsy	Anxiety	Birth defects
Migraine headaches	Depression	Drug allergies
Hydrocephalus	Bipolar disorder	Substance abuse
Neurofibromatosis*	Manic disorder	Cleft lip / Cleft palate
Other neurological disease: ______	Other psychological disorder: ______	Organ or Tissue transplant
		Any other disease or disorder: ______ ______

Family Medical History

The following information is related to your relative's medical history.

Has anyone in your family ever been diagnosed with or treated for any of the following conditions? Check ALL that apply.

Any disease/disorder marked with an asterisk (*) indicates that there is a definition on the following page.

Cardiac (Heart)

- Congenital heart disease
- Congestive heart failure
- Coronary artery disease
- Heart attack before age 50
- Heart attack after age 50
- High blood pressure
- Other cardiac disease: ____________________

Respiratory (Lungs)

- Allergies (seasonal)
- COPD*
- Cystic Fibrosis (CF)
- Emphysema
- Esophageal cancer
- Lung cancer
- Other breathing problem: ____________________

Urinary (Kidneys)

- Alport Syndrome*
- Bladder cancer
- Kidney cancer
- Kidney failure
- Polycystic kidney disease
- Prostate cancer
- Other kidney disease: ____________________

Gastrointestinal (Stomach)

- Celiac disease
- Colon cancer
- Colon polyps
- Glactosemia*
- Lupus
- Phenyloketonuria*
- Other GI disorder: ____________________

Endocrine (Hormones)

- Diabetes Type I
- Diabetes Type II
- Gactosemia*
- High cholesterol
- Phenyloketonuria*
- Thyroid disease
- Other disease: ____________________

Hematological (Blood)

- Bleeding disorder
- Clotting disorder
- Hemacromatosis*
- Hepatitis (any type)*
- Sickle Cell Anemia
- Thalassemia*
- Other blood disease: ____________________

Eyes, Ears, Skin

- Albinism*
- Alopecia*
- Alport syndrome*
- Childhood blindness
- Childhood deafness
- Retinitis pigmentosis*
- Retinoblastoma*
- Skin cancer / Melanoma
- Other disease: ____________________

Psychological (Mental)

- Anxiety
- Bipolar disorder
- Depression
- Fragile X syndrome*
- Manic disorder
- OCD or ADD
- PTSD*
- Schizophrenia or DID*
- Other mental disorder: ____________________

Neurological (Brain)

- Adrenoleukodystrophy*
- Alzheimer's disease
- Down syndrome
- Epilepsy
- Huntington's disease*
- Hydrocephalus
- Mental retardation
- Multiple sclerosis*
- Neural tube defect*
- Neurofibromatosis*
- Tay-Sach's disease*
- Other nerve disease: ____________________

Reproductive (Uterus, Testicles)

- Breast cancer
- Early menopause (before age 40)
- Endometriosis
- Hypospadias*
- Infertility
- Ovarian cancer
- Ovarian failure
- Prostate cancer
- Testicular cancer
- Uterine cancer
- Uterine fibroids
- Other disease: ____________________

Musculoskeletal (Muscle, Bone)

- Cleft lip / Cleft palate
- Clubfeet
- Congenital hip dysplasia
- Dwarfism
- Leukemia
- Marfan Syndrome*
- Muscular Dystrophy*
- Osteoarthritis
- Rheumatoid arthritis
- Other disease: ____________________

Other disorders / diseases

- Birth defect
- Early death (before age 35)
- Eating disorder
- Organ / Tissue transplant
- Substance abuse
  - Alcoholism
  - Drug addiction
  - Other substance abuse
- Childhood death
- Any other disease not listed in the categories above ____________________

____

Family History

If any member of your family listed below as deceased, give their age at the time of death in the "Age" box.
If you are unsure of a family member's age, you can estimate. Enter "40s" if you know that they are between 40-49 years old.

Do you have any siblings? YES NO If YES, how many? ________

Relation Age Health Problems / Cause of Death

If you have more than 3 siblings use the space at the end of this section to enter the additional information.

Mother Age Health Problems / Cause of Death

Living Deceased

Does your mother have siblings? YES NO If YES, how many? ________

Relation Age Health Problems / Cause of Death

If your mother has more than 3 siblings use the space at the end of this section to enter the additional information.

Maternal Grandmother Age Health Problems / Cause of Death
Living Deceased

Maternal Grandfather Age Health Problems / Cause of Death
Living Deceased

Father Age Health Problems / Cause of Death
Living Deceased

Does your father have siblings? YES NO If YES, how many? ________

Relation Age Health Problems / Cause of Death

If your mother has more than 3 siblings use the space at the end of this section to enter the additional information.

Paternal Grandmother Age Health Problems / Cause of Death
Living Deceased

Paternal Grandfather Age Health Problems / Cause of Death
Living Deceased

Additional Sibling Information

YOUR siblings

Relation - Age - Health issues

MOTHER's siblings

Relation - Age - Health issues

FATHER's siblings

Relation - Age - Health issues

Adrenoleukodystrophy - ALD. This brain disorder destroys myelin, the protective sheath that surrounds the brain's neurons -- the nerve cells that allow us to think and to control our muscles.

Albinism - a congenital disorder characterized by the complete or partial absence of pigment (color) in the skin, hair and eyes.

Alport syndrome - A genetic condition characterized by kidney disease, hearing loss, and eye abnormalities.

Alopecia - disease causing hair loss on the scalp, face, and sometimes on other areas of the body.

COPD - Chronic obstructive pulmonary disease. Lung disease that is most often caused by smoking.

DID - Dissociative identity disorder, previously called multiple personality disorder.

Fragile X syndrome - is a genetic condition that causes intellectual disability, behavioral and learning challenges and various physical characteristics.

Galactosemia - A disorder that affects how the body processes a simple sugar called galactose. This disease is diagnosed in infancy.

GERD - Gastoesophageal reflux disease.

Hemochromatosis - Hereditary disease that causes your body to absorb too much iron from food.

Huntington's disease - An inherited condition in which nerve cells in the brain break down over time. It usually results in progressive movement, thinking (cognitive), and psychiatric symptoms.

Hypospadias - A relatively rare congenital condition where the opening of the penis is on the underside of the organ.

IBS - Irritable bowel syndrome.

Marfan syndrome - A genetic defect that affects the heart, eyes, blood vessels, and bones. People with this disease generally have heart and vision problems, are tall, and have long limbs.

Muscular dystropyhy - Abnormal genes (mutations) lead to muscle degeneration.

Neurofibromatosis - A genetic disorder that causes tumors to form on nerve tissue.

Phenylketonuria - PKU - An inborn error of metabolism that results in decreased metabolism of the amino acid phenylalanine.

PTSD - A disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event.

Retinitis pigmentosa - An inherited degenerative eye disease that causes severe vision impairment, including decreased vision at night or in low light and loss of side vision (tunnel vision).

Retinoblastoma - an eye cancer that begins in the retina

Thalassemia -Inherited blood disorder causing low hemoglobin and fewer red blood cells that may cause anemia.

Egg Donation Information and Notification

Have you previously been an egg donor? YES NO

If YES, please provide information of the cycle including the clinic name.

Please answer all of the following questions. **(Note that the duration of a cycle is 6-8 weeks)**	YES	NO
I can and will discontinue my form of birth control for the duration of the cycle.		
I can and will abstain from intercourse for the duration of the cycle.		
I have a support person to assist me during the cycle process (including injections and transportation)		
I have a schedule that will allow for frequent early morning appointments during the cycle.		

Do you have knowledge of and the ability to complete the following tasks related to the donation process?

Self injectable medications	YES	NO
Early morning appointments	YES	NO
Frequent lab testing	YES	NO
Frequent vaginal ultrasounds	YES	NO
Psychological evaluation	YES	NO
Use an alternate form of birth control when instructed	YES	NO
Commit to the timeframe once a donation cycle has started	YES	NO

Include any additional information about yourself and / or your family that you would like to share.

What led you to choose egg donation?

When submitting your screening form for review, please include a few photos of yourself that you wouldn't mind sharing.

By giving my signature below I attest that the information that I have provided in this screening form is true and accurate to the best of my knowledge.

Print name Signature/e-Signature Date