

EGG DONOR QUESTIONNAIRE



The Donor Branch
of FCLV



EGG DONOR QUESTIONNAIRE PERSONAL CHARACTERISTICS

Name: _____

Address: _____

SS# _____

Phone: _____

Email: _____

Age: _____

Religion: _____

Height: _____

Weight: _____

Eye Color: _____

Natural Hair Color: _____

Hair Texture: Fine ____ Medium ____ Thick ____ Wavy ____ Curly ____ Straight ____

Skin Type: Fair ____ Medium ____ Dark ____

Body Type/Build: Small ____ Medium ____ Large ____ Athletic ____

Native Tongue: _____

Predominant Hand: _____

Sexual Orientation: _____

Blood Type: _____

Marital Status: _____

Distinguishing Characteristics: _____



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Race:

Please check ALL that apply. You may check more than one. You will be able to enter more specific ethnic heritage below.

- Asian (i.e. Chinese, Japanese) _____
- Black (i.e. African-American, Caribbean) _____
- Caucasian (i.e. White, European) _____
- East Indian (i.e. Asian Indian) _____
- Hispanic (i.e. Latino, South American, Puerto Rican) _____
- Middle Eastern (i.e. Arab, Moroccan) _____
- Native American (i.e. Alaskan Native, Cherokee) _____
- Other: _____

Ethnic Heritage / Nationality: Please check ALL that apply.

You may check more than one.

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> African American | <input type="checkbox"/> English | <input type="checkbox"/> Lebanese | <input type="checkbox"/> South African |
| <input type="checkbox"/> Alsace | <input type="checkbox"/> Ethiopian | <input type="checkbox"/> Mexican | <input type="checkbox"/> Spanish |
| <input type="checkbox"/> Argentinean | <input type="checkbox"/> Filipino | <input type="checkbox"/> Moroccan | <input type="checkbox"/> Swedish |
| <input type="checkbox"/> Austrian | <input type="checkbox"/> Finnish | <input type="checkbox"/> Native American | <input type="checkbox"/> Swiss |
| <input type="checkbox"/> Belgian | <input type="checkbox"/> French | <input type="checkbox"/> Nicaraguan | <input type="checkbox"/> Taiwanese |
| <input type="checkbox"/> Bolivian | <input type="checkbox"/> French-Canadian | <input type="checkbox"/> Norwegian | <input type="checkbox"/> Thai |
| <input type="checkbox"/> Brazilian | <input type="checkbox"/> German | <input type="checkbox"/> Pacific Islander | <input type="checkbox"/> Turkish |
| <input type="checkbox"/> Bulgarian | <input type="checkbox"/> Greek | <input type="checkbox"/> Pakistani | <input type="checkbox"/> Ukranian |
| <input type="checkbox"/> Canadian | <input type="checkbox"/> Guatemalan | <input type="checkbox"/> Palestinian | <input type="checkbox"/> Uruguayan |
| <input type="checkbox"/> Chilean | <input type="checkbox"/> Guatemalan | <input type="checkbox"/> Panamanian | <input type="checkbox"/> Venezuelan |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Hawaiian | <input type="checkbox"/> Paraguayan | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Columbian | <input type="checkbox"/> Hungarian | <input type="checkbox"/> Persian | <input type="checkbox"/> Welsh |
| <input type="checkbox"/> Costa Rican | <input type="checkbox"/> Icelandic | <input type="checkbox"/> Polish | <input type="checkbox"/> Yugoslavian |
| <input type="checkbox"/> Creole | <input type="checkbox"/> Iranian | <input type="checkbox"/> Portuguese | <input type="checkbox"/> Zairian |
| <input type="checkbox"/> Croatian | <input type="checkbox"/> Irish | <input type="checkbox"/> Puerto Rican | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Czech | <input type="checkbox"/> Israeli | <input type="checkbox"/> Romanian | |
| <input type="checkbox"/> Danish | <input type="checkbox"/> Italian | <input type="checkbox"/> Russian | |
| <input type="checkbox"/> Dutch | <input type="checkbox"/> Jamaican | <input type="checkbox"/> Scandinavian | |
| <input type="checkbox"/> East Indian | <input type="checkbox"/> Japanese | <input type="checkbox"/> Scottish | |
| <input type="checkbox"/> Ecuadorian | <input type="checkbox"/> Jewish | <input type="checkbox"/> Slavic | |
| <input type="checkbox"/> Egyptian | <input type="checkbox"/> Korean | <input type="checkbox"/> Slovakian | |



EGG DONOR QUESTIONNAIRE PERSONAL CHARACTERISTICS

Education/Occupation

High School GPA: _____

Level of Education: _____

College Attended/Attending: _____

College Major: _____

College GPA: _____

SAT Scores: _____

Other Test Scores: _____

Academic Strengths: _____

Current Occupation: _____

Medical History

Have you ever been under the care of a psychiatrist? _____

Have you ever received treatment for depression? _____

Have any members of your immediate family ever received treatment for depression? Yes _____ No _____

If so, why? _____

Have you ever received treatment for drug/alcohol abuse? _____

Have any members of your immediate family ever received treatment for drug/alcohol abuse? _____

Do you have any learning disabilities? Yes _____ No _____

Please list any drug allergies:

Are you currently taking any medications/treatments (including non-prescription)? Yes _____ No _____

List any current medications (including over the counter medications)



EGG DONOR QUESTIONNAIRE PERSONAL CHARACTERISTICS

Have you ever taken Depo-Provera? Yes _____ No _____

If so, when was your last injection of Depo? _____ / _____ / _____

Are you currently under a physician's care? Yes _____ No _____

If so, why? _____

List any hospitalizations and/or surgeries: (Please include dates.)

Were you adopted? Yes _____ No _____

Do you wear glasses/contact lenses? Yes _____ No _____

Have you ever worn braces? Yes _____ No _____

Do you have hearing problems? Yes _____ No _____

Past or present use of intravenous drugs? Yes _____ No _____

List any medical conditions/problems:

Nutritional History

Describe your diet (i.e. vegetarian, meat-eater, etc.)

What best describes your exercise regime?

Have you ever had plastic surgery? Yes _____ No _____

If so, what type of plastic surgery? (Please include dates.)



EGG DONOR QUESTIONNAIRE PERSONAL CHARACTERISTICS

How often do you use the following:

Coffee: _____

Beer: _____

Wine: _____

Liquor: _____

Cigarettes: _____

Marijuana: _____

Cocaine: _____

Have you ever had your blood drawn? Yes _____ No _____

If yes, have you ever fainted during or after a blood draw? Yes _____ No _____

Have you ever given yourself injections? Yes _____ No _____



EGG DONOR QUESTIONNAIRE PERSONAL CHARACTERISTICS

Sexual History

Have you ever been told you are infertile? Yes _____ No _____

Have you been sexually active during the past six months? Yes _____ No _____

Are you currently sexually active? Yes _____ No _____

Are you in a monogamous relationship? Yes _____ No _____

If no, enter the number of partners you have been sexually active with over the past 6 months. _____

Have you ever been refused as a blood donor? Yes _____ No _____

If yes, please list date(s) and reason(s):

____ / ____ _____

____ / ____ _____

Have you had any tattoos or body piercings within the last twelve months? Yes _____ No _____

If Yes, please indicate the date and whether it was a tattoo or piercing:

____ / ____ _____

Have you been exposed to radiation or toxic chemicals in your work or personal life (lead, mercury, gold)? Yes _____ No _____

If you answered 'Yes' to any of the questions above, please provide any relevant details:



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Reproductive History:

Have you ever been a donor?	Yes _____	No _____
# of Donor Cycles:	_____	

Medical History

Please list any reproductive illnesses or diseases that you have experienced (please indicate the date(s), complications outcome, etc.):

Have you ever had an abnormal pap smear? Yes _____ No _____

If so, when and what was done to correct the situation? _____

Menstrual History:

How often is your period? _____

How many days does your period last? _____

At what age did you begin menstruation? _____

Are your menstrual periods regular? _____

What is your current method of birth control? _____

How long have you been on this method of birth control? _____



EGG DONOR QUESTIONNAIRE PERSONAL CHARACTERISTICS

Pregnancy History

Have you ever been pregnant? Yes _____ No _____

of Pregnancies: _____

Dates of pregnancies: ____ / ____ ____ / ____

Live Births: Yes _____ No _____

Dates of births: ____ / ____ ____ / ____

Miscarriages: Yes _____ No _____

Dates of miscarriages: ____ / ____ ____ / ____

Abortions: Yes _____ No _____

Dates of abortions: ____ / ____ ____ / ____

Any complications with deliveries or abortions? Yes _____ No _____

Please describe which with dates:



EGG DONOR QUESTIONNAIRE PERSONAL CHARACTERISTICS

Donor Name: _____

Please look through the list of the following medical problems and indicate which one of your relatives have been affected.

Medical Condition	Self	Mother	Father	Grandparents	Sibling	Aunt	Uncle	Cousin
Anemia								
Immune Deficiency								
Leukemia								
Sickle Cell Anemia								
Hemophilia								
Heart Disease								
Liver Disease								
Cancer								
Colon Cancer								
Breast Cancer								
Ovarian Cancer								
Cystic Fibrosis								
Crohn's Disease								
Ulcerative Colitis								
Thyroid Problems								
Diabetes								
Depression								
Huntington's Disease								
Anxiety								
Mental Illness								
Learning Disorders								
Drug Addiction								
Alcoholism								
Hearing Disorder								
Blindness								
Asthma								
Acne								
Psoriasis								
Birth Defects								
Seizure Disorder								
Autism								
Down Syndrome								
High Blood Pressure								
Polycystic Kidney Disease								
Schizophrenia / Manic Depression								



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Genetic History - continued

- Respiratory Disease (Acute) Yes _____ No _____
- Schizophrenia/Manic Depressive Disorder Yes _____ No _____
- Seizure Disorder Yes _____ No _____
- Serious birth defects Yes _____ No _____
- Severe bleeding tendency Yes _____ No _____
- Skin Disease Yes _____ No _____
- Spina Bifida or Hydrocephalus Yes _____ No _____
- Same cancer in more than one family member Yes _____ No _____
- Tuberculosis Yes _____ No _____
- Tuberous Sclerosis Yes _____ No _____
- Two or more miscarriages or stillborn Yes _____ No _____
- Typhoid Disease Yes _____ No _____

If Yes, describe below:

If yes, have you been tested as a carrier of Thalassemia? Yes _____ No _____

If Yes, enter result below:

Are you of Jewish ancestry? Yes _____ No _____

If yes, have you been tested as a carrier of Tay Sachs disease? Yes _____ No _____

If Yes, enter result below:

Are you of African ancestry? Yes _____ No _____

If yes, have you been tested as a carrier of Sickle Cell disease? Yes _____ No _____

If Yes, enter result below:

Are there any known genetic conditions or birth defects in your family? Yes _____ No _____

If you indicated that either you or one of your relatives has been diagnosed with one of the above conditions, please provide any relevant details:



EGG DONOR QUESTIONNAIRE PERSONAL CHARACTERISTICS

Relation: Mother

Current age (if applicable): _____

Age at death and cause of death (if applicable):

Height: _____

Weight: _____

Ethnic Origin: _____

Eye Color: _____

Natural Hair Color: _____

Hair Texture: _____

Skin Type: _____

Occupation: _____

Level of Education: _____

Did your mother take DES while she was pregnant with you? Yes _____ No _____

Is there a history of infertility in your family? Yes _____ No _____

Special skills, talents and abilities:

Please add any relevant details or additional explanations about the family member listed:

Relation: Father

Current age (if applicable): _____

Age at death and cause of death (if applicable):

Height: _____

Weight: _____

Ethnic Origin: _____

Eye Color: _____

Natural Hair Color: _____

Hair Texture: _____

Skin Type: _____

Occupation: _____

Level of Education: _____

Special skills, talents and abilities:

Please add any relevant details or additional explanations about the family member listed:



EGG DONOR QUESTIONNAIRE PERSONAL CHARACTERISTICS

Relation: Maternal Grandmother

Current age (if applicable): _____

Age at death and cause of death (if applicable):

Height: _____

Weight: _____

Ethnic Origin: _____

Eye Color: _____

Natural Hair Color: _____

Hair Texture: _____

Skin Type: _____

Occupation: _____

Level of Education: _____

Special skills, talents and abilities:

Please add any relevant details or additional explanations about the family member listed:

Relation: Maternal Grandfather

Current age (if applicable): _____

Age at death and cause of death (if applicable):

Height: _____

Weight: _____

Ethnic Origin: _____

Eye Color: _____

Natural Hair Color: _____

Hair Texture: _____

Skin Type: _____

Occupation: _____

Level of Education: _____

Special skills, talents and abilities:

Please add any relevant details or additional explanations about the family member listed:



EGG DONOR QUESTIONNAIRE PERSONAL CHARACTERISTICS

Relation: Paternal Grandmother

Current age (if applicable): _____

Age at death and cause of death (if applicable):

Height: _____

Weight: _____

Ethnic Origin: _____

Eye Color: _____

Natural Hair Color: _____

Hair Texture: _____

Skin Type: _____

Occupation: _____

Level of Education: _____

Special skills, talents and abilities:

Please add any relevant details or additional explanations about the family member listed:

Relation: Paternal Grandfather

Current age (if applicable): _____

Age at death and cause of death (if applicable):

Height: _____

Weight: _____

Ethnic Origin: _____

Eye Color: _____

Natural Hair Color: _____

Hair Texture: _____

Skin Type: _____

Occupation: _____

Level of Education: _____

Special skills, talents and abilities:

Please add any relevant details or additional explanations about the family member listed:



EGG DONOR QUESTIONNAIRE PERSONAL CHARACTERISTICS

Relation: Sibling #1

Current age (if applicable): _____

Age at death and cause of death (if applicable):

Height: _____

Weight: _____

Ethnic Origin: _____

Eye Color: _____

Natural Hair Color: _____

Hair Texture: _____

Skin Type: _____

Occupation: _____

Level of Education: _____

Special skills, talents and abilities:

Please add any relevant details or additional explanations about the family member listed:

Relation: Sibling #2

Current age (if applicable): _____

Age at death and cause of death (if applicable):

Height: _____

Weight: _____

Ethnic Origin: _____

Eye Color: _____

Natural Hair Color: _____

Hair Texture: _____

Skin Type: _____

Occupation: _____

Level of Education: _____

Special skills, talents and abilities:

Please add any relevant details or additional explanations about the family member listed:



EGG DONOR QUESTIONNAIRE PERSONAL CHARACTERISTICS

Relation: Sibling #3

Current age (if applicable): _____

Age at death and cause of death (if applicable):

Height: _____

Weight: _____

Ethnic Origin: _____

Eye Color: _____

Natural Hair Color: _____

Hair Texture: _____

Skin Type: _____

Occupation: _____

Level of Education: _____

Special skills, talents and abilities:

Please add any relevant details or additional explanations about the family member listed:

Relation: Sibling #4

Current age (if applicable): _____

Age at death and cause of death (if applicable):

Height: _____

Weight: _____

Ethnic Origin: _____

Eye Color: _____

Natural Hair Color: _____

Hair Texture: _____

Skin Type: _____

Occupation: _____

Level of Education: _____

Special skills, talents and abilities:

Please add any relevant details or additional explanations about the family member listed:



EGG DONOR QUESTIONNAIRE PERSONAL CHARACTERISTICS

Please describe your character; i.e. how your friends and family might describe you:

Favorite Color: _____

Favorite Food: _____

Favorite Book: _____

Favorite Movie: _____

Please list any special skills, talents and abilities you have:

Please describe your future goals (personal and career):

How important is spirituality to you? _____

What does family mean to you?

Hobbies:

Musical Instruments:

Athletics:



EGG DONOR QUESTIONNAIRE PERSONAL CHARACTERISTICS

Please explain your personal reasons for wanting to be an ovum donor:

What would your message be to the possible recipients?

I fully understand the importance of disclosing the entire truth regarding my personal and family history to the potential donor egg recipients. I understand they will have access to the pictures I provide of myself and family, but will not have access to my name. I hereby state that the above information listed in this donor questionnaire to be the truth and that I have not omitted any relevant information pertaining to my personal or family history.

Potential Donor's Signature: _____ Date: _____

Printed Donor's Name: _____

Witness Signature: _____

Reviewed by: _____ Date: _____