



## ACCOMPLISHMENTS

Education:     completed grade school             completed high school

currently in college, pursuing degree in \_\_\_\_\_

completed college, degree in \_\_\_\_\_

pursuing advanced degree in \_\_\_\_\_

completed advanced degree in \_\_\_\_\_

Current Occupation: \_\_\_\_\_ Duties: \_\_\_\_\_

Company Name & Location: \_\_\_\_\_

Special Skills (e.g. computers, languages, instruments): \_\_\_\_\_

\_\_\_\_\_

Hobbies/Favorite Past-times: \_\_\_\_\_

\_\_\_\_\_

## FERTILITY HISTORY

Age at first menstrual period: \_\_\_\_\_ Are your current periods regular? \_\_\_\_\_ Number of days of each cycle: \_\_\_\_\_

Have you ever donated eggs before?  Yes  No,

If yes, When? \_\_\_\_\_ Where? \_\_\_\_\_ For how long? \_\_\_\_\_

How many births resulted from your donations? \_\_\_\_\_

Have you ever applied to a fertility program and been rejected? If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

Is there any history of fertility problems in your family (difficulty conceiving or frequent miscarriage)?  Yes  No

If yes, please explain: \_\_\_\_\_

Did you ever have trouble conceiving?  Yes  No    Have you ever been pregnant?  Yes  No    # of Pregnancies: \_\_\_\_\_

PREGNANCY OUTCOME:	NO	YEAR	Live Birth	Miscarriage	Ectopic	Termination	COMMENTS
1							
2							
3							
4							
5							

Complications: \_\_\_\_\_

## PERSONAL HEALTH HISTORY

Do you currently have any **allergies**?  Yes  No If yes, are they to:  Food  Medications  Environmental  Other

Please list below specific substances and reaction(s) produced:

<u>SUBSTANCE</u>	<u>REACTION</u>	<u>AGE</u>
_____	_____	_____
_____	_____	_____

As per the above, please describe any childhood allergies you have outgrown: \_\_\_\_\_

How is your **vision** without corrective lenses?  Poor  Fair  Good  Excellent

Do you wear corrective lenses?  Yes  No For What?  Nearsighted  Farsighted  Other \_\_\_\_\_

Your vision is: Right Eye: 20 / \_\_\_\_\_ Left Eye: 20 / \_\_\_\_\_

How is your **hearing** without corrective aids?  Poor  Fair  Good  Excellent

Do you wear corrective aids?  Yes  No If yes, what type? \_\_\_\_\_

What is the condition of your **teeth**?  Poor  Fair  Good  Excellent

Do you have false teeth?  Yes  No If yes,  easily removed [bridges]  semi-fixed [caps]  fixed [posts]

Your **diet** is:  Vegetarian  Non-Vegetarian

Do you consider your diet to be:  Poor  Fair  Good  Excellent

How much **exercise** do you get?  None  Occasional  Regular  Professional Level

Type of exercise: \_\_\_\_\_

Have you ever had **surgery** (ies)?  Yes  No If yes, please explain: \_\_\_\_\_

Have you had any **hospitalization**(s) not mentioned above? \_\_\_\_\_

Have you ever had a blood or blood product **transfusion**?  Yes  No If yes, please explain: \_\_\_\_\_

Have you had major **radiation** or X-ray exposure?  Yes  No If yes, please explain: \_\_\_\_\_

## PERSONAL SEXUAL HISTORY

Number of sex partners within the last six (6) months: \_\_\_\_\_ Within the last two (2) years: \_\_\_\_\_

What was your shortest relationship with a partner? \_\_\_\_\_ What was your longest? \_\_\_\_\_

Are you currently in a relationship now? \_\_\_\_\_ How long? \_\_\_\_\_

Method of Contraception used: \_\_\_\_\_ For how long: \_\_\_\_\_

Have you or any of your sexual partners had:

	SELF	PARTNER	WHEN	HOW OFTEN
Syphilis				
Gonorrhea				
NSU (Non-Specific Urethritis)				
Chlamydia				
Venereal Warts				
Genital Herpes				
Hepatitis				
HIV-1/2 or HTLV-1 infection (AIDS)				
Other sexually transmitted diseases				
Engaged in prostitution				
Used non-therapeutic IV (intravenous) drugs				
Homosexual relationships				
Been a recipient of blood or blood-product transfusion				
Sexual partners came from sub-Saharan countries or Haiti				
Received pituitary-derived human growth hormone				
Tattoo and/or body piercing procedure- which procedure?				

## PERSONAL HABITS

Have you used or are you currently using any of the following drugs?

	YES	NO	Frequency of usage	Reason
Marijuana				
Cocaine				
Barbiturates				
Narcotics (Heroin, Methadone, Opium, etc)				
Amphetamines				
Hallucinogens				
Tranquilizers				
Anti-Depressants				
PCP				
Inhalants (Amyl or Butyl Nitrates, aerosols)				
Non-therapeutic injected drugs – list drugs?				
Over the counter drugs – list drugs?				

Alcoholic drinks? How many drinks per week or day?				
Cigarette smoking? How many packs per day?				
Coffee? How many cups per day?				
Other:				

## OCCUPATIONAL HISTORY / EXPOSURE

Please list all the jobs you have had in the past five (5) years and your possible exposure to chemicals, drugs or gases.

	Job / Duties	Dates of Employment		Exposed to which chemicals, drugs or gases (please describe)
		Year Began	Year Ended	
1				
2				
3				
4				
5				

In the past six (6) months, have you been exposed to any of the following in your living environment or while involved in hobbies?

EXPOSED TO	YES	NO	WHEN	HOW OFTEN
Toxic Chemicals				
Sprays				
Fumes / Exhaust				
Radiation				
Insecticides				
Lead / Lead Products				
Asbestos / Asbestos Products				
Cleaning Solutions / Solvents				
Recreational Drugs				

## FAMILY HEALTH HISTORY

Please describe the members of your family according to the following characteristics: (Use natural eye and hair colors)

(MGM = maternal grandmother    MGF = maternal grandfather    PGM = paternal grandmother    PGF = paternal grandfather)

	Eye Color	Hair Color	Complexion	Height	Body Type	Vision
Mother						
Father						
MGM						
MGF						
PGM						
PGF						

How many blood siblings are in your immediate family (yourself included)? \_\_\_\_\_

How many males: \_\_\_\_\_    How many females: \_\_\_\_\_    How many were adopted: \_\_\_\_\_

Are there any twins or triplets in your family?  Yes     No    If yes, what relation are they to you? \_\_\_\_\_

List below at what age members of your family died and the cause of their deaths? Please be specific and note if siblings were adopted

	Age if Living	Age at time of death	Cause of Death
Grandfather (Paternal)			
Grandmother (Paternal)			

Grandfather (Maternal)			
Grandmother (Maternal)			
	Age if Living	Age at time of death	Cause of Death
Mother			
Father			
Brother(s)			
Sister(s)			

## FAMILY MEDICAL HISTORY

Carefully review the following list of medical problems and identify any that are present in the listed family members.

	Yes	No	You	Mother	Father	Sibling	MGM / MGF PGM / PGF	Aunt / Uncle	Cousin
<b>HEART</b>									
Stroke									
Heart attack									
Heart disease									
from birth									
other									
Hardening of the arteries									
High blood pressure									
High cholesterol level									
<b>BLOOD</b>									
Anemia									
Hemophilia or other bleeding disorder									
HIV virus									
Immune deficiency									
Leukemia									
Lymphoma									
Sickle-cell anemia									
Other blood disorder									
<b>RESPIRATORY</b>									
Asthma									
Emphysema									
Hayfever / environmental allergy									
Lung cancer									
Pneumonia									
Tuberculosis									
Other lung disease									
<b>GASTRO-INTESTINAL</b>									
Colon cancer									
Crohn's disease									
Cystic fibrosis									
Developmental disorders of the stomach and intestine									
Gall stones									
Hepatitis A (infectious)									
Hepatitis B (serum)									

Intestinal cancer									
Liver cirrhosis									
<b>GASTRO-INTESTINAL</b>									
(Continued)	Yes	No	You	Mother	Father	Sibling	MGM / MGF PGM / PGF	Aunt / Uncle	Cousin
Other liver disease									
Pyloric stenosis									
Rectal disorder									
Ulcer of stomach or duodenum									
Ulcerative colitis									
Any other cancer or problem of the digestive system									
<b>METABOLIC/ENDOCRINE</b>									
Adrenal disorder or dysfunction									
Diabetes mellitus									
Goiter									
Hyperactivity									
Hypoglycemia									
Thyroid cancer									
Thyroid disease									
Other metabolic / endocrine disease									
<b>URINARY</b>									
Kidney disease									
Other disease of urinary tract (urethra, bladder, ureter)									
<b>GENITAL/REPRODUCTIVE</b>									
Cancer of cervix, ovaries or uterus									
Hermaphroditism									
Hypospadias									
Ovarian cysts									
Prostate cancer									
Testicular cancer									
Undescended testicle									
Uterine fibroids									
Other genital / reproductive disease									
<b>REPRODUCTIVE OUTCOMES</b>									
2 or more miscarriages									
Stillborn									
Death of a newborn infant									
Neonatal jaundice									
<b>NEUROLOGICAL</b>									
Alzheimer's disease									
Cerebral palsy									
Creutzfeldt-Jacob disease									
Down's syndrome									
Epilepsy / seizures									
Gaucher's disease									
Huntington's disease									
Hydrocephalus									
Mental retardation									

Migraines									
Multiple sclerosis									
<b>NEUROLOGICAL</b>									
(Continued)	Yes	No	You	Mother	Father	Sibling	MGM / MGF PGM / PGF	Aunt / Uncle	Cousin
Paraplegia									
Parkinson's disease									
Scoliosis									
Senility before age 50									
Spina bifida / neural tube defect									
Turret's syndrome									
Wilson's disease									
Other nervous system diseases									
<b>MENTAL HEALTH</b>									
Schizophrenia									
Manic depressive or bipolar disorder									
Other mental health disorder									
<b>MUSCLE / BONE / JOINTS</b>									
Arthritis									
Deformity of spine									
Dwarfism									
Gout									
Hereditary low back disease									
Loss of muscle coordination									
Lupus									
Muscular dystrophy									
Myasthenia gravis									
Osteoporosis									
Other chronic muscle disease									
<b>SIGHT / SOUND / SMELL</b>									
Blindness									
Cataracts before age 50									
Color blindness									
Congenital word blindness									
Deafness before age 60									
Deformity of the ear									
Deviated septum									
Glaucoma									
Retinoblastoma									
Other sight/sound/smell disorder									
<b>SKIN</b>									
Acne									
Eczema									
Skin cancer									
Pigmentation disorders									
Neurofibromatosis									
Other disorders of the skin									
<b>CONGENITAL ANOMALIES</b>									
Cleft lip / palate									
Congenital hip problems									

Club foot									
Other congenital anomalies									
<b>THERMOSOMAL ABNORMALITIES</b>									
	Yes	No	You	Mother	Father	Sibling	MGM / MGF PGM / PGF	Aunt / Uncle	Cousin
Turner's syndrome									
Klinefelter's syndrome									
Other									
<b>GENETIC DISORDERS</b>									
Cri du chat syndrome									
Trisomy 18									
Trisomy 13									
Fragile X syndrome									
Other genetic defects									
<b>OTHER</b>									
Alcoholism									
Drug abuse or addiction									
Breast cancer									
Early childhood / infancy death									
Learning disorder									
Recurring or chronic physical									
Any other cancer not mentioned									
Any other conditions not									
Explain	_____								
	_____								
	_____								

**CHILDRENS MEDICAL HISTORY**

Do you have any children?  Yes  No

YOUR CHILDREN	SEX	AGE	Living	Deceased	Health Problems / Age Diagnosed	Age at death	Cause of death

## YOUR GENETIC HISTORY

Have you ever been tested for the following genetic tests?

SCREENING TEST	Ethnic Background	Test Done		DATE TESTED	RESULT	
		YES	NO		Carrier	Non-carrier
Chromosomal Analysis	All					
Cystic Fibrosis	Caucasians					
Alpha ( $\alpha$ ) Thalassemia	Southeastern Asians & Philippines					
SCREENING TEST (cont)	Ethnic Background	Test Done		DATE TESTED	RESULT	
Beta ( $\beta$ ) Thalassemia	Mediterranean populations					
G-6-PD Deficiency	Italian & Greek origin					
Sickle Cell Disease	African ancestry					
Tay-Sachs Disease	Jewish ancestry					
Fragile X Syndrome						
Other :						

Do you have copies of your genetic tests?  Yes  No

Where are the results of your tests? Name of facility: \_\_\_\_\_

Address: \_\_\_\_\_

## DONOR CONSENT TO USE PHOTOGRAPH

I understand that my photograph taken and used by medical staff at American Fertility Services to enable a proper match with recipient.

I authorize AFS to show my current photograph to recipients as a part of my Anonymous Donor Profile:  Yes  No

I authorize AFS to show photographs of myself as a baby or child that I will provide to AFS :  Yes  No

Initials \_\_\_\_\_ Date \_\_\_\_\_

I, \_\_\_\_\_ swear that the information that I have provided in this Health and History Form is whole and true to the best of my knowledge.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## DONOR PERSONAL STATEMENT

Why do you want to be an egg donor? \_\_\_\_\_

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In your own words, describe your personality, character and temperament: \_\_\_\_\_

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What are your hobbies, interests and special talents? \_\_\_\_\_

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If you could pass on a message to the recipient(s) of your eggs, what would that message be? \_\_\_\_\_

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PLEASE FAX COMPLETED FORM TO:

AMERICAN FERTILITY SERVICES, GALINA KARPENKO, MD, MEDICAL DIRECTOR, EGG DONOR PROGRAM @ 212-750-3344

OR MAIL TO: AMERICAN FERTILITY SERVICES, PC, THE GALLERIA, 115 E. 57<sup>TH</sup> STREET, SUITE 500, NY, NY 10022

FOR MORE INFORMATION, E-MAIL [EGGDONATION@AMERICANFERTILITY.COM](mailto:EGGDONATION@AMERICANFERTILITY.COM)