DONOR APPLICATION & MEDICAL/GENETIC HISTORY

To: Prospective Donor

Thank you for your interest in becoming a donor. All prospective donors must complete this application and medical/genetic history questionnaire. We thank you for your honesty in supporting our efforts to maintain a safe donor population for our community.

The undersigned agrees that, to the best of her knowledge and belief, the information provided in this application is complete and correct. The undersigned furthermore agrees to report to our clinic any significant changes in the status of her health, especially in regards to sexually transmitted disease.

I certify that, to the best of my knowledge and belief, the following information provided by me in this document is complete and correct.

Donor name _____

Social Security Number_____**Birth Date (**_____**/**_____**/**_____**)**

Address _____

_____

Phone _____
Home Cell Work

_____
Donor Name (Printed) Donor Signature Date

.....

Donor Application Number (Clinic will complete):_____

_____
Reviewed By ***[Clinic Physician Name]*** Date

_____
Reviewed By ***[Other Clinic Representative]*** Date

_____
Reviewed By ***[Other Clinic Representative]*** Date

INSTRUCTIONS: Please print all of the requested information. **Write "NA" in blanks that are not applicable**. Please be specific. Avoid expressions such as "natural" or "old age" for causes of death. List any health problems as specifically as possible. Give ages to your best approximation. List exact relationships, such as "first cousin through my mother's sister." Please provide information on all relatives requested. You do not need to list names. If you have questions, please contact the clinic at *[insert donor coordinator number here*].

PERSONAL INFORMATION

Date of Birth _____ **Place of Birth** _____

Nationality (i.e. German, Irish, etc) of Mother _____ **of Father**_____

Are you adopted? Yes No

Hair color: Black Dark Brown Brown Light Brown Blonde Auburn Red

Hair texture: Straight Wavy Curly Kinky

Eye color: Blue Brown Hazel Green Blue-Green Blue-Grey Black

Height: _____inches **Weight:** _____pounds

Bone size: Small Small-Medium Medium Medium-Large Large

Complexion: Very Fair Fair Medium Olive Dark

Baldness: Yes No **Baldness in Family:** Yes No

Current Occupation: _____

Highest Degree earned: High School Vo-Tech AA Bachelors Masters Doctorate:_____

Specify Degrees: _____

Race: Native American Black, Non-Hispanic White, Non-Hispanic Latina /Hispanic
Asian/Pacific Islander East Indian Multi Race

Religion: Protestant Catholic Jewish Other (Specify):_____

Current hobbies and interests: _____

Marital Status: Married Single Divorced

How many children do you have? _____

Have you ever been convicted of a crime: Yes No

If yes, for what reason _____

If yes, did you spend any time in jail/prison: Yes No Length of time _____

DONOR RISK FACTOR HISTORY- PART 1

Specific information concerning your potential risk of HIV or hepatitis infection is required. Respond to each exclusion factor below by circling "YES" for any category you are in or "NO" for any category you are not in.

A.	Yes	No	•Persons who have injected drugs for non-medical reason in the preceding five years, including intravenous, intramuscular, or subcutaneous injections.
B.	Yes	No	•Persons with hemophilia or related clotting disorders who have received human-derived clotting factor concentrates, including non-viral inactivated Factor VIII or Factor IX concentrate.
C.	Yes	No	•Persons who have engaged in sex in exchange for money or drugs in the preceding five years.
D.	Yes	No	•Persons who have had sex in the preceding 12 months with any person described in the previous three items of this section or with any person known or suspected to have HIV infection, clinically active hepatitis B infection, or hepatitis C infection.
E.	Yes	No	•Persons who have been exposed in the preceding 12 months to known or suspected HIV, HBV, and/or HCV-infected blood through percutaneous inoculation (e.g., needle-stick) or through contact with an open wound, non-intact skin, or mucous membrane.
F.	Yes	No	•Current inmates of correctional systems (including jails and prisons) and individuals who have been incarcerated for more than 72 consecutive hours during the preceding 12 months.
G.	Yes	No	• Persons who have had close contact within the preceding 12 months with another person having clinically active viral hepatitis (e.g., living in the same household, where sharing of kitchen and bathroom facilities occurs regularly).
H.	Yes	No	•Persons who within the preceding 12 months have undergone tattooing, ear piercing, or body piercing in which shared instruments are known to have been used.
I.	Yes	No	•Persons who have had a past diagnosis of clinical, symptomatic viral hepatitis after age 11; unless evidence from the time of illness documents that the hepatitis was identified as hepatitis A (e.g., a reactive IgM anti-HAV test.
J.	Yes	No	•Persons who have known or suspected sepsis at this time.
K.	Yes	No	•Persons who have had a recent smallpox vaccination (vaccinia virus).
L.	Yes	No	•Persons who acquired a clinically recognizable vaccinia virus infection (scab or skin lesions) by close contact with someone who received the smallpox vaccine in the preceding three months.
M.	Yes	No	•Persons who have had a medical diagnosis of WNV (West Nile Virus) infection (including diagnosis based on symptoms and laboratory results, or confirmed WNV viremia in the preceding 28 days.
N.	Yes	No	•Persons who have had both a fever and a headache (simultaneously) during the preceding 7 days.
O.	Yes	No	•Persons who are suspected to have SARS or who are known to have SARS or treatment for SARS within the preceding 28 days.
P.	Yes	No	•Persons who have had close contact with the preceding 14 days with persons with SARS or suspected SARS.
Q.	Yes	No	•Persons who have traveled to or resided in areas affected by SARS within the preceding 14 days.

R. Yes No •Persons who are xenotransplantation product (transplantation, implantation, or infusion of live cells, tissues or organs from a nonhuman animal source) recipients or intimate contacts of a xenotransplantation product recipient.

S. Yes No •Persons who cannot be tested for HIV infection because of refusal, inadequate blood samples, or any other reasons.

T. Yes No •Persons with a repeatedly reactive screening assay for HIV-1, HIV-2, Hepatitis C or HTLV-1 antibody infection or high-risk behavior, such as a diagnosis of AIDS, sexually transmitted diseases or needle tracks or other signs of parenteral drug abuse.

U. Yes No •Persons whose history, physical examination or medical records reveal other evidence of hepatitis B or hepatitis C infection, such as a diagnosis of hepatitis B or hepatitis C, unexplained yellow jaundice, AST and bilirubin or prothrombin time.and Hepatitis B.

V. Yes No •Persons whose history, physical examination and medical records reveal other evidence of HIV

Please <u>circle</u> Yes or No indicating whether you have experienced each of the following conditions.

Yes No A prior reactive screening test for HIV

Yes No Unexplained weight loss

Yes No Unexplained night sweats

Yes No Blue or purple spots on or under the skin or mucous membranes typical of Kaposi's sarcoma

Yes No Disseminated lymphadenopathy (swollen lymph nodes) for longer than one month

Yes No Unexplained temperature of greater than 100.5 F. (38.6 C.) For more than 10 days

Yes No Unexplained persistent cough or shortness of breath

Yes No Opportunistic infections

Yes No Unexplained persistent diarrhea

Yes No Unexplained persistent white spots or unusual blemishes in the mouth

Yes No A prior reactive screening test for hepatitis B virus or hepatitis C virus

Yes No Unexplained jaundice

Yes No Hepatomegaly (enlarged liver)

Yes No Past diagnosis of clinical, symptomatic viral hepatitis after age 11, unless evidence from the time of illness documents that the hepatitis was identified as Hepatitis A (e.g., a reactive IgM antibody Hepatitis A virus test)

Yes No Have had or have been treated for syphilis or gonorrhea during the 12 months preceding the egg retrieval

Yes No Smallpox vaccination in the 12 months preceding the egg retrieval

Yes No Eczema vaccinatum (complication of a smallpox vaccination if a person has eczema)

Yes No Vesicular rash (small blisters) following a smallpox immunization or following close contact (e.g., living in the same household, where sharing of kitchen and bathroom facilities occurs regularly) with someone who recently had a smallpox immunization

Yes No Progressive necrosis (dying skin tissue) in the area of a smallpox vaccination

Yes No Encephalitis following smallpox vaccination

Yes No Vaccinial keratitis (infection of the cornea of the eye following smallpox vaccination)
Yes No Fever, headache, body aches, or eye pain, accompanied by skin rash on the trunk of the body
Yes No Fever, headache, body aches, or eye pain, accompanied by swollen lymph glands
Yes No Severe illness diagnosed as encephalitis, meningitis, meningoencephalitis, or acute flaccid paralysis
Yes No Symptoms of severe illness, including headache, high fever, neck stiffness, stupor, disorientation, coma, tremors, convulsions and muscle weakness or paralysis
Yes No Have been exposed or suspect exposure to SARS

If you answered yes to the previous question, complete the following

Yes No Have had a moderate respiratory illness with a temperature of greater than 100.4F (38C) and lower respiratory illness [e.g., cough, shortness of breath, difficulty breathing or hypoxia (low concentration of oxygen)]
Yes No Have had a severe respiratory illness with a temperature of greater than 100.4 F (38C) and lower respiratory illness (e.g., cough, shortness of breath, difficulty breathing or hypoxia) and radiographic evidence of pneumonia or respiratory distress syndrome
Yes No Lymphopenia (low lymphocyte count) with normal or low white blood cell count
Yes No Elevated hepatic transaminases (liver enzymes)
Yes No Elevated creatine phosphokinase
Yes No Elevated lactate dehydrogenase
Yes No Elevated C-reactive protein
Yes No Prolonged activated partial thromboplastin time
Yes No Diagnosis of sepsis (including bacteremia, septicemia, sepsis syndrome, systemic infection or septic shock)
Yes No Evidence of infection with unexplained temperature of greater than 100.4F (38C), elevated heart rate, elevated respiratory rate or elevated white blood cell count
Yes No More severe signs of sepsis including unexplained hypoxemia, elevated lactate, oliguria (less than normal urination), altered mentation and hypotension (low blood pressure)
Yes No Positive blood cultures associated with the conditions in the previous question
Yes No Reactive screening test for HTLV
Yes No Unexplained paraparesis (weakness in the lower extremities)
Yes No Diagnosis of adult T-cell leukemia

DONOR RISK FACTOR HISTORY - PART 2

1. Are you presently taking any prescribed medications? Yes No
   If yes, please specify what and why: _____

2. Did you take any prescribed medications within the last six weeks? Yes No
   If yes, please specify what and why: _____

3. Have you ever used marijuana or other illegal drugs? Yes No
   If yes, what, when and how often? _____

4. Do you smoke cigarettes? Yes No

5. Have you ever had or been treated for any form of sexually transmitted disease, including syphilis or gonorrhea?
Yes No
If yes, specify: _____

6. Did you exhibit any of the following conditions within the preceding 12 months?
Dysuria (painful urination) Yes No
Urethral Discharge Yes No
Genital Ulcer Yes No

7. In the preceding six months, did you have a sexual partner who had a Trichomonas infection? Yes No

8. Have you ever experienced any of the following conditions?
Genital Herpes Yes No If yes, list date _____
Genital Warts Yes No If yes, list date _____
Hepatitis Yes No If yes, list date _____

In the preceding 12 months, did you have sex or close contact (e.g., living in the same household, where sharing of kitchen and bathroom facilities occurred regularly) with anyone who has had?

Genital Herpes Yes No
Genital Warts Yes No
Chronic Hepatitis (carrier) Yes No

10. Do you have any tattoos? Yes No If yes, list date received: _____

11. Have you ever had acupuncture/ear piercing/body piercing? Yes No
If yes, identify type and list date(s): _____

12. Have you ever been previously excluded from blood donation? Yes No
If yes, identify the reason and date(s): _____

13. Have you ever been treated with human pituitary-derived growth hormone (pit-hGH)? Yes No
If yes, explain _____

14. Did you have a blood transfusion in the preceding 12 months? Yes No
If yes, explain _____

15. Were you bitten by an animal suspected of rabies in the preceding 12 months? Yes No
If yes, when:_____ explain _____

16. Have you been diagnosed with Creutzfeldt-Jakob (“mad cow”) disease or do you have any blood relatives with
17. non-iatrogenic Creutzfeldt-Jakob disease? Yes No
If yes, explain _____

18. Do you have any history of dementia or degenerative neurologic disorders of viral or unknown etiology?
Yes No
If yes, explain _____

18. Have you received a transplant of human dura mater? Yes No
If yes, explain _____

19. Have you been diagnosed with West Nile Virus, encephalitis or meningitis of viral or unknown cause?

Yes No

If yes, explain _____

20. Did you have a vaccination or immunization in the preceding 12 months? Yes No
If yes, explain _____

21. In the preceding 12 months, did you have sex or close contact with someone who received the smallpox vaccine? Yes No
If yes, explain _____

PERSONAL MEDICAL HISTORY

Allergies (medicines, food, pollen, etc)? Yes No

If yes, please list substance and reaction caused: _____

List any childhood allergies that you have outgrown: _____

Do you wear glasses or contact lenses or have you had laser surgery? Yes No

If yes, are/were you: _____Nearsighted _____Farsighted _____Other, please list:_____

Do you have normal hearing? Yes No

If no, please explain: _____

Condition of your teeth: _____Poor _____Fair _____Good

Usual weight?_____lbs. Recent loss or gain? Yes No

If yes _____ lbs gain/loss (circle one)

Your diet is: _____Vegetarian _____Non-vegetarian

Your diet is: _____Poor diet _____Average diet _____Excellent diet

How much exercise do you get? _____None _____Occasionally _____Regularly _____Professional Athlete

What type of exercise?_____

Have you had any serious illness or surgical procedures in the past? Yes No

If yes, please explain: _____

Have you had any operations: Yes No

If yes, please complete: Year Type of Operation

_____ _____
_____ _____
_____ _____

Have you had any hospitalizations other than for surgery? Yes No

If yes, please complete: Year Type of Illness

_____ _____
_____ _____
_____ _____

Have you ever had any broken bones? Yes No

If yes, please explain: _____

Have you ever had any serious illness? Yes No

If yes, please explain: _____

How many days in the preceding 12 months could you not work because of illness, etc. (colds, flu, accidents, surgery, etc)?
_____

Are you currently under a physician's care for any reason? Yes No

If yes, please explain:_____

List all drugs you had taken in the preceding 12 months (prescription, nonprescription, herbal & sports supplements, recreational):

Medication	How Often	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all current medications (include vitamins, aspirin, antacids, laxatives, herbal & sports supplements, etc.)

Medication	How Often	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever taken anti-malarial drugs or had malaria? Yes No

If yes, please explain: _____

Have you had any major radiation exposure or X-ray exposure? Yes No

If yes, please explain: _____

Have you ever had or been treated for syphilis? Yes No

If yes, when: _____ How many times? _____ When was the last time? _____

Have you ever had or been treated for gonorrhea? Yes No

If yes, when: _____ How many times? _____ When was the last time? _____

Have you been tested for HIV (AIDS)? Yes No

If yes, when: _____ Reason for testing: _____

Sexual Preference: Homosexual Heterosexual Both Neither

Have you or any of your sexual partners ever had:

NSU (non specific urethritis)	Myself:	Yes	No	If yes, when_____
	Partner:	Yes	No	If yes, when_____
Chlamydia	Myself:	Yes	No	If yes, when_____
	Partner:	Yes	No	If yes, when_____
Venereal warts	Myself:	Yes	No	If yes, when_____
	Partner:	Yes	No	If yes, when_____

Have you or any of your sexual partners ever had:

Herpes	Myself:	Yes	No	If yes, when_____
	Partner:	Yes	No	If yes, when_____
Other sexually Transmissible diseases	Myself:	Yes	No	If yes, when_____
	If Yes explain STD:_____			
	Partner:	Yes	No	If yes, when_____
	If Yes explain STD:_____			

Have you ever had any major illnesses such as amoebic dysentery, hepatitis, pneumonia, mononucleosis, etc? Yes No

If yes, please explain:_____

Has anyone in your family, including yourself, experienced recurring and/or chronic physical symptoms that have not been evaluated by a physician? (Please include those symptoms that you may not consider serious.) Yes No

If yes, please explain:_____

Did you travel outside the United States (except Canada) in the preceding three years? Yes No

If yes, when and where? _____

Have you ever been exposed to "agent orange" or any other herbicides or chemicals in military action or elsewhere? (forest service, highway maintenance, etc.) Yes No

Which substance(s)? _____

If yes, when: _____ Where? _____

Have you ever used or do you currently use any of the following drugs?

Marijuana	Yes	No	If yes, Frequency/Year(s)_____	How Used_____
Cocaine	Yes	No	If yes, Frequency/Year(s)_____	How Used_____
Barbiturates	Yes	No	If yes, Frequency/Year(s)_____	How Used_____
Narcotics/Opiates (Heroin, Methadone, Opium, Morphine, Codeine)	Yes	No	If yes, Frequency/Year(s)_____	How Used_____
Amphetamines	Yes	No	If yes, Frequency/Year(s)_____	How Used_____
Hallucinogens	Yes	No	If yes, Frequency/Year(s)_____	How Used_____

Tranquilizers Yes No If yes, Frequency/Year(s)_____How Used_____

PCP Yes No If yes, Frequency/Year(s)_____How Used_____

Inhalants Yes No If yes, Frequency/Year(s)_____How Used_____

Steroids Yes No If yes, Frequency/Year(s)_____How Used_____

Do you drink alcoholic beverages: Yes No

If yes, which kinds? _____Beer _____Wine _____Liquor

Approximately how many drinks per day or week do you consume?_____

If you drink less than 3 drinks per day, was there ever a time when you drank more? Yes No

If yes, how much_____ When (give years)_____

Do you have any relatives with alcoholism? Yes No

If yes, who?_____

Do you use tobacco products? Yes No

If cigarettes, how many packs a day? _____How long have you been smoking regularly?_____

Other tobacco products? _____

If you did smoke but quit, when did you last smoke?_____

What is your current or most recent occupation?_____

Please list all the jobs you have had in the preceding five years and your possible exposure to chemicals, drugs and gases. Please consider carefully.

Jobs/Duties	Dates of Employment		Exposed to which chemicals, drugs or gases.
	Year Began	Year Ended	
1.			
2.			
3.			
4.			
5.			

In the preceding six months, were you exposed to any EXCESSIVE amounts of the following in your living environment or while involved in hobbies? If yes to any of these, give dates and how often you have been exposed. Please consider carefully.

Exposed to	Yes/No	When	How Often
Toxic Chemicals or Substances	Yes No		
Sprays	Yes No		
Fumes/Exhaust	Yes No		
Radiation	Yes No		
Flea powder/sprays	Yes No		
Lead/Lead products	Yes No		
Asbestos/Asbestos products	Yes No		
Cleaning solutions/solvents	Yes No		

Do you have any brothers or sisters who died in infancy or childhood? Yes No
If yes, what was the cause?_____

Are there any known genetic diseases or conditions that run in your family? Yes No
If yes, what are they? _____

Family Fertility History: Please list below any family members who experienced miscarriages:

Family Member (Sister, Aunt, etc.)	Paternal or Maternal	Age	Number of Miscarriages
1.			
2.			
3.			
4.			

Were you vaccinated for any reason in the preceding 12 months? Yes No
If yes, why, when and for what? _____

Were you exposed to known or suspected HIV, Hepatitis B or Hepatitis C infected blood through percutaneous inoculation or through contact with an open wound, non-intact skin or mucous membrane in the preceding 12 months? Yes No

If yes, explain: _____

Please indicate with a check mark whether you currently have, have had in the past, or have ever been treated for:

Yes	No		Yes	No	
_____	____	Blood transfusion	_____	____	frequent urinating
_____	____	Prolonged fever	_____	____	waking at night to urinate
_____	____	Urethral discharge	_____	____	cancer
_____	____	Renal disease	_____	____	sores or discharge
_____	____	Psychiatric disorders	_____	____	bleeding or bruising
_____	____	Rashes, color change	_____	____	poor appetite
_____	____	Itching	_____	____	gas, cramps, pains
_____	____	Warts, moles	_____	____	heartburn, indigestion
_____	____	Eczema, lumps, hives	_____	____	nausea, vomiting, constipation, diarrhea
_____	____	Very dry skin	_____	____	diabetes
_____	____	Excessive sweating	_____	____	yellow jaundice, hepatitis B or C
_____	____	Minor injury	_____	____	hemorrhoids
_____	____	Anemia	_____	____	hernia
_____	____	Lymph node or gland swelling	_____	____	gall bladder problems
_____	____	Ear trouble, infections	_____	____	pains in joints, arthritis
_____	____	Blood in stool or black stool	_____	____	swollen joints
_____	____	Hearing loss, ringing in ear	_____	____	back pain, neck pain
_____	____	Eye problems	_____	____	head injury, concussion
_____	____	Nosebleeds	_____	____	headaches
_____	____	Sore throats	_____	____	dizziness, fainting
_____	____	Stuffy nose, sinus trouble, hay fever	_____	____	convulsions, seizures, fits
_____	____	High blood pressure	_____	____	shaking, tremor
_____	____	Hoarseness	_____	____	weakness, paralysis
_____	____	Dental or gum problems	_____	____	numbness, tingling
_____	____	Enlarged or painful breasts	_____	____	difficulty walking, coordination
_____	____	Breast lumps	_____	____	poor circulation, varicose veins
_____	____	Discharge from nipples	_____	____	depression, anxiety
_____	____	Shortness of breath	_____	____	poor sleeping
_____	____	Cough, chest colds	_____	____	nervousness, tension
_____	____	Wheezing, asthma	_____	____	trouble thinking, remembering
_____	____	Chest pain, pleurisy	_____	____	crying, upset, worrying
_____	____	Tb or exposure to Tb	_____	____	sexual problems
_____	____	Fevers, sweats, chills	_____	____	goiter, thyroid problems
_____	____	Pneumonia	_____	____	blood clots
_____	____	Previous heart trouble	_____	____	murmurs or rheumatic fever
_____	____	Fast or irregular heartbeat	_____	____	waking short of breath
____	____	Chest pain, tightness, pressure	_____	____	swelling of feet or ankles
_____	____	trouble breathing when lying down	_____	____	trouble swallowing
_____	____	endometriosis	_____	____	genital warts/papilloma virus (HPV)
_____	____	Pelvic infection (PID	_____	____	vaginal bleeding other than menses
_____	____	Diabetes	_____	____	urethritis
_____	____	Cervical polyps	_____	____	abnormal pap test

If yes for any of the above, please explain:_____

_____

_____

_____

_____

_____

Donor Fertility\Social History

Age at onset of menses _____

# of days from beginning of one cycle to the next naturally:_____ Average:_____ Range:_____

# of days from beginning of one cycle to the next if on Birth Control Pills_____

Number of current sexual partners:_____

Number of sexual partners during last six months:_____

Number of total past sexual partners:_____

Pregnancy History:

# of times you have had a confirmed pregnancy_____

# of losses_____ Spontaneous_____ Elective_____

# of living children_____

Length of time it took you to get pregnant. Shortest_____ Longest_____

Contraceptive History:

Currently use: _____IUD _____Diaphragm _____Condom _____Birth Control Pills

_____Rhythm _____Spermicide _____Depo-Provera

If Birth Control Pills, _____(name)

How long on Birth Control Pills_____

Why did you start taking Birth Control Pills?_____

If Depo-Provera when was your last injection?_____

Explain any "yes" answers: _____

_____

_____

_____

_____

Donation History

Have you applied or been screened to be an egg donor before? _____Yes _____No

If yes, list name and location of egg donor program(s):_____

_____

_____

Were you accepted as a egg donor? _____ Yes _____ No

If yes, how many times did you cycle? _____

Are you currently enrolled as an egg donor in another program?_____Yes _____No

If YES, what IVF Center?_____

DONOR GENETIC HISTORY

Were you born with any birth defects (heart defect, cleft lip or palate, club feet, other)? Yes No
If yes, explain:_____

Are there any known genetic conditions or birth defects in your family? Yes No
If yes, explain:_____

Are you of Jewish ancestry? Yes No Unknown

If yes, please check: _____ Ashkenazi _____ Sephardic _____ Other

Have you been tested as a carrier for any of the following diseases:

Tay Sachs:	Yes	No
Gaucher:	Yes	No
Canavan:	Yes	No
Fanconi Anemia Group C:	Yes	No
Niemann-Pick type A:	Yes	No
Mucolipidosis type IV:	Yes	No
Familial Dysautonomia:	Yes	No
Blooms Syndrome:	Yes	No

If yes, result(s):

Tay Sachs:	_____carrier	_____not carrier	_____unknown
Gaucher:	_____carrier	_____not carrier	_____unknown
Canavan:	_____carrier	_____not carrier	_____unknown
Fanconi Anemia Group C:	_____carrier	_____not carrier	_____unknown
Niemann-Pick type A:	_____carrier	_____not carrier	_____unknown
Mucolipidosis type IV:	_____carrier	_____not carrier	_____unknown
Familial Dysautonomia:	_____carrier	_____not carrier	_____unknown
Blooms Syndrome:	_____carrier	_____not carrier	_____unknown

Are you of African American Ancestry? Yes No Unknown
If yes, have you been tested as a carrier of sickle cell disease? Yes No Unknown

If yes, result: _____carrier _____not carrier _____unknown

Are you of Mediterranean, Chinese or Southeast Asian ancestry? Yes No Unknown

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

If yes, result: _____carrier _____not carrier _____unknown

FAMILY HISTORY

A. Please list the requested information below:

Relative	Eye Color	Hair Color	Complexion*	Height	Bone Size**	Ethnic Origin
Mother						
Father						
Maternal Grandfather						
Maternal Grandmother						
Paternal Grandfather						
Paternal Grandmother						

* Fair, Fair-Medium, Medium, Olive, Dark ** Small, Small-Medium, Medium, Medium-Large, Large

B. Fill in the appropriate space for each of the following relatives. List all specific health problems, operations, and/or causes of death (include stillborns, infant deaths and childhood deaths) for each individual. Please use the "Specific Conditions listed below to aid in the completion of this segment. Do not use "old age" or "natural causes."

Your Mother

Current Age or Age at Death	Health Problem	Age Diagnosed	Living / Dead
	_____	_____	_____ _____
	_____	_____	_____ _____
	_____	_____	_____ _____

Your Father

Current Age or Age at Death	Health Problem	Age Diagnosed	Living / Dead
_____	_____	_____	_____ _____
	_____	_____	_____ _____
	_____	_____	_____ _____
	_____	_____	_____ _____

Your Brothers

Current Age or Age at Death	Health Problem	Age Diagnosed	Living / Dead
_____	_____	_____	_____ _____
_____	_____	_____	_____ _____
_____	_____	_____	_____ _____
_____	_____	_____	_____ _____

Your Sisters

Current Age or Age at Death	Health Problems	Age Diagnosed	Living / Dead
_____	_____	_____	_____ _____
_____	_____	_____	_____ _____
_____	_____	_____	_____ _____
_____	_____	_____	_____ _____
_____	_____	_____	_____ _____

Your Daughters

Current Age or Age at Death	Health Problems	Age Diagnosed	Living / Dead
_____	_____	_____	_____ _____
_____	_____	_____	_____ _____
_____	_____	_____	_____ _____
_____	_____	_____	_____ _____

Your Sons

Current Age or Age at Death	Health Problems	Age Diagnosed	Living / Dead
_____	_____	_____	_____ _____
_____	_____	_____	_____ _____
_____	_____	_____	_____ _____
_____	_____	_____	_____ _____

Your Grandfather (your mother's father)

Current Age or Age at Death	Health Problems	Age Diagnosed	Living / Dead
_____	_____	_____	_____ _____
	_____	_____	_____ _____
	_____	_____	_____ _____
	_____	_____	_____ _____

Your Grandmother (your mother's mother)

Current Age or Age at Death	Health Problems	Age Diagnosed	Living / Dead	
_____	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

Aunts (your mother's sisters)

Current Age or Age at Death	Health Problems	Age Diagnosed	Living / Dead	
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____		_____	_____
_____	_____	_____	_____	_____

Uncles (your mother's brothers)

Current Age or Age at Death	Health Problems	Age Diagnosed	Living / Dead	
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____		_____	_____

Your Grandfather (your father's father)

Current Age or Age at Death	Health Problems	Age Diagnosed	Living / Dead	
_____	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

Your Grandmother (your father's mother)

Current Age or Age at Death	Health Problems	Age Diagnosed	Living / Dead
_____	_____	_____	_____ _____
	_____	_____	_____ _____
	_____	_____	_____ _____
	_____	_____	_____ _____

Aunts (your father's sisters)

Current Age or Age at Death	Health Problems	Age Diagnosed	Living / Dead
_____	_____	_____	_____ _____
_____	_____	_____	_____ _____
_____	_____	_____	_____ _____
_____	_____	_____	_____ _____

Uncles (your father's brothers)

Current Age or Age at Death	Health Problems	Age Diagnosed	Living / Dead
_____	_____	_____	_____ _____
_____	_____	_____	_____ _____
_____	_____	_____	_____ _____
_____	_____	_____	_____ _____

Look through the following list of medical problems and indicate (check) which ones you or one of your relatives have had. Please consider each condition carefully for each family member. Explain any conditions you check below, indicating which side of the family (maternal/paternal), the age of the family member at the onset of the condition/problem, and any other pertinent information. If you and none of your indicated family members have a history of the specific medical condition, you must check "None."

Medical Problem	None	Self	Mother	Father	Sibling	Child	Grand parents	Aunt/ Uncle	Cousin	Explain which side of family, age at onset, etc
1. Heart										
Stroke										
Heart Attack										
Congenital Heart Disease										
Heart Disease										
High Blood Pressure										
2. Blood										
Anemia										
Sickle-cell anemia										
Hemophilia or other bleeding problem										
Leukemia										
Immune deficiency										
Polyarteritis nodosa										
Other blood disorder										
3. Respiratory (lungs)										
Hay fever										
Asthma										
Emphysema										
Tuberculosis										
Lung Cancer										
Pneumonia										
Cystic fibrosis										
Alpha-1 antitrypsin disorder										
Other lung disease										

Medical Problem	None	Self	Mother	Father	Sibling	Child	Grand parents	Aunt/ Uncle	Cousin	Explain which side of family, age at onset, etc
4. Gastrointestinal										
Ulcer of stomach/ duodenum										
Gallstones										
Hepatitis A (infectious)										
Hepatitis B (serum)										
Other liver disease										
Ulcerative colitis										
Pyloric stenosis										
Crohn's disease										
Intestinal cancer										
Inflammatory bowel disease										
Rectal disorder										
Any other cancer/ problem of the digestive system										
5. Metabolic/ Endocrine										
Diabetes mellitus requiring insulin therapy										
Diabetes not requiring insulin therapy										
Hypoglycemia										
Thyroid cancer										
Thyroid disease										
Goiter										
Adrenal dysfunction or Disorder										
Hyperactivity										
PKU or inherited metabolism disorder										
6. Urinary										
Progressive kidney disease										
Polycystic kidney disease										
Other disease of urinary tract (urethra, bladder, ureter)										

Medical Problem	None	Self	Mother	Father	Sibling	Child	Grand parents	Aunt/ Uncle	Cousin	Explain which side of family, age at onset, etc
7. Genital/ Reproductive System										
Uterine fibroids										
Ovarian cysts										
Cancer of cervix, ovaries or uterus										
Miscarriage or Stillborn										
Herpes Simplex Virus, Genital										
8. Neurological										
Migraines										
Mental retardation										
Senility or mental deterioration before age 50										
Multiple sclerosis										
Cerebral palsy										
Epilepsy/seizures										
Neural tube defects (open spine or hydrocephalus/ water on the brain)										

Medical Problem	None	Self	Mother	Father	Sibling	Child	Grand parents	Aunt/ Uncle	Cousin	Explain which side of family, age at onset, etc
9. Mental Health										
Schizophrenia										
Manic depressive psychosis										
10. Muscles/Bones /Joints										
Muscular dystrophy										
Other chronic muscle disease										
Loss of muscle coordination										
Spinal muscular atrophy										
Systemic Lupus										
Deformity of spine										
Osteoporosis										
Dwarfism										
Disorders of the spinal cord										
Gaucher's disease										
Wilson's disease										
Creutzfeldt-Jakob disease										
Huntington's disease										
Tuberous Sclerosis										
Neurofibromatosis										
Dementia or degenerative disorder										
Alzheimer's										
Parkinson's disease										
Brain tumor										
Myasthenia Gravis										
Down's syndrome/ mongolism										
Transmissible Spongiform Encephalopathy										
Other diseases of nervous system										
Hereditary low back disorder										
Rheumatoid Arthritis										
Reiter's disease										

Gout										
Club foot										
Metabolic bone disease										
11. Sight/Sound/ Smell										
Deafness before age 60										
Deformity of the ear										
Cataracts before age 60										
Blindness in both eyes before age 60										
Color Blindness										
Glaucoma										
Deviated septum										
Any other sight/ Sound /smell disorder										

Medical Problem	None	Self	Mother	Father	Sibling	Child	Grand parents	Aunt/ Uncle	Cousin	Explain which side of family, age at onset, etc
12. Skin										
Acne										
Eczema										
Psoriasis										
Pigmentation disorders										
Albinism										
Infectious skin disease										
More than 5 purple- or coffee- colored spots on skin (size of quarter or larger)										
Numerous lumps under the skin										
Other skin disorders										
13. Other										
Alcoholism										
Drug abuse, misuse, or addiction										
Breast cancer										
Any cancer not mentioned above										
Cleft palate or cleft lip										
Serious birth defects										
Inguinal hernia										
Early Death (less than age 50)										
Sarcoidosis										
Premature degeneration of any organ system										
Any other condition not mentioned above										

OOCYTE DONOR ELIGIBILITY SUMMARY OF RECORDS

Donor Identification # _____ Donor Age_____

Pre-IVF Donor Eligibility Documentation

		Acceptable (Initial/Date)	**Non-Acceptable (Initial/Date)**
a.	Medical/Genetic History	_____	_____
b.	Physical Examination	_____	_____
c.	Initial Serology Testing:		
	Blood Draw Date:_____		
	ABO, Rh: _____	_____	_____
	HIV 1 &2	_____	_____
	HBsAg	_____	_____
	HBcore	_____	_____
	HVC	_____	_____
	Syphilis	_____	_____
	CBC	_____	_____
	Chlamydia	_____	_____
	N. gonorrhea	_____	_____
	NAT: HIV1/HCV	_____	_____
d.	Genetic Testing (Enter NA and Initial/Date if not completed)		
	Cystic Fibrosis	_____	_____
	Chromosome Analysis		
	Jewish Ethnic Testing	_____	_____
	Hemoglobinopothies		
	Other testing (list)		
	_____	_____	_____
e.	Endocrinology	_____	_____
f.	Donor Age	_____	_____
g.	Psychology Evaluation	_____	_____

Pre-IVF Donor Preliminary Approval: _____ _____

Medical Director Date

Note: Additional serology testing is required only if the initial blood draw date is more than 30 days prior to the oocyte retrieval date.

Original Blood Draw Date within 30 days of oocyte retrieval Yes / No

Final Blood Draw Date: _____

Ooctye Retrieval Date: _____

	Acceptable (Initial/Date)	**Non-Acceptable (Initial/Date)**
Serology Testing		
HIV 1 &2	_____	_____
HBsAg	_____	_____
HBcore	_____	_____
HVC	_____	_____
Syphilis	_____	_____
Chlamydia	_____	_____
N. gonorrhea	_____	_____
NAT: HIV1/HCV	_____	_____

Based on Results of Screening and Testing the donor is; **ELIGIBLE / INELIGIBLE**
(circle one)

Final Donor Approval: _____ _____

Medical Director Date