



First Name:

Last Name:

Address:

City:

State: **Zip Code:**

Phone:

Email Address :

Ethnicity: **Jewish:** Yes

Ethnic Origin Maternal:

Ethnic Origin Paternal:

Religious / Spiritual Affiliation:

Date of Birth: mm/eddy

Weight: pounds

Height:

Eye Color:

Natural Hair Color:

Current Hair Color:

Complexion
:

Academic Achievement

Educational Level:

SAT: **ACT:**

GPA: College: High School:

Major:

Degree:

Family Background

| | Age | Height | Hair Color | Eye Color |
|------------------------------|----------------------|----------------------|----------------------|----------------------|
| Father: | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Mother: | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Paternal Grandfather: | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Paternal Grandmother: | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Maternal Grandfather: | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Maternal Grandmother: | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Sibling 1 | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Sibling 2 | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Sibling 3 | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Sibling 4 | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

Mother's Occupation:

Mother's Educational Level:

Father's Occupation:

Father's Educational Level:

Sibling's Occupations:

Educational Level:

Children If Applicable

Name: Age Eye Color Hair Color

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Personality

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Name: Age Eye Color Hair Color

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Personality

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Name: Age Eye Color Hair Color

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Personality

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Describe your personality and character:

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Hobbies/Talents:

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Describe yourself as a child:

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Why do you want to become a donor?

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What message would you like to pass on to the recipients of your eggs?

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Health History

Blood type : (If Known)

General Health Condition :

Do you have any past or current medical problems? Please explain.

Are you currently taking any over the counter or prescription medications, including vitamin or herbal supplements? Please explain.

Do you or anyone in your family wear glasses or contacts?

Do you or anyone in your family have a history of drug or alcohol abuse? Please explain.

List deceased family members: (Please include any primary relatives or grandparents)

| Name | Relationship | Age at time of Death | Cause of Death |
|----------------------|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

Family and Personal Medical History

Medical Conditions (Please indicate which family member including (Mother, Father, Aunts, Uncles, Cousins, Siblings, Grandmother, Grandfather)

SELF

*FAMILY

COMMENTS

1 Physical malformations, e.g. cleft palate, club foot, congenital heart defect, birth defects, etc.

2 Paralysis or crippling disorder e.g. muscular dystrophy, multiple sclerosis, cerebral palsy, spina bifida, etc.

3 Seizure, convulsions, or epilepsy

4 Sight, hearing, or speech impairments

5 Learning disabilities, Autism Spectrum Disorders

6 Chromosomal abnormalities, e.g. Down's Syndrome, etc.

7 Endocrine disorder e.g. diabetes, thyroid, etc

8 Arthritis (rheumatoid, osteo)

9 Allergies (food, seasonal), asthma, hay fever, eczema, bee stings

10 Blood diseases e.g. hemophilia, sickle cell anemia, hepatitis, etc

11 Ovarian problems e.g. cysts, cancer

12 Uterine/Cervical problems e.g. fibroids, endometriosis, cervical disease, abnormal pap smear

13 Memory loss, dementia, Alzheimer's

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14 Osteoporosis

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15 Kidney disorder (stones, failure, infection)

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16 Cardiovascular problems e.g. high blood pressure, stroke, heart attack, etc.

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17 Alcoholism

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18 Cancer (type/location)

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19 Significant illness (cystic fibrosis, lupus, etc)

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20 Spontaneous abortions, miscarriages, stillbirths, neonatal deaths.

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Psychological History

Have you or anyone in your family been diagnosed with a psychological/neurological disorder such as Alzheimer's, bi-polar disorder, clinical depression or schizophrenia? Please explain who and the details.

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Have you or anyone in your family been diagnosed or treated for depression? Please explain.

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Have you or has anyone in your family been on medication for a psychological condition? Please explain.

Do you or anyone in your family have a history or treated for hyperactivity/ADHD/ADD?

Fertility History

Number of Children:

Males

Ages

Females

Ages

Number of Pregnancies

Has anyone in your family had multiple births (i.e. twins, triplets)? Please explain

Previous Donor?

Yes No

Did a pregnancy occur?

Yes No

What method of birth control are you currently using?

Lifestyle

Current Occupation:

Previous Occupation(s):

Career Goals:

Marital Status:

Do you have a sexual partner? Yes No For how long?

Have you or any of your sexual partners ever had: Other:

Have you ever had a sexual partner that was bi-sexual or a partner that has been sexual with a bisexual? Yes
 No

Have you had plastic surgery? Yes No

If yes, please explain:

Have you had a tattoo or body piercing within the last year? Yes No

Have you ever been arrested? Yes No

If yes, what was the charge?

Were you convicted? Yes No

Any criminal history in your family? Yes No

If yes, please explain:

My current living situation is:

Do you smoke?

Yes No

Do you drink alcohol? If so, how many drinks per week? (Specify wine or beer and how many drinks per week.)

Do you use illicit, illegal drugs, e.g. Cocaine, LSD, Methamphetamines, Marijuana? Yes No

Have you or your sexual partners ever injected illicit drugs? Yes No