



Donor # _____

Egg Donor Application

The Center for Egg Options, LLC

Date _____

Personal Information

Full Legal Name _____

Present Address _____

street

apt.#

city

state

zip code

Home Phone (_____) _____ May we leave a message? Yes No

Work Phone (_____) _____ May we leave a message? Yes No

Cell Phone (_____) _____ May we leave a message? Yes No

E-mail address _____

Social Security # ____ - ____ - _____

Who to contact in case of Emergency _____

Phone Number (_____) _____ Relationship _____

How did you hear about us? _____

Would you be interested in donating to a single parent? Yes No

To a same-sex couple? Yes No

The following information will be shown to potential recipients for their review. Do not put any identifying information on the following pages. If a couple chooses you as their donor, they will keep this information as a medical history base for their potential offspring. We appreciate your accuracy in filling out your donor application. Please include as much detail as possible when filling in your family medical history.

General Information

Age _____ Date of Birth ____/____/____ Birthplace _____

Height _____ Weight _____ Eye Color _____ Natural Hair Color _____

Hair Type: (check the appropriate) Curly Wavy Straight Thick Medium Thin

Skin Tone: (check the appropriate) Fair Medium Olive Dark

Are you: (check the appropriate) Right Handed Left Handed Ambidextrous

Marital Status: (check the appropriate) Married Significant Other Single Separated Divorced

Racial Group: Caucasian African American Asian Hispanic Other _____

Ancestral Background of Mother: _____

Ancestral Background of Father: _____

Are you adopted? _____

If yes, do you know the medical history of your birth parents? _____

Are either of your biological parents adopted? _____

Religion: _____ Currently practicing? Yes No

Have you ever been an egg donor before? Yes No If yes, who was the doctor? _____

Do you know how many eggs were retrieved? _____

Do you know if your donation resulted in a pregnancy? _____

Are you currently employed? Yes No If yes, what is your occupation?

Future Career Goals? _____

Have you ever been arrested? Yes No

If yes, please explain when and why? _____

Level of Education

Completed High School Yes No Year _____ GPA _____

Received GED Yes No Year _____

Testing Scores: SAT _____ ACT _____ GRE _____ MCAT _____ Other _____

Do you have any College Education or attended any Certification Programs? Yes No

If yes, what college or certification program do/did you attend? _____

What is/was your major? _____

Did you earn a degree? Yes No GPA _____

If yes, what is it? _____

If no, when will you finish your degree? _____

Have you pursued an advanced degree? Yes No If yes, name of the institution and what is the degree in? _____

Honors and Awards _____

List your favorite classes _____

List your least favorite classes _____

Education level of Mother _____ **Mother's Occupation** _____

Education level of Father _____ **Father's Occupation** _____

Education level of Siblings _____

Siblings Occupations: _____

Medical Information

Describe your current health status: Excellent Good Fair Poor

Date of your last physical exam? _____

Are you currently under a physician's care for any reason? Yes No If yes, please explain:

Do you exercise regularly? Yes No

Vision: (check the appropriate) 20/20 Nearsighted Farsighted

If near or farsighted, please check the severity: Mild Moderate Severe

Do you have: (check the appropriate) Glasses Contacts Corrective Eye Surgery None

Hearing: Normal Impaired, please explain: _____

Blood Type (if known) _____

Have you ever had a blood transfusion Yes No If yes, please explain when and why: _____

Have you ever had any surgery (including plastic surgery)? Yes No If yes, please explain the surgical

procedure and date: _____

Have you ever worn braces? Yes No

Please list any major illnesses you have experienced: _____

Do you have any allergies to food, medications and other substances? Yes No If yes, please explain:

List any prescription, non-prescription medications, vitamins or herbs that you are taking:

Name of Drug	How often	Reason	Length of time
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Have you ever taken any anti-depressants, tranquilizers or anti-anxiety medication? Yes No

If yes, please explain: _____

Do you or have you ever used any recreational/illegal drugs (including steroids) Yes No

If yes, please list and explain: _____

Have you ever smoked? Yes No If yes, when did you quit? _____

Do you drink alcoholic beverages? Yes No How old were you when you started drinking? _____

When was the last time you had a drink? _____ How many times a month do you drink? _____

Have you had any body piercing, tattooing or acupuncture in the last 12 months where questionable sterile procedures were used? Yes No If yes, please describe: _____

Reproductive History

Are you currently sexually active? Yes No

If yes, are you in a monogamous relationship (only one sexual partner at a time) Yes No

What type of contraception are you currently using? (check the appropriate):

- Not Sexually Active
- Condoms
- Birth Control Pills
- Depo Provera
- IUD
- Patch
- Tubal Ligation
- Vasectomy

How long have you been using this form of birth control? _____

Have you ever been treated for the following sexually transmitted diseases? Yes No

- Syphilis
- Genital Warts
- Gonorrhea
- Chlamydia
- Herpes
- Other

Have you or any of your sexual partners ever had sex with gay/bisexual men or IV drug users? Yes No

Do you have any clinical or laboratory evidence of HIV (AIDS)? Yes No

Have you had sex with any person with known or suspected HIV (AIDS) or hepatitis infection? Yes No

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Have you been exposed to known or potentially HIV or hepatitis-infected blood through needle sticks, an open wound, or mucous membranes in the last 12 months? Yes No

Do you have regular periods? Yes No Age at onset of first menstrual period: _____

How many days apart are your periods? _____ Duration of flow: _____

Do you have any problems related to your periods? Yes No If yes, please explain: _____

Date of Last Pap Smear: _____ Normal Abnormal

Have you ever had an abnormal pap smear? Yes No If abnormal, please explain _____

Do you plan on having children in the future? Yes No

Have you ever been pregnant? Yes No If yes, how many children do you have? _____

Age and sex of child/children: _____

Describe your child/children's current health history and any medical problems: _____

Are you currently breastfeeding? Yes No

Have you ever had an abortion? Yes No If yes, how many times? _____

Have you ever had a miscarriage? Yes No If yes, how many times and what were the circumstances?

(how far along were you, health problems, etc.) _____

Do you have any family history of miscarriage? Yes No

Have you ever undergone any fertility treatments to become pregnant? Yes No If yes, please explain: _____

Family Medical History

Do you or anyone in your family (mother, father, brothers, sisters, aunts, uncles, cousins, nieces, nephews, grandparents, children) have/ had any of the following medical or psychiatric conditions? If yes, please explain (at what age did the condition begin and what side of the family) in the spaces provided.

- **It may be helpful to contact other family members to get more specific details regarding past or present medical and/or psychological conditions.**
- **Please try to include the date/age of diagnosis and other medications used for any particular disorder.**
- **For the tables on the following pages, please indicate whether the relative in question is on your father or mother's side of the family. Also, please indicate gender (M=male; F=female) if not already specified. Do not include information about step-family members, such as stepfather or stepsister.**

Use the following abbreviations for the following pages:

MGM = maternal grandmother
PGM = paternal grandmother

MGF = maternal grandfather
PGF = paternal grandfather

MA/MU = maternal aunt/uncle
PA/PU = paternal aunt/uncle

	No One	You	Mother	Father	Sister/Brother	MGM/MGF PGM/PGF	Aunt/Uncle	Cousin
BLOOD								
Anemia								
Leukemia								
Lymphoma								
Immune deficiency								
Hemophilia								
Clotting disorder								
Thalassemia								
Sickle cell disease								
Other bleeding disorders								
HEART								
Heart disease (from birth)								
Irregular heart beat (arrhythmia)								
Heart valve disease								

Heart attack								
High blood pressure								
High cholesterol								
Stroke								
Aneurysm								
Other heart conditions								
	No One	You	Mother	Father	Sister/Brother	MGM/MGF PGM/PGF	Aunt/Uncle	Cousin
RESPIRATORY								
Asthma								
Emphysema								
Lung cancer								
Pneumonia								
Cystic fibrosis								
Other respiratory conditions								
GASTROINTESTINAL								
Ulcer of stomach/duodenum								
Gallstones								
Cirrhosis								
Hepatitis A (infectious)								
Hepatitis B (serum)								
Hepatitis C								
Ulcerative colitis								
Colon cancer								
Crohn's disease								
Intestinal cancer								
Other gastrointestinal disorders								
METABOLIC/ENDOCRINE								
Tay-Sach's disease								
Diabetes—type 1 (juvenile onset)								
Diabetes—type 2 (adult onset)								
Thyroid disease								

Thyroid cancer								
Other metabolic/ endocrine disorders								
URINARY								
Kidney disease								
Other Urinary disorders								
	No One	You	Mother	Father	Sister/Brother	MGM/MGF PGM/PGF	Aunt/Uncle	Cousin
REPRODUCTIVE								
Prostate cancer								
Uterine fibroids								
Ovarian cysts								
Cancer of cervix/ovaries/ uterus								
Endometriosis								
Breast disorders								
Breast cancer								
Recurrent miscarriages								
Still births								
Death of a newborn								
Infertility								
Other reproductive disorders								
CONGENITAL ANOMOLIES								
Congenital hip problems								
Cleft lip/palate								
Chromosome problems								
Down's syndrome								
Trisomy 13 or 18								
Fragile X syndrome								
Turner's syndrome								
Other congenital anomalies								
MUSCLES/BONES/JOINTS								
Rheumatoid arthritis								
Scoliosis								

Other muscle/bone/joint disorders								
	No One	You	Mother	Father	Sister/Brother	MGM/MGF PGM/PGF	Aunt/Uncle	Cousin
NEUROLOGICAL								
Migraines								
Mental retardation								
Multiple sclerosis								
Cerebral palsy								
Epilepsy/seizures								
Spina bifida/neural tube defects								
Other neurological disorders								
MENTAL HEALTH								
Schizophrenia								
Depression								
Bipolar disorder								
Postpartum depression								
Attention deficit hyperactivity disorder (ADHD)								
Other mental health disorders								
SKIN								
Severe acne								
Eczema								
Skin cancer								
Other skin disorders								
OTHER								
Alcoholism								
Drug abuse or addiction								
Obesity								
Other disorder								

Have you ever lived outside of the United States? Yes No If yes, where and dates. _____

Personal Questions

1. Explain your personal reasons for becoming an egg donor.

2. Have you discussed your desire to donate with your family/friends? Are they supportive of your decision?

3. Describe your personality (both positive and negative aspects).

4. What skills or talents do you possess (i.e. arts, academics, interactive skills, etc.)? Have you received any types of awards or recognition for these skills/talents?

5. What are your hobbies and interests?

6. What clubs, organizations, groups or teams do you belong to or have belonged to in the past?

7. What physical activities do you participate in? What physical activities do you excel in? Have you received any awards or recognition in regard to these activities?

8. Do you have any vocal ability or do you play any instruments?

9. Do you speak, write or read any languages besides English?

10. What accomplishments are you particularly proud of (i.e. completed goals, careers)?

11. How would you describe your childhood?

12. Would you be willing to travel out of state for a donation cycle? (Expenses would be reimbursed per contract).

Additional Family Information

	Age	Natural Hair Color	Eye Color	Height/Weight	Living?	Deceased Date Cause of Death
Mother						
Father						
Maternal Grandmother						
Maternal Grandfather						
Paternal Grandmother						
Paternal Grandfather						
Brother(s)						
Sisters(s)						
Son(s)						
Daughter(s)						

Have you ever applied to other programs as an egg donor or surrogate? Yes No

If yes, who was the doctor? _____ When did you apply? _____

Were you accepted? Yes No If yes, what is your current status? _____

The potential Egg Donor specifically understands that the information provided on this application, with the exception of names, addresses, phone numbers, e-mail addresses and social security number, will be made available to potential recipients in its entirety.

The potential Egg Donor authorizes The Center for Egg Options, LLC to release any information and photographic material enclosed in this and other application material. All information provided is complete and honest to the best of the applicant's knowledge.

Date ____ / ____ / ____ **Signature of Potential Egg Donor** _____

