



REPEAT OOCYTE DONOR HISTORY

To: Returning Donor

Thank you for your continued interest in being a donor. All repeat 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

E-mail address _____

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.

PERSONAL INFORMATION

Marital Status: Married Single Divorced

How many children do you have? _____

Other personal information you would like to include/update:

DONOR RISK FACTOR HISTORY - PART 2

- | | | | |
|----|---|-----|----|
| 1. | Are you presently taking any prescribed medications?
If yes, please specify what and why: _____ | Yes | No |
| 2. | Did you take any prescribed medications within the last six weeks?
If yes, please specify what and why: _____ | Yes | No |
| 3. | Have you ever used marijuana or other illegal drugs?
If yes, what, when and how often? _____ | Yes | No |
| 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?

If yes, specify: _____ | Yes | No |
| 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 _____ |

9. 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 recent tattoos? Yes No
If yes, list date received and location: _____
11. Do you have any recent 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 non-iatrogenic Creutzfeldt-Jakob disease? Yes No
If yes, explain _____
17. 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. Have you been diagnosed with West Nile Virus, encephalitis or meningitis of viral or unknown cause? Yes No
If yes, explain _____

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

22. 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: _____

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

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 gonorrhoea? 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 Yes No If yes, Frequency/Year(s) _____
How Used _____
(Heroin, Methadone, Opium, Morphine, Codeine)

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 _____

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

List name and location of egg donor program(s): _____
you have donated with : _____

How many times did you cycle? _____

If you know the pregnancy results –
indicate how many times your cycles resulted in a pregnancy - _____

Are you currently enrolled as an egg donor in another program? _____ Yes _____ No

If YES, what IVF Center? _____

DONOR GENETIC HISTORY

List only NEWLY DIAGNOSED genetic conditions or birth defects in your family:
