INITIALS_____

DONOR APPLICATION

LAST NAME_____ FIRST NAME_____ MIDDLE INITIAL_____

HOME PHONE_____ WORK PHONE_____

CELL PHONE _____ E-MAIL_____

ADDRESS_____

CITY_____ STATE_____ ZIP_____

BIRTHDATE_____SOCIAL SECURITY #_____

HEALTH INSURANCE? Y/N
How did you hear about our program? _____
Have you ever applied to be an egg donor in another program? _____
If **yes**, please indicate:
Name of Program: _____
Date of last egg retrieval: _____
How many eggs were retrieved? _____
Are you currently enrolled with another program? _____
Are there any restrictions on your availability to perform the donor process? _____
When are you available for egg donation? _____

Thank you for your interest in becoming an egg donor. All prospective egg 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.

_____
Egg Donor Signature Date

For IVF Michigan use only:

_____
Reviewed By (Donor Coordinator) Date

_____
Reviewed By (IVF Michigan Physician) Date

INITIALS_____

PERSONAL DATA:

Birth Year _____ Marital Status_____ Children_____

PHYSICAL CHARACTERISTICS:

Height_____ Weight_____ Recent weight loss or gain? _____ How much? _____

Body Build: Slender/Med/Large Eye Color_____ Skin Tone: Fair/Med/Olive/Dark

Hair Color_____ Hair type: Wavy/Curly/Straight Thick/Avg/Thin

Are you predominantly: Left Handed/Right Handed/Ambidextrous

Race: (Asian, Caucasian, Hispanic, African American, other) _____

Countries of Ancestry (i.e. German, Irish, etc.) _____

EDUCATION/EMPLOYMENT:

High School (# of years) _____ Graduated? _____

ACT Score_____ SAT Score _____

College (# of years) _____ Graduated? _____

Major _____ GPA_____

Graduate School or other education_____

Plans on further education: _____

Career Goals: _____

What kind of work do you do currently? _____

What kind of work have you done in the past? _____

What kind of work is most appealing to you? _____

What kind of things (i.e. activities or hobbies, etc) interest you the most or what types of things do you enjoy spending time doing? _____

_____

_____

PERONALITY: INITIALS _____

Why do you want to become an egg donor? _____

_____

Personality weakness(s): _____

Favorite type of music: _____

Favorite book/author: _____

Favorite musician/band: _____

Favorite food: _____

Favorite sports: _____

Who is your hero and why? _____

_____

What are your favorite words to live by or a particular philosophy that you associate with? _____

_____

If you were completely alone for one day, how would you spend that day? _____

_____

Do you have a pet? _____

Do you enjoy traveling? _____

Name a few favorite places you have traveled to: _____

Where would you most like to visit and why? _____

What language(s) did you grow up with? _____

What languages do you speak? _____

What personal achievement are you most proud of? _____

_____

Comments that you would like to tell the prospective recipient about yourself: _____

_____

_____

PERSONAL HABITS: INITIALS_____

Do you drink alcohol? _____ if yes, how often? _____

Have you ever smoked cigarettes? Yes / No; if yes, do you currently smoke? Yes/No; Amount: _____
How long:_____

Have you ever used any illicit drugs? _____

If "Yes", please explain: Type: _____ Last time used: _____

Do you exercise regularly? _____ Type _____ Times per week_____

Do you have any tattoos? _____ body piercings? _____ had acupuncture done? _____

When done? _____ Single use needle or instrument used? _____

Have you ever donated blood? _____Have you ever been excluded from donating blood? _____

PERSONAL MEDICAL HISTORY:

Are you currently under a physician's care for any reason? _____

If "Yes", please describe: _____

Do you have allergies?_____ if yes, please explain: _____

How is your vision without glasses or contacts? _____

If poor or fair, at what age did you begin wearing glasses? _____

If poor or fair, are you nearsighted or farsighted? _____

Do you have normal hearing? _____

What is the condition of your teeth? _____Did you receive orthodontic treatments? _____

Have you ever taken growth hormones? _____if yes, what kind and when? _____

Do you have any current chronic medical problems or conditions? _____

If "Yes", please explain: _____

Have you ever had counseling for depression or emotional problems? _____

If "Yes", please explain: _____

Have you ever taken antidepressants for more than three months at a time? _____

If "Yes", please explain: _____

Have you ever had any of the following conditions? INITIALS_____

Anorexia or Bulimia	Y/N
Depression	Y/N
Bi-polar	Y/N
Obsessive-Compulsive Disorder	Y/N
Self Mutilation	Y/N
Schizophrenia	Y/N

CHILDHOOD DISEASES:

Have you ever had any of the following?

Chicken Pox	Y/N	Mumps	Y/N	Scarlet Fever	Y/N
Rheumatic Fever	Y/N	Streptococcal Infections	Y/N	Poliomyelitis (Polio)	Y/N
Whooping Cough	Y/N	German measles (Rubella)	Y/N	Measles	Y/N
Diphtheria	Y/N	Chorea (St. Vitus Dance)	Y/N	Heart Murmur	Y/N

REPRODUCTIVE HISTORY:

How old were you when you had your first period? _____

What was the first day of your last menstrual period? _____

Do you have regular periods? _____

How often (from 1st day to 1st day) do you have menstrual periods? _____

How many days does your period usually last? _____

Have you ever had any trouble getting pregnant? _____

If yes, please explain: _____

Have you ever taken or currently taking birth control pills? _____

If yes, what type and for how long? _____

What method of contraception have you used in the last six months? _____

What types of contraception have you used in the past? _____

When did you have your last Pap smear? _____

Have you ever had any of the following conditions?

Abnormal Pap Smear	Y/N	HPV	Y/N
Chlamydia	Y/N	Venereal Warts	Y/N
HIV/AIDS	Y/N	Tuberculosis	Y/N
Hepatitis B	Y/N	Hepatitis C	Y/N
Gonorrhea	Y/N	Syphilis	Y/N
Herpes	Y/N	Pelvic Inflammatory Disease	Y/N
Polycystic Ovarian Disease	Y/N		

SEXUAL HISTORY: INITIALS_____

Are you currently sexually active? _____

How many sexual partners have you had in the last 6 months? _____

Are you currently in a mutually monogamous relationship? _____

Are you now, or have you ever had homosexual experiences? _____

PREGNANCY HISTORY:

Have you ever been pregnant? _____

Have you ever had any miscarriages? _____

Have you had any abortions? _____

Have you ever had an ectopic pregnancy? _____

YEAR	TYPE OF DELIVERY	OUTCOME	COMPLICATIONS

YOUR CHILDREN:

AGE	SEX	HEALTH PROBLEMS

HIGH RISK BEHAVIORS: **INITIALS_____**

Have you ever had any blood transfusions? _____

Do you take or have you ever taken any concentrated products derived from blood or blood substances? _____

Have you ever given yourself, or had anyone give you IV injections for any reason? _____

Have you ever known or associated with anyone who was told they have a positive HIV/AIDS test? _____

Have you ever been in a situation that would give you a higher risk of coming in contact with sexually transmitted diseases, including HIV/AIDS? _____

Have you ever had, or been exposed to Hepatitis? _____
Have you been vaccinated for Hepatitis? _____

Have you ever traveled outside the United States, excluding Canada? _____

If yes, list locations and travel dates:_____

Have you ever tested for the AIDS virus (HIV)? _____Results: _____

Have you ever been treated for any sexually transmitted diseases (such as Herpes, Gonorrhea, Chlamydia, genital warts (HPV), Syphilis, Trichamonas, etc)? _____ When? _____

Have you ever had a sexual partner that was being treated for any of the diseases listed above? _____

Have you ever taken anti malarial drugs? _____

Have you ever taken pituitary derived growth hormone? _____

Have you ever been bitten by an animal suspected of having rabies? _____

Have you been diagnosed with Creutzfeldt-Jakob disease? _____

Have you had any history of dementia or degenerative neurological disorders? _____

Have you been diagnosed with West Nile, encephalitis or meningitis? _____

Have you been vaccinated in the last 12 months? _____

Have you come in close contact with someone vaccinated against small pox? _____

Have you had amoebic dysentery, hepatitis, pneumonia, or mononucleosis? _____

Have you been exposed to Agent Orange or other herbicides or chemicals in military action or elsewhere?_____

Have you received any type of tissue transplant? _____

Is there any reason, from a medical standpoint, based on these questions, that you should not be used as a donor?

_____

MEDICATIONS: **INITIALS_____**

Please list all medications (including birth control) that you are taking, or have taken in the past 12 months, and the reason for the medication. List additional medications on the back of this sheet.

Medication_____ Reason_____

Medication_____ Reason_____

Medication_____ Reason_____

SURGICAL HISTORY:

Date: _____ Procedure_____ Reason_____

Date: _____ Procedure_____ Reason_____

Date: _____ Procedure_____ Reason_____

Date: _____ Procedure_____ Reason_____

Please list any medical problems or hospitalizations (other than surgery) that are or have been treated for:

_____

_____

FAMILY HISTORY:

Are you adopted? _____ If yes, do you have a family medical history? _____

Are you a twin_____ Is there a history of multiple births in your family? _____

If yes, which family member? _____

Do you have any brother's or sister's that died in infancy or childhood? _____

Explain: _____

Has anyone in your family, including yourself, experienced recurring and/or chronic physical symptoms that have not been evaluated by a physician? _____ Explain: _____

_____

GENETIC HISTORY:

Are there any known genetic diseases or conditions that run in your family? _____

If yes, please list: _____

Please mark yes or no if you have ever been found to be a carrier of:

___Tay-Sach's disease ___Sickle cell disease ___Thalassemia ___Cystic Fibrosis ___Gaucher

Have you or a close relative (children, parents, siblings, grandparents, aunts/uncles) ever had any of the following:	YES	NO	Type/family member/age of onset
Asthma			
Emphysema			
Tuberculosis			
Pneumonia			
Alpha-1 antitrypsin disorder			
Other lung disease			
Drug allergies			
Food allergies			
Hay fever			
Insect allergies			
Artherosclerosis			
Blood lipid abnormality (cholesterol, triglycerides, etc.)			
Cooley's Anemia			
Thalassemia			
Hemophilia			
Sickle Cell Anemia			
Immune deficiency			
Polyarteritis nodosa			
Other Hemoglobinopathies, Anemia's (Pernicious, Spherocytosis, etc.) or blood disorders			
Leukemia			
Lymphoma			
High Blood Pressure			
Stroke			
Heart disease			
Blood clots			
Congenital heart defect			
Other cardiovascular disease			
Learning Disability			
Attention Deficit Disorder			
Migraine Headaches			
Other severe or disabling headaches			
Wilson's Disease			
Chromosomal Translocation			
Cleft lip or palate			
Club foot			
Gastrointestinal tract disease			
Ulcer of stomach/duodenum			
Gallstones			
Hepatitis A, B or C			
Other liver disease			

Have you or a close relative (children, parents, siblings, grandparents, aunts/uncles) ever had any of the following:	YES	NO	Type/family member/age of onset
Cancer of the colon			
Crohn's Disease			
Colon Polyps			
Ulcerative Colitis			
Inflammatory Bowel Disease			
Rectal disorder			
Porphyria			
Pyloric Stenosis			
Abnormalities of bone growth and development			
Abnormal postural positions			
Amyloidosis			
Ankylosing Spondylitis			
Arthritis			
Rheumatoid Arthritis			
Reiter's Disease			
Gout			
Metabolic bone disease			
Dupuytren's Contracture			
Muscular Dystrophy			
Muscle wasting			
Myotonia			
Other musculo-skeletal disorder			
Spinal muscular atrophy			
Deformity of the spine			
Systemic Lupus			
Osteoporosis			
Hereditary low back disorder			
Ataxia			
Epilepsy or seizure disorder			
Familial spastic paralysis			
Huntington's Chorea			
Dementia or degenerative disorder			
Alzheimer's			
Brain tumor			
Myasthenia Gravis			
Malignant Hypothermia			
Neurofibromatosis			
Paralysis in a limb for an extended period of time			
Parkinson's Disease			
Other diseases of nervous system			
Dwarfism			
Short stature			

Have you or a close relative (children, parents, siblings, grandparents, aunts/uncles) ever had any of the following:	YES	NO	Type/family member/age of onset
Congenital hip dislocation			
Skeletal Abnormality			
Blindness (specify cause and diagnosis)			
Cataract			
Glaucoma			
Night blindness			
Color Blindness			
Eysight deficiency (not correctable with glasses)			
Retinoblastoma			
Strabismus (crossed eyes, one eye turned out)			
Deformity of the ear			
Deafness			
Other hearing loss (specify cause or diagnosis)			
Serious dental problems			
Deviated septum			
Any other sight/smell disorder			
Malocclusion			
Tic			
Tremor			
Hyperactivity			
Sensory Disturbance (i.e. increased pain perception, unprovoked tingling, etc.)			
Stuttering or other speech problems			
Adult onset Diabetes Mellitus			
Juvenile Diabetes			
Hypoglycemia			
Thyroid disease			
Thyroid Cancer			
Goiter			
Adrenal dysfunction or disorder			
PKU or inherited metabolism disorder			
Delusions of greatness			
Depression			
Failing memory			
Mood swings (from euphoria to deep depression)			
Manic depressive psychosis			
Hallucinations			
Hot or violent temper			
Hysteria			
Schizophrenia			
Senility or mental deterioration before age 50			
Gaucher's disease			

Have you or a close relative (children, parents, siblings, grandparents, aunts/uncles) ever had any of the following:	YES	NO	Type / family member / age of onset
Creutzfeldt-Jakob Disease			
Mental disorder			
Mental retardation			
Down's syndrome/Mongolism			
Transmissible Spongiform Encephalopathy			
Marfan Syndrome			
Hypospadias			
Infertility			
Uterine fibroids			
Ovarian cysts			
Cancer of cervix, ovaries, or uterus			
Miscarriage or Stillbirth			
Birth Defects			
Inguinal Hernia			
Neural tube defect			
Cystic Fibrosis			
Tay-Sachs			
Spina Bifida			
Disorders of the spinal cord			
Polycystic kidney disease			
Progressive kidney disease			
Other disease of urinary tract (urethra, bladder, ureter)			
Alcoholism			
Drug abuse, misuse, or addiction			
Acne			
Eczema			
Psoriasis			
Pigmentation disorders			
Albinism			
Infectious skin disease			
More than 5 purple or coffee colored spots on the skin (size of quarter or larger)			
Numerous lumps under the skin			
Other skin disorders			
Breast Cancer			
Any cancer not mentioned above			
Early Death (before age 50)			
Sarcoidosis			
Premature degeneration of any organ system			

Do you have any known genetic diseases or other illness that is not listed in this application? _____

Explain: _____

FAMILY MEMBER	ETHNIC ORIGIN	HAIR COLOR	EYE COLOR	AGE	HT	WT	SKIN TONE	BODY BUILD	ALIVE/ DECEASED	AGE AT DEATH	HEALTH PROBLEMS
MOTHER											
FATHER											
MATERNAL GRANDMOTHER											
MATERNAL GRANDFATHER											
PATERNAL GRANDMOTHER											
PATERNAL GRANDFATHER											
CHILD											
CHILD											
CHILD											

FAMILY MEMBER	ETHNIC ORIGIN	HAIR COLOR	EYE COLOR	AGE	HT	WT	SKIN TONE	BODY BUILD	ALIVE/ DECEASED	AGE AT DEATH	HEALTH PROBLEMS
SIBLING											
SIBLING											
SIBLING											
SIBLING											
MATERNAL AUNT/UNCLE											
MATERNAL AUNT/UNCLE											
PATERNAL AUNT/UNCLE											
PATERNAL AUNT/UNCLE											

Use the area below for additional family members if needed