Center of Reproductive Medicine

EGG DONOR SCREENING INFORMATION

Thank you for inquiring about our egg donor program. If you are interested, please complete the following information and send back to us. All information will be kept strictly confidential. We will call you to schedule an appointment once we receive this information. Please do not hesitate to call if you have any questions.

Date:_____ Name_____

How did you hear about us?_____

D.O.B._____ Age_____
Address_____
_____

Home Tele_____ Wk Tele_____ Other_____
Best place to call?_____ Time?_____ Email: _____
(Minimum of 2 contact #'s required)

Social Security: _____-_____-_____ and or Driver License #: _____

What is your approximate height and weight?_____

What is your ethnic background?_____

Do you smoke? □Yes □No
If you smoked previously, how long did you smoke?_____
When was the last time you had a cigarette?_____

Do you drink? □Yes □No
If yes, approximately how many drinks do you have in a week?_____

Do you now or have you ever used marijuana, cocaine, crack, or any other drugs? □Yes □No
When was the last time you ever used these drugs?_____

Are you currently taking any medications, including over the counter medications or vitamins/herbs? □Yes □No
If yes, please list below:
_____
_____

Are you adopted? □Yes □No
If yes, do you know anything about your family history? □Yes □No
If yes, explain: _____

How many days pass from the first day of your period to the first day of your next period? _____
Have you ever had irregular periods? □Yes □No
If yes, please explain:
_____
Have you been an egg donor before? □Yes □No
If yes, when and where?
_____
_____

Have you been pregnant before? □Yes □No

If yes, how many times have you been pregnant?_____

Have you had any miscarriages? □Yes □No

Have you had any abortions? □Yes □No

Do you have any children with any disabilities? □Yes □No

How many living children do you have?_____

What is the age of your youngest child?_____

How long did it take you to get pregnant?_____

Have you ever gone through infertility treatment? □Yes □No

If yes, what type of treatment?

_____

_____

Have you had any sexually transmitted diseases, such as Chlamydia, Herpes, Gonorrhea, or Syphilis? □Yes □No

If yes, please explain:

_____

Have you ever been diagnosed with pelvic inflammatory disease? □Yes □No

Have you ever been diagnosed with endometriosis? □Yes □No

Do you have any medical problems? □Yes □No

If yes, list date and types of problems:

DATE	**MEDICAL DIAGNOSIS**
_____	_____
_____	_____
_____	_____
_____	_____

Do you have any family history of genetic problems? □Yes □No

If yes, please explain:

_____

_____

Do you have any personal or family history of psychiatric problems? □Yes □No

If yes, please explain:

_____

_____

Are you willing to have numerous screening blood tests, including HIV? □Yes □No

Are you willing to undergo a psychological consult and personality testing? □Yes □No

Are you willing to take injectable medications? □Yes □No

When will you be available for this process?_____

COMMENTS:_____

_____

_____ _____

Signature Date