

NEW ENGLAND FERTILITY INSTITUTE

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Egg Donor Intake

Dear Egg Donor Applicant,

Welcome! This form allows us to learn more about your personal, medical, social, and family history so that we can determine if you are a suitable egg donor candidate. Please completely and honestly answer the following questions. All of the information that you provide to us will be kept confidential. Please do not hesitate to contact us with any questions.

1. Today's Date: _____
2. Name: _____
3. Address: _____
4. City: _____ 5. State: _____ 6. Zip: _____
7. Home Phone: _____ 8. Work Phone: _____
9. Cell Phone: _____ 10. Email Address: _____
11. How did you hear about our program? Newspaper Ad (Please specify publication: _____)
 Website/Internet Friend Radio Ad (Please specify station: _____)
 Other (Please specify: _____)
12. Date of Birth: _____
13. Race (circle all that apply): Caucasian African American/Black Asian Hispanic Other: _____
14. Height: _____ 15. Weight: _____
16. Eye Color: _____ 17. Hair Color: _____
18. Skin Tone: _____
19. Parents' ethnic origin (i.e. your ancestors' countries of origin, for example, Greece, Puerto Rico, etc. Please note if you are of Jewish ancestry.)
Mother's Side: _____
Father's Side: _____
20. Were you or either of your parents adopted? Yes No
21. What is your highest level of education? _____
22. Are you currently a student? Yes No
a. If yes, where? _____
b. What is your major? _____
23. What is your current occupation? _____
24. What is your marital status? _____
25. What is your primary/first language? _____
26. In the past 12 months, have you been in jail for more than 72 hours (3 days)? Yes No
27. Since 1980, have you lived in or traveled to Europe, which includes the United Kingdom? Yes No
a. If yes, please specify the countries that you lived in/traveled to and the amount of time spent in each country. _____

28. Were you born in or have you lived in or traveled to any African country since 1977? Yes No

a. If yes, please list the country/countries: _____

Medical/Social History

29. Do you smoke? Yes No
a. If yes, how many packs/cigarettes per day? _____
30. Do you drink alcoholic beverages? Yes No
a. If yes, how much and how often (i.e. number of drinks per day or per week)? _____
31. Have you ever used illegal drugs (for example heroin, ecstasy, cocaine, etc.)? Yes No
a. If yes, what drugs and how often? _____
32. In the past 12 months, have you had a tattoo, ear or body piercing, or accidental needle stick? Yes No
33. Do you have any allergies? Yes No
a. If yes, please list the specific substances/foods/medications and any reactions produced. _____

34. Do you have any illnesses? Yes No
a. If yes, please specify: _____
35. Have you ever been hospitalized? Yes No
a. If yes, when and why? _____
36. Are you currently taking any medications (prescription or over the counter), including birth control? Yes No
a. If yes, please specify: _____
37. Have you ever been treated for depression, anxiety, or any other psychological problem? Yes No
a. If yes, please specify: _____
38. Have you ever been treated for a sexually transmitted disease (for example genital warts, herpes, gonorrhea, chlamydia, syphilis, etc.)? Yes No
a. If yes, for which condition(s) and when? _____
39. Do you get monthly periods? Yes No
a. If no, why not? _____
40. Have you ever been pregnant? Yes No
a. If yes, number of pregnancies _____
 number of live births _____
 number of miscarriages _____
 number of abortions _____
 number of ectopics _____
 number of stillbirths _____
41. Have you ever been an egg donor before? Yes No
a. If yes, when and where? _____

Family History

42. Do you have any relatives with alcoholism or drug addiction? Yes No
a. If yes, who? _____
43. Are you or any family member a carrier of a genetic condition (for example cystic fibrosis or sickle cell anemia)?
 Yes No
a. If yes, please specify: _____

44. Were you or any family member born with a birth defect (for example cleft lip/palate, clubfoot, heart defect)?

Yes No

a. If yes, please specify: _____

45. Please fill in the appropriate sections for each of the following table:

<u>Family Member</u>	<u>Living</u>	<u>Deceased</u>	<u>Current Age or Age at Death</u>	<u>Health Problems and Age at Diagnosis OR Cause of Death</u>
Father				
Mother				
Brothers				
Sisters				
Father's Father				
Father's Mother				
Mother's Father				
Mother's Mother				

THANK YOU FOR YOUR TIME AND COOPERATION!