

Center for Reproductive Medicine and Infertility

Weill Medical College of Cornell University

Oocyte Donor Personal History

Before you can become an egg donor at CRMI, we need to learn some important information about your personal and medical history. Your responses to these questions will help us to make sure that your health and genetic make-up are compatible with the egg donation process, and that being an egg donor will not involve any special risks for you. This effort will also help us to match you to an appropriate recipient.

Please provide complete and accurate information to these questions. Your responses, and any other information you provide during the egg donation process, remain completely confidential. Information from this questionnaire may be made available *anonymously* to the recipient couple.

I, the undersigned, acknowledge that the following answers are accurate and truthful to the best of my knowledge and include all relevant information.

Signature: _____ **Date:** _____

Name: _____

Address: _____

Telephone 1st choice: _____

2nd choice: _____

Date of Birth: _____

Where did you see our advertisement? _____

Are you eligible to work in the United States? Yes No

Do you have a social security number or tax identification number? Yes No

The money received from donation is taxable.

Answers to the following questions will not affect your qualification for the program.

Would you be comfortable submitting a baby photo of yourself to be seen by the prospective recipient? Yes Not Completely Comfortable

Would you be comfortable donating to a single parent?

Yes Not Completely Comfortable

Would you be comfortable donating to a gay or lesbian couple?

Yes Not Completely Comfortable

Please send a recent photograph of yourself along with this questionnaire. (This photograph is for internal use only and will not be shared with any recipients.)

Physical Characteristics

Age: _____ Year of Birth: _____

Height: _____ Weight: _____

Race: _____ Ethnic Origin: _____

Place of Birth: _____ Religion born into: _____

Date moved to this country: _____

Please circle appropriate response

BODY TYPE/ BONE STRUCTURE:

HANDS:	small	medium	large	
	right-handed	left-handed	ambidextrous	
EYES:				
• color	brown	hazel	green	blue
• set	narrow	average	wide	
• size	small	medium	large	
• shape	round	oval	almond	

HAIR:

• natural color	blonde	brown	black	red	other: _____
• color as a young child	blonde	brown	black	red	other: _____
• shade	light	medium	dark		
• type	straight	wavy	curly		
• fullness	thin	medium	thick		
• texture	fine	medium	coarse		

NOSE:

• size	small	medium	large
• width	narrow	medium	large
• length	short	average	wide
• nostril flare	small	average	wide

CHEEKBONES:

• set	low	average	high
• prominence	slight	medium	strong

MOUTH:

• size	small	average	large
• lips	thin	average	full

CHIN:

- **shape** square oval round
- **prominence** slight average strong
- **cleft** none slight medium strong

SKIN:

- **tone**
 rosy (always burns, never tans) brown (rarely burns, tans profusely)
 fair (always burns, minimal tan) olive (burns minimally, tans well)
 medium (burns minimally, tans gradually) dark brown (never burns, tans deeply)
 - **condition** oily medium dry combination
 - **acne** none slight medium severe
- At what age:** _____

OTHER FACIAL FEATURES:

- **moles** none one several numerous
- **freckles** none several moderate numerous
- **dimples** none slight medium deep

EYESIGHT:

- **vision** normal near-sighted far-sighted
 - **correction** none glasses bifocals contacts Lasix
 - **astigmatism** yes no
- Age diagnosed** _____

DENTAL:

- **device** none braces retainer other _____
- **reason** cosmetic accident disease other _____
- **age during use** _____ to _____ years of age

OTHER:

- **List** _____
- **Reason/ cause** _____

Describe your family by the following physical characteristics:

	Eye Color	Hair Color	Complexion	Height	Body Type/ Weight
Father					
Mother					
Brothers 1					
2					
3					
Sisters 1					
2					
3					

Personal Characteristics

LEVEL OF EDUCATION:

Completed high school: Yes No

_____ Currently in college, pursuing a degree in: _____

_____ Completed college, degree in: _____

_____ Currently pursuing an advanced degree in: _____

_____ Completed an advanced degree in: _____

LANGUAGES:

Speak: _____

Read: _____

Write: _____

ATHLETIC ACTIVITY (circle appropriate choice):

athletic active average inactive

What physical activities do you engage in? _____

Have you excelled in any physical activities? _____

MANUAL DEXTERITY:

dexterous average clumsy

What manual skills do you have? _____

TEMPERAMENT/PERSONALITY:

How would you describe yourself? Please include a description of your personality and

temperament: _____

What other skills or talents do you have (e.g., painting, writing, ability to do games, crossword puzzles, handcrafts, etc.) Please describe: _____

MUSICAL ABILITY:

musical average non-musical

Voice: soprano alto

Instrument: _____ years experience

Other: _____ years experience

Reproductive History

Age at first period _____

Are your cycles regular? _____

Interval between periods _____

(From first day of period to first day of next period. e.g. 28 days)

PREGNANCY HISTORY (INCLUDING TERMINATIONS AND MISCARRIAGES)

Year	Outcome	Any Complications

Did your mother takes DES while she was pregnant with you? _____

Have you ever been diagnosed with infertility? _____

Explain: _____

Have you been told of any gynecological problems (endometriosis, fibroids, ovarian cysts, abnormal Pap smear, etc.)? _____

Have you been sexually active during the past 6 months? _____

Are you currently sexually active? _____

Are you in a monogamous relationship? Yes No If no, then the number of partners you have been sexually active with over the past six months? _____

Have you or a partner of yours ever had a sexually transmitted disease (trichomoniasis , condyloma, herpes, Chlamydia, gonorrhea, hepatitis, syphilis, etc.)? _____

If so, please describe your diagnosis, year, and treatment: _____

Have you had more than 10 sexual partners? _____

Medical History

Allergies (food, pollen, bee stings, medications, etc.) _____

Describe childhood allergies you have outgrown: _____

Do you have any medical illness (asthma, diabetes, seizures, disorders, etc.)? _____

Do you have excessive hair growth that requires regular removal? _____

Do you have frequent nose bleeds, bleeding gums when you brush your teeth, and/or menstrual periods with blood clots? _____

List the drugs, prescription and non-prescription, that you take regularly: _____

Any other medicines taken in the last 5 years: _____

Do you smoke cigarettes? _____ How much? _____

What types of alcoholic beverages (beer, wine, alcohol) do you drink? _____

How many alcoholic drinks do you consume a: day? _____ week? _____ month? _____

Have you ever used any kind of recreational drugs such as marijuana, LSD, heroin, ecstasy or cocaine? If yes, please give details and state last date used: _____

Have you ever used neuroleptic agents (tranquilizers, valium, thorazine, etc.) or anti-depressants? If yes, please give details and state date last used: _____

Have you ever had surgery? _____ If so, describe _____

Family Health History

	Age (if alive)	or Age at death	Medical problems or cause of death
Mother			
Father			
Brothers: 1			
2			
3			
Sisters: 1			
2			
3			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Children: (if any) 1			
2			
3			

Has any member of your family, including yourself, had a problem or defect at birth of any of the following body systems?

1. Bones, muscles, joints, limbs
2. Gastrointestinal system
3. Nervous system, brain, spinal cord
4. Blood circulation
5. Respiratory system
6. Organ (heart, lung, kidney, etc.)
7. Genital/urinary
8. Metabolic (hormones, enzymes, etc.)

No _____ Yes _____

If "yes", please list below the specific defect in each case.

Birth	Who	When did this happen?	Relevant Circumstances

Do you have any brothers or sisters who died in infancy or childhood? _____

If yes, what was the cause? _____

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

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 _____

Please explain: _____

Family Health History (cont'd.)

Please read the following list of medical problems carefully and indicate which ones you or one of your relatives have had. Please consider each condition carefully for each family member.

	Yourself	Mother	Father	Siblings	Gr'dparents	Other Family	Describe
Medical Problems							
Heart							
A. stroke							
B. heart attack							
C. heart disease							
1. From birth							
2. Other							
D. hardening of arteries							
E. high blood pressure							
Blood							
A. anemia							
B. sickle-cell anemia							
C. hemophilia or other bleeding problem							
D. leukemia							
E. immune deficiency							
F. other blood disorder							
Respiratory (lungs)							
A. hay fever							
B. asthma							
C. emphysema							
D. tuberculosis							
E. lung cancer							
F. pneumonia							
G. other lung disease							
Gastro-intestinal							
A. ulcer of stomach or duodenum							
B. gall stones							
C. hepatitis A (infectious)							
D. hepatitis B (serum)							
E. other liver disease							
F. colon cancer							
G. ulcerative colitis							
H. Crohn's disease							
I. Cystic fibrosis							
J. intestinal cancer							
K. any other cancer/ problem of digestive system							

Family Health History (cont'd.)

	Yourself	Mother	Father	Siblings	Gr'dparents	Other Family	Describe
Medical Problems							
Metabolic/ Endocrine							
A. diabetes mellitus							
B. hypoglycemia							
C. thyroid cancer							
D. thyroid disease							
E. goiter							
F. adrenal dysfunction or disorder							
G. hyperactivity							
Urinary							
A. kidney disease							
B. other disease of urinary tract (urethra, bladder, ureter)							
C. rectal disorder							
Genital/ Reproductive							
A. undescended testicles							
B. hypospadias							
C. breast cancer							
D. prostate cancer							
E. uterine fibroids							
F. ovarian cysts							
G. cancer of cervix, ovaries, uterus							
Neurological							
A. migraines							
B. mental retardation							
C. senility before age 50							
D. multiple sclerosis							
E. cerebral palsy							
F. epilepsy							
G. hydrocephalus							
H. disorder of the spinal cord							
I. Huntington's chorea							
J. Gaucher's disease							
K. Wilson's disease							
L. Creutzfeldt- Jacob's Disease							
M. Alzheimer's Disease							
N. other diseases of the nervous system							

Family Health History (cont'd.)

	Yourself	Mother	Father	Siblings	Gr'dparents	Other Family	Describe
Medical Problems							
Mental Health							
A. schizophrenia							
B. manic depression							
C. other mental health disorders requiring hospitalization							
Muscular/Bones/Joints							
A. muscular dystrophy							
B. other chronic muscle disease							
C. lupus							
D. deformity of the spine							
E. osteoporosis							
F. dwarfism							
G. hereditary low back disease							
H. arthritis							
I. Gout							
Sight/ Sound/Smell							
A. deafness before age 60							
B. deformity of the ear							
C. cataracts before age 50							
D. blindness							
E. color blind							
F. glaucoma							
G. deviated septum							
H. any other sight/ sound/ smell disorder							
Skin							
A. acne							
B. eczema							
C. skin cancer							
D. pigmentation disorder							
E. any other disorders of the skin							
Other							
A. alcoholism							
B. drug abuse, misuse or addiction							
C. any other cancer not mentioned above							
D. any other condition not mentioned above							

INITIAL OOCYTE DONOR RISK QUESTIONNAIRE

Name: _____

Date: _____

Please circle the correct response (Yes or No) and comment when appropriate. This form may only be completed in pen and you may not cross out any answers. If you make a mistake, please ask for a new form. Additionally, no white out may be used.

Question	Yes No	Comment
1. In the past 12 months, have you had sex with a man who has had sex with another man in the past 5 years?	Yes No	
2. Have you injected drugs for a non-medical reason in the last 5 years, including intravenous, intramuscular and subcutaneous injection?	Yes No	
3. Have you received human-derived clotting factor concentrates including factor VIII and/or factor IX concentrate for hemophilia or a related clotting disorder?	Yes No	
4. In the past 5 years, have you been given money or drugs in exchange for having sex?	Yes No	
5. In the past 12 months, have you been in jail for more than 72 consecutive hours?	Yes No	
6. In the past 12 months, have you had sex with anyone who would answer yes to any of questions 1, 2, 3, 4, or 5?	Yes No	
7. In the past 12 months, have you had sex with a person known or suspected to have HIV infection, hepatitis B infection or hepatitis C infection?	Yes No	
8. In the past 12 months, have you been exposed to known or suspected HIV, hepatitis B and/or hepatitis C infected blood through percutaneous inoculation (e.g., needle stick) or through contact with an open wound, non-intact skin or mucous membrane?	Yes No	
9. In the past 12 months have you had an accidental needle stick, sharp instrument injury, contact with human blood, serum or plasma in the eye, mucous membranes (lips or interior of nose) or sores?	Yes No	
10. In the past 12 months, have you lived with (resided in the same dwelling) another person who has hepatitis B or clinically active (symptomatic) hepatitis C infection?	Yes No	
11. In the past 12 months, have you had ear, skin or body piercing, scarification or tattooing?	Yes No	If no, go to question 12. If yes, go to question 11a.
11a. Did you have a tattoo or scarification in the past 12 months? If so, when?	Yes No	If no, go to question 11c. If yes, go to question 11b.
11b. Were sterile instruments used?	Yes No	
11c. Did you have an ear, skin or body piercing performed in the past 12 months? If so, when?	Yes No	If no, go to question 12. If yes, go to question 11d.
11d. Were sterile instruments used?	Yes No	
12. Have you had a clinical diagnosis of hepatitis?	Yes No	If no, go to question 13. If yes, go to question 12a.
12a. Was the hepatitis identified as hepatitis A (e.g. reactive IgM anti-HAV test), Epstein-Barr, or cytomegalovirus?	Yes No	

OOCYTE DONOR RISK QUESTIONNAIRE CONTINUED

Question	Yes No	Comment
13. Have you, your sexual partner(s) and/or any member of your household ever had a transplant or medical procedure that involved being exposed to live cells, tissue or organs from an animal?	Yes No	If no, go to question 13. If yes, go to question 13a.
13a. If the person referred to in question 13 was a member of your household, were you exposed to that individual's blood, saliva or other body fluids (e.g., through deep kissing, shared toothbrushes, razors, or needles, or through open wounds or sores)?	Yes No	
14. Have you been suspected to have or diagnosed with West Nile Virus (including diagnosis based on symptoms and/or laboratory results, or confirmed WNV viremia) in the past 120 days?	Yes No	
15. Within the past 8 weeks, have you had a smallpox vaccination?	Yes No	If no, go to question 16. If yes, go to question 15a.
15a. Did the scab separate/ fall off by itself?	Yes No	
15b. Did you have any illness or complications from your vaccination?	Yes No	
16. Within the past 8 weeks, have you had close contact with a smallpox vaccination site of someone else who received the vaccination (examples include touching the site, the bandages covering the site or handling bedding or clothing that has been in contact with an unbandaged vaccination site)?	Yes No	If no, go to question 17. If yes, go to question 16a.
16a. Have you had any new skin rash or sore since the time of contact?	Yes No	
16b. Have you had any illness or complications from your close contact with someone who was vaccinated?	Yes No	
16c. Did the scab separate/fall off by itself from the person who had the smallpox vaccination?	Yes No	
17. Have you ever been treated for or diagnosed with Chlamydia, gonorrhea, herpes simplex type 2 and/or syphilis? If so, when?	Yes No	
18. Have you or any of your blood relatives been diagnosed with Creutzfeldt-Jakob disease (CJD)?	Yes No	
19. Have you been diagnosed with dementia or any degenerative or demyelinating disease of the central nervous system or other neurological disease of unknown etiology?	Yes No	
20. Have you ever received growth hormone made from human pituitary glands?	Yes No	
21. Have you ever received a non-synthetic dura mater (brain covering) graft?	Yes No	
22. Have you received a bite from an animal suspected for rabies within the last 6 months?	Yes No	
23. Have you been exposed to significant levels of radiation, toxic chemicals, or heavy metals (such as lead, mercury or gold) in your home or work environment?	Yes No	

OOCYTE DONOR RISK QUESTIONNAIRE CONTINUED

Question	Yes No	Comment
24. Have you been excluded as a blood donor for an infectious disease reason?	Yes No	
25. Have you received a blood transfusion within the last 12 months?	Yes No	
26. Have you been diagnosed or suspected to have T. Cruzi infection or Chagas disease?	Yes No	
27. From 1980 through 1996 were you a member if the U.S. military, a civilian military employee or a dependent of a military member or civilian military employee?	Yes No	If no, go to question 28. If yes, go to question 27a.
27a. Did you spend a total of 6 months or more associated with a military base in any of the following countries: Germany, Belgium, or the Netherlands between 1980 and 1990; or Greece, Turkey, Spain, Portugal, or Italy between 1980 and 1996?	Yes No	
28. Since 1980, have you ever lived in or traveled to Europe (Includes: Albania, Austria, Belgium, Bosnia-Herzegovina, Bulgaria, Croatia, Czech Republic, Denmark, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Liechtenstein, Luxembourg, Macedonia, Netherlands, Norway, Poland, Portugal, Romania, Slovak Republic, Slovenia, Spain, Sweden, Switzerland, and Yugoslavia)?	Yes No	If no go to question 29. If yes, go to question 28a.
28a. From the beginning of 1980 through the end of 1996 did you spend time that adds up to 3 months or more in the U.K. (includes England, Ireland, Scotland, Wales, the Isle of Man, the Channel Islands, Gibraltar, and the Falkland Islands)?	Yes No	
28b. Since 1980, have you received a blood transfusion of blood or blood components in the U.K. or France?	Yes No	
28c. Since 1980 have you spent time that adds up to 5 years or more in Europe (including time spent in the U.K. between 1980 and 1996)?	Yes No	

I, the undersigned, acknowledge that I have thoroughly read the above questions and have answered them truthfully to the best of my knowledge. I have included all relevant information. I have been given the opportunity to address any uncertainties or to clarify any questions with a physician or nurse.

Signature

Date

Physician/Nurse Practitioner/Physician Assistant Review

Date