

Southwest Fertility Center
3125 N 32nd Street, Suite 200
Phoenix AZ 85018
PH 602-956-7481, Fax 602-956-7591

Dear Possible Egg Donor,

Thank you for your interest in becoming an Oocyte Donor in our program. Prior to becoming a donor you will need to complete an extensive medical and social history. Due to the nature of Oocyte donation it is very important that you complete the questionnaire accurately and in its entirety. You may mail or fax your medical history questionnaire to us.

Mail packet to: Southwest Fertility Center
Egg Donor Profile
3125 N 32nd Street, Suite 200
Phoenix AZ 85018

Or fax to: (602) 956-7591

Upon receipt it will be reviewed and you may be contacted by phone to clarify information. After review of your history, we will contact you to set up a consultation with our Nurse Practitioner. If you are deemed ineligible for any reason, you will receive a letter of regret from our office.

Thank you very much for your interest in our program.

Sincerely,

Heather Pisarski, R.N., O.G.N.P.
(Donor Oocyte Program Coordinator)

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Date ____ / ____ / ____

Patient Name _____ Age ____ Date of Birth ____ / ____ / ____

Address _____ City _____ State ____ Zip _____

Home Phone _____ Cell _____ Work _____

Email address: _____

Social security number _____ Sex _____

Employer _____ Occupation _____

Address _____ City _____ State ____ Zip _____

Name of Parent or Spouse _____ Age ____ Date Birth _____

Home Phone _____ Work Phone _____ SS# _____ Sex ____

Employer _____ Occupation _____

Address _____ City _____ State ____ Zip _____

In Case of Emergency, Notify _____ Phone: _____

Signature _____ Date _____

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OOCYTE DONATION

Code: _____ Interviewer _____ Date: ___/___/___ Updated history ___/___/___

Physical Characteristics:

Date of Birth: ___/___/___ Age: _____ Race: _____

Ht.: _____ Weight: _____ Do you smoke? Y N

Eye color: _____ Hair Color: _____ Curly ___ Wavy ___ Straight ___

Complexion: Fair ___ Med. ___ Dark ___

Body Type: Sm ___ Med. ___ Large ___ Family: Sm ___ Med ___ Lg. ___

Ethnic Ancestry/ origin: _____

Do you have any Jewish ancestors? Yes No Unknown

Do you have any African ancestors? Yes No Unknown

Do you have any Mediterranean(Greek, Spanish, Italian) ancestors? Yes No Unknown

Education: (Check all that apply)

_____ Completed Grade School

_____ Completed High School Grade Point Average GPA _____

_____ Currently in college studying GPA _____

_____ Completed College Degree in _____ GPA _____

_____ Currently pursuing advanced degree in _____ GPA _____

_____ Completed Advance degree in _____ GPA _____

_____ Trade School in _____ GPA _____

Menstrual History

Menstrual cycle: Regular _____ Irregular _____ age of 1st period _____

Length of cycle (from 1st day of one period to the 1st day of the next) _____

Length of flow: _____ Light _____ Mod _____ Heavy _____

Menstrual Cramping: Y N Severity (0 none-10 severe) _____

Medications taken: _____

Any spotting between periods? Y N

Any breast tenderness or nipple discharge? Y N

Ever have an abnormal pap? Y N If yes explain: _____

Ever have a pelvic infection? Y N Explain _____

Marital status: Married Number of years married: _____

Single Number of years in present relationship. _____

Number of partners in last year. _____

Current method of contraception _____

Past types of contraception _____

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Obstetrical History

Have you ever been Pregnant? Yes No

If yes , How many pregnancies? _____ How many Males _____ Females _____

Have you ever had an infection, fever, pain, or bleeding following childbirth, miscarriage or abortion? _____

	Date	Abortion	Miscarriage Ectopic	Complications	Conception Time	Live Birth	Gestation Week
1 Preg:	_____	_____	_____	_____	_____	_____	_____
2 Preg:	_____	_____	_____	_____	_____	_____	_____
3 Preg:	_____	_____	_____	_____	_____	_____	_____
4 Preg:	_____	_____	_____	_____	_____	_____	_____

For each child, please write their age and any health problems they may have.

AGE	Sex	Health Problems
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Health History:

Do you have any allergies to medications? Y N Please list: _____

Do you have any allergies to food or environmental allergens? Please list: _____

Please list any health problems you have been diagnosed with.

Have you had any surgeries or hospitalizations? Y N If yes please explain:

Have you ever had a blood transfusion or any medical treatment that involved blood since 1977?
Y N Where & When: _____

Have you ever had any major radiation exposure or X-Ray exposure? Y N If yes
please explain: _____

Have you ever received a non-synthetic dura mater transplant or a human growth hormone
injection? Y N

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Health History Continued:

Have you, anyone you live with, anyone you have had intimate contact, and/or sex with had any Xenotransplantation? Y N

Xenotransplantation is any procedure that involves the transplantation, implantation, or infusion into a human recipient of either: (1) live cells, tissues, or organs from a nonhuman animal source; or (2) human body fluids, cells, tissues, or organs that have had ex vivo contact with live nonhuman animal cells, tissues or organs.

How is your vision without glasses? Poor _____ Fair _____ Good _____
Do you wear glasses/ contacts? Y N Nearsighted _____ Farsighted _____
Other Please specify _____ Your vision is about _____ / _____

Do you have normal hearing? Y N If no please specify _____

What is the condition of your teeth? Good Fair Poor

Are you on a special diet? _____

Exercise History: None Occasionally Regularly Professional level
What type of exercise? _____
How many hours per week? _____

Social History:

Do you drink Alcoholic beverages? Never Occasionally Moderate Daily
Explain _____

Has there ever been a time where you drank more than you do now? Y N
If yes how much? _____ How long ago? _____

Do you smoke? Y N If yes how many packs per day? _____ How long? _____
If you previously smoked, how long ago did you quit? _____

Have you or your sexual partners ever had or have had a reactive screening test to:

HIV	Y N	Self / Partner	When _____	Treated Y N
Hepatitis B	Y N	Self / Partner	When _____	Treated Y N
Hepatitis C	Y N	Self / Partner	When _____	Treated Y N
Chlamydia	Y N	Self / Partner	When _____	Treated Y N
Venereal Warts	Y N	Self / Partner	When _____	Treated Y N
HPV	Y N	Self / Partner	When _____	Treated Y N
Herpes	Y N	Self / Partner	When _____	Treated Y N
Syphilis	Y N	Self / Partner	When _____	Treated Y N
Other	Y N	Self / Partner	When _____	Treated Y N

Please Specify: _____

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Social History continued:

Have you ever used or do you currently use any of the following drugs:

	Frequency/ Years	How used
Y N Marijuana	_____	_____
Y N Cocaine	_____	_____
Y N Barbiturates	_____	_____
Y N Narcotics/Opiates (Heroin, methadone, opium, morphine, or codeine)	_____	_____
Y N Amphetamines	_____	_____
Y N Hallucinogens	_____	_____
Y N Crystal	_____	_____
Y N Huffing	_____	_____
Y N Tranquilizers	_____	_____
Y N PCP	_____	_____
Y N Inhalants	_____	_____
Y N Other	_____	_____
Y N Over the counter Medications	_____	_____

_____ Prescription medications: Please list what you are taking, the dosage, and for how long you have been on the medication.

Have you ever injected drugs other than for a medical reason? Y N

Have you had sex with any one who has injected drugs other than for a medical reason? Y N

Have you ever had sex for money or drugs? Y N

Have you ever slept with anyone who has had sex for money or drugs? Y N

Have you ever slept with a man who has had sex with another man? Y N

Have you ever been exposed to known or suspected HIV, HBV, HCV, and/or xenotransplantation infected blood through percutaneous inoculation (needle stick) or contact with an open wound, non-intact skin, or mucous membrane? Y N

Have you ever had sex with anyone who is known or suspected to be infected with HIV, HBV, and/or HCV virus? Y N

Have you lived with another person who has hepatitis B or C infection within the last 12 months? Y N

Have you had sex with anyone who has hemophilia or other related clotting disorders? Y N

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Social History continued:

Were you or any of your sexual partners born or lived in Africa since 1977? Y N

Have you had any tattoos or body piercing in the last 12 months? Y N
If yes were they done under sterile conditions? Y N

Have you had any vaccines in the last 12 months? Y N
Do you reside with anyone who has had the smallpox vaccine within the last 12 months? Y N

Have you ever traveled outside the United States? Y N
If yes, when and for how long: _____
Have you spent 3 months in Europe, Africa, or the United Kingdom since 1980? Y N

Have you ever served overseas in the military? Y N If yes where: _____

Have you been in prison for 72 hours or greater in the last 12 months? Y N
Have you had intercourse with anyone who has been in jail for 72 hours or greater in the last 12 months? Y N

In the past 6 months have you ever been exposed to any of the following:

EXPOSED TO	WHEN	HOW OFTEN
Toxic Chemicals	_____	_____
Radiation	_____	_____
Lead/ Lead products	_____	_____
Asbestos products	_____	_____
Commercial cleaning Solutions/ solvents	_____	_____

Personal Description

In general, are you? (Circle all that apply)

Somewhat shy Sociable Very outgoing Demanding Perfectionist
Very cautious Planner Take it as it comes Risk Taker

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Do you have special abilities or talents that seem to come naturally? (Check all that apply)

Ability	None	Some Talent	Very Talented	Expert	Explain
English Language & Writing	_____	_____	_____	_____	_____
Foreign Language(s)	_____	_____	_____	_____	_____
Mathematics	_____	_____	_____	_____	_____
Physical Sciences (physics, chemistry, geology, etc.)	_____	_____	_____	_____	_____
Social Sciences (psychology, politics, etc.)	_____	_____	_____	_____	_____
Intuition	_____	_____	_____	_____	_____
Business	_____	_____	_____	_____	_____
Organization	_____	_____	_____	_____	_____
Music	_____	_____	_____	_____	_____
Singing Voice	_____	_____	_____	_____	_____
Artistic	_____	_____	_____	_____	_____
Athletic	_____	_____	_____	_____	_____
Other:	_____	_____	_____	_____	_____

Do you have specific interests/hobbies? (Reading, travel, musical instrument, sewing, clubs, woodworking, painting, etc.)

Donor History

Have you ever been refused as a blood donor? Y N If yes please explain

Have you ever been an egg donor before? Y N If yes When _____

Where _____ How many eggs obtained: _____

How many births resulted from your donation? _____

Have you ever been refused as an egg donor before? Y N If yes please explain:

Have you ever had a problem conceiving? Y N If yes please explain

Did your parents, sisters, or aunts have problems conceiving? Y N

Explain: _____

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Immediate Family Attributes (specify below)

Relation	Age	Eye Color	Hair Color	Complexion	Height	Body	Vision
<u>Mother</u>	_____	_____	_____	_____	_____	_____	_____
	If deceased age at death _____			Cause _____	_____	_____	_____
Maternal Grandmother	_____	_____	_____	_____	_____	_____	_____
	If deceased age at death _____			Cause _____	_____	_____	_____
Maternal Grandfather	_____	_____	_____	_____	_____	_____	_____
	If deceased age at death _____			Cause _____	_____	_____	_____
<u>Father</u>	_____	_____	_____	_____	_____	_____	_____
	If deceased age at death _____			Cause _____	_____	_____	_____
Paternal Grandmother	_____	_____	_____	_____	_____	_____	_____
	If deceased age at death _____			Cause _____	_____	_____	_____
Paternal Grandfather	_____	_____	_____	_____	_____	_____	_____
	If deceased age at death _____			Cause _____	_____	_____	_____
Brother	_____	_____	_____	_____	_____	_____	_____
Brother	_____	_____	_____	_____	_____	_____	_____
Brother	_____	_____	_____	_____	_____	_____	_____
Brother	_____	_____	_____	_____	_____	_____	_____
	If deceased age at death _____			Cause _____	_____	_____	_____
Sister	_____	_____	_____	_____	_____	_____	_____
Sister	_____	_____	_____	_____	_____	_____	_____
Sister	_____	_____	_____	_____	_____	_____	_____
Sister	_____	_____	_____	_____	_____	_____	_____
	If deceased age at death _____			Cause _____	_____	_____	_____

How many blood siblings are in your family (including yourself)? _____

Do twins run in your family? Y N If yes, what relation are they to you? _____

Family history:

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

- | | |
|---|--------------------------------|
| _____ Bones, muscles, joints or limbs | _____ Respiratory system |
| _____ Nervous system, brain, or spinal cord | _____ Blood circulation |
| _____ Organ (Heart, lung, Kidney Etc.) | _____ Genital/ urinary systems |
| _____ Metabolic (Hormones, enzymes, Etc.) | _____ Gastrointestinal systems |
| _____ Vision or Eye problems | _____ Hearing or Ear problems |

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In your own words

Why do you want to be a donor?

Describe your personality and character.

What are your hobbies, interests, and talents?

If you could pass a message to the recipients of your oocytes, what would that message be?
