EGG DONOR PROGRAM OF MICHIGAN - APPLICATION FORM

PERSONAL INFORMATION

Date Filled Out

Name

Date of Birth

Age

Marital Status

Mailing Address

City / State

Zip Code

Telephone where you can be reached

E-mail Address

Do you drive and have a valid driver license? ◯ Yes ◯ No

Do you own a car? ◯ Yes ◯ No

What is your current occupation?

How long have you been employed in this occupation?

PRIOR DONOR HISTORY

(We will need copies of these records sent to us-blood tests, psych screen, cycle sheet)

Have you ever been an oocyte donor before? ◯ YES ◯ NO

If yes, when?

Where?

Do you know how many eggs were produced each time?

Do you know how many births have resulted from these donations?

PERSONAL CHARACTERISTICS

Race

Height

Weight

Natural Hair Color

Natural Eye Color

Hair ◯ Thick ◯ Thin ◯ Average

Hair ◯ Curly ◯ Wavy ◯ Straight

Complexion ◯ Fair ◯ Medium ◯ Dark

Blood Type (if known)

Are you:

Do you have dimples, freckles, birthmarks? If yes, explain where

Body Type:

Were you adopted? ◯ Yes ◯ No

Ethnic Origin/Ancestry: (Example: French, Irish, Brazilian, etc.)

Religion by birth

Religion now

PREGNANCY HISTORY

Have you ever had a miscarriage and/or abortion? If so, when?

Are you currently breast-feeding?

If you have been pregnant before, please fill out with age, sex & age of child now, duration of pregnancy & if there is a complication or not

REPRODUCTIVE HISTORY

Age of First Period ◯ Regular ◯ Irregular

Interval between period(count start of flow to start of next flow)

Do you have menstrual cramps? ◯ Yes ◯ No

Do you have bleeding in between your periods? ◯ Yes ◯ No

When was your last pap smear?

If over a year would you be willing to to have it repeated? ◯ Yes ◯ No ◯ Don't Know

Have you ever had an abnormal pap? ◯ Yes ◯ No

If yes, when?

Have you had a normal pap smear since? ◯ Yes ◯ No

If so, When?

Do you have discharge from one or both breasts? ◯ Yes ◯ No

Have you ever had Endometriosis? ◯ Yes ◯ No

Have you ever had pelvic inflammatory disease? ◯ Yes ◯ No

Have you ever had any of the following (Select All that Apply)

- ☐ Gonorrhea
- ☐ Chlamydia
- ☐ Condyloma(venereal warts)
- ☐ Syphilis
- ☐ Herpes
- ☐ Other

If you have any of the above, please list each with date, age and what type of treatment you received

Is there a history of infertility in your family? ◯ No ◯ Yes ◯ Don't Know

CONTRASEPTIVE/SEXUAL HISTORY:

What contraceptives have you used (Select All That Apply)

- ☐ The Pill
- ☐ IUD
- ☐ Diaphragm
- ☐ Condom
- ☐ Patch
- ☐ Depo Provera

For each contraceptive that you used above - please list it here with the description of when, how long did you use it and whether or not you have any adverse reaction to it.

Which method do you currently use?

Which method does your partner use?

Are you:

Are you sexually active now?

- ◯ Yes
- ◯ No

How long have you been with your partner?

Is your relationship monogamous?

- ◯ Yes
- ◯ No

How many partners have you had in the past 1 year?

PERSONAL HEALTH HISTORY

Do you have any allergies?

- ◯ Yes
- ◯ No

If yes, are they to:

- ☐ Food
- ☐ Drugs
- ☐ Environmental
- ☐ Other

Please list specific substances and reaction(s) produced:

Do you have any allergies that you have outgrown? If yes, please explain:

Has anyone in your family, including yourself, experienced recurring and/or chronic physical symptoms that have not yet been evaluated by a physician? Please include those symptoms that you might not consider serious.

- ◯ No
- ◯ Yes, please explain in the text box blow

Explain Chronic Physical symptom

How is your vision (without glasses)

Do you wear glasses or contact lenses? ◯ Yes ◯ No

If so which do you wear?

Do you have normal hearing? ◯ Yes ◯ No

If no, please explain

What is the condition of your teeth?

Did you ever wear braces or a retainer? ◯ Yes ◯ No

If yes, explain

Your diet (check one) ◯ Vegetarian ◯ Non-vegetarian

Your appetite (check one) ◯ Poor ◯ Average ◯ Excellent

How much do you currently exercise? ◯ None ◯ Some ◯ Regularly

What type of exercise do you enjoy?

Have you ever had surgery? ◯ Yes ◯ No

If yes, please explain

Have you had any hospitalization not previously mentioned? ◯ Yes ◯ No

If yes, please explain

Have you had any major radiation or x-ray exposure? ◯ Yes ◯ No

If yes, please explain

Have you ever had a blood transfusion? ◯ Yes ◯ No

If yes, when?

Have you ever smoked cigarettes? ◯ Yes ◯ No

Do you still smoke cigarettes now? ◯ Yes ◯ No

Age Started:

Number per day:	
Age Quit:	

Have you ever had serious complications resulting from surgery(bleeding, embolism, coma, or anesthesia?) ◯ Yes ◯ No

If yes, explain

Have you or any member of your family had malignant hyperthermia or high fevers after surgery, injury, or exercise? ◯ Yes ◯ No

If yes, explain

Do you take any medications at the present time? ◯ Yes ◯ No

If yes, which ones

Have you ever been advised to have any diagnostic testing, hospitalization, or surgery which was not completed? ◯ Yes ◯ No

If yes, explain

Have you gained or lost more than 10 pounds in the past year? ◯ Yes ◯ No

If yes, explain

Do you consume alcoholic beverages ◯ Yes ◯ No

If yes, what kind of alcoholic beverages do you drink?

How many do you consume per day

How many do you consume per week

How many do you consume per month

Have you ever used intravenous drugs? ◯ Yes ◯ No

Have you ever been with a partner who may have used intravenous drugs? ◯ Yes ◯ No

Have you had and/or been treated for a substance/alcohol abuse/addiction problem? ◯ Yes ◯ No

Do you have any tattoos or piercing's? ◯ Yes ◯ No

If yes, explain when & where they are located

Do you have any legal cases pending against you? ◯ Yes ◯ No

Have you ever been convicted of a crime? ◯ Yes ◯ No

Have you ever participated in mental health counseling? ◯ Yes ◯ No

Are you comfortable doing an anonymous donation? ◯ Yes ◯ No ◯ Maybe

Are you willing to talk or meet with the prospective parents? ◯ Yes ◯ No

Are you willing to meet a child conceived as a result of your donation? ◯ Yes ◯ No

Are you comfortable with frozen embryos made from your donation to be adopted out? ◯ Yes ◯ No

Have you told any family or friends about your decision to donate? ◯ Yes ◯ No

If so, who have you told and are they supportive? ◯ Yes ◯ No

Are you willing to donate to gay prospective parents? ◯ Yes ◯ No ◯ Maybe

Are you willing to donate to international prospective parents? ◯ Yes ◯ No

Are you willing to donate to all ethnicity? ◯ Yes ◯ No

Are you willing to donate to a single parent? ◯ Yes ◯ No

Are there any types of prospective parents who you will not donate to? ◯ Yes ◯ No

If Yes Please elaborate

EDUCATION

Education Level Completed
(Select All that Apply)

- ☐ Completed Grade School
- ☐ Completed High School
- ☐ Completed some college/area of study
- ☐ Currently in college/area of study
- ☐ Completed college/degree
- ☐ Currently pursuing postgraduate degree
- ☐ Completed advanced degree

Please include your GPA of each level completed if known)

List any clubs, sports, activities, honors, etc

INDIVIDUAL QUESTIONS

What are some qualities that stand out unique to your personality?

Why do you want to be an egg donor?

What do you like most about yourself?

What are your personal interests, talents, special skills or activities you enjoy?

What are doing at this point in your life?

What are your future goals?

What else would you like the recipient of your donation to know about you?

What is your favorite memory as a child?

When you were a child, what did you want to be when you grew?

Have you ever been tested to determine if you carry the Cystic Fibrosis gene?

Are you or any family members known carriers of the Cystic Fibrosis gene?

Have you ever been tested to determine if you carry the Tay Sachs gene?

Are you or any family members known carriers of the Tay Sachs gene?

Have you ever been tested to determine if you carry the Fragile X gene?

Are you or any member of your family members known carriers of the Fragile X gene?	

FAMILY CHARACTERISTICS

Biological Mother	◯ Alive	◯ Deceased	◯ Don't Know
Biological Father	◯ Alive	◯ Deceased	◯ Don't Know
Biological Maternal Grandmother	◯ Alive	◯ Deceased	◯ Don't Know
Biological Maternal Grandfather	◯ Alive	◯ Deceased	◯ Don't Know
Biological Paternal Grandmother	◯ Alive	◯ Deceased	◯ Don't Know
Biological Paternal Grandfather	◯ Alive	◯ Deceased	◯ Don't Know

For all the relative above - if deceased please list cause of death and age of death

Siblings
Please list each sibling you have and whether or they are alive or deceased. If deceased please list cause of death and age of death

Have twins or other multiple births occurred in your family? ◯ Yes ◯ No ◯ Don't Know

MEDICAL BACKGROUND

In the next several pages indicate if you or your grandparents, parents, siblings, children, aunts, uncles, cousins or other extended family members(blood relatives) have had or now have any of the following medical conditions listed below. If answering yes, please give age at onset, treatment, medication, etc.

Have or Your Family Member Suffered from the following Heart Conditions (Select All that Apply)

- [ ] Stroke
- [ ] Heart Attack
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Hardening of the Arteries
- [ ] High Blood Pressure
- [ ] High Cholesterol

For any conditions above that you selected - the describe each as well as you can

Have or Your Family Member Suffered from the following Blood Conditions (Select All that Apply)

- [ ] Anemia
- [ ] Sickle-cell Anemia
- [ ] Hemophilia or other bleeding problem
- [ ] Leukemia
- [ ] Immune Deficiency
- [ ] Thalassemia
- [ ] Other Blood Disorder

For any conditions above that you selected - the describe each as well as you can

Have or Your Family Member Suffered from the following Respiratory (Lungs) (Select All that Apply)

- [ ] Hay fever
- [ ] Asthma
- [ ] Emphysema
- [ ] Tuberculosis
- [ ] Lung cancer
- [ ] Pneumonia
- [ ] Cystic Fibrosis
- [ ] Other Lung disease

For any conditions above that you selected - the describe each as well as you can

Have or Your Family Member Suffered from the following Gastro-Intestinal (Select All that Apply)

- [ ] Ulcer of stomach or Duodenum
- [ ] Gallstones
- [ ] Hepatitis A (infectious)
- [ ] Hepatitis B_(serum)
- [ ] Hepatitis C
- [ ] Other liver disease
- [ ] Colon cancer
- [ ] Ulcerative colitis
- [ ] Crohn’s disease
- [ ] Intestinal cancer
- [ ] Cirrhosis
- [ ] Pyloric Stenosis
- [ ] Rectal disorder
- [ ] Any other problem of the digestive system

For any conditions above that you selected - the describe each as well as you can

Have or Your Family Member Suffered from the following Metabolic/Endocrine Conditions
(Select All that Apply)

- [ ] Diabetes mellitus
- [ ] Hypoglycemia
- [ ] Thyroid disease
- [ ] Thyroid cancer
- [ ] Goiter
- [ ] Adrenal dysfunction
- [ ] Phenyl Ketonuris (PKU)

For any conditions above that you selected - the describe each as well as you can

Have or Your Family Member Suffered from the following Urinary Conditions
(Select All that Apply)

- [ ] Kidney disease
- [ ] Kidney stones
- [ ] Other diseases of the urethra, bladder, ureter

For any conditions above that you selected - the describe each as well as you can

Have or Your Family Member Suffered from the following Genital/Reproductive Conditions
(Select All that Apply)

- [ ] Undescended testicle
- [ ] Hypospadias
- [ ] Prostate cancer
- [ ] Uterine fibroids
- [ ] Endometriosis
- [ ] Cervical cancer
- [ ] Ovarian cancer
- [ ] Ovarian cysts
- [ ] Uterine cancer
- [ ] Spontaneous abortion,miscarriage, stillbirth
- [ ] Early infant death
- [ ] Premature menopause
- [ ] Hermaphroditism
- [ ] Ambiguous Genitals

For any conditions above that you selected - the describe each as well as you can

Have or Your Family Member Suffered from the following Neurological Conditions (Select All that Apply)

- [ ] Migraines
- [ ] Mental Retardation
- [ ] Down's syndrome
- [ ] Turner's syndrome
- [ ] Fragile X
- [ ] Multiple sclerosis
- [ ] Cerebral palsy
- [ ] Hydrocephalus
- [ ] Spinal Cord disorder
- [ ] Huntington's chorea
- [ ] Gaucher's disease
- [ ] Canavan's disease
- [ ] Tay sach's
- [ ] Wilson's disease
- [ ] Parkinson's disease
- [ ] Alzheimer's disease
- [ ] Senility before age 50
- [ ] Other diseases of the Nervous system

For any conditions above that you selected - the describe each as well as you can

Have You or Your Family Member Suffered from the following Mental Health Conditions
(Select All that Apply)

- [ ] Schizophrenia
- [ ] Manic depression
- [ ] Depression
- [ ] Suicide
- [ ] Other mental health disorders requiring hospitalization

For any conditions above that you selected - the describe each as well as you can

Have You or Your Family Member Suffered from the following Muscular/Bones/Joints Conditions
(Select All that Apply)

- [ ] Muscular dystrophy
- [ ] Other chronic Muscle disease
- [ ] Lupus
- [ ] Deformity of spine/Spina Bifida
- [ ] Osteoporosis
- [ ] Dwarfism
- [ ] Rheumatoid arthritis
- [ ] Gout
- [ ] Cleft Palate/Cleft lip
- [ ] Marfan syndrome

For any conditions above that you selected - the describe each as well as you can

Have You or Your Family Member Suffered from the following Sight/Sound/Smell Conditions
(Select All that Apply)

- [ ] Deafness before age 60
- [ ] Deformity of the ear
- [ ] Cataracts before age 50
- [ ] Blindness
- [ ] Color blindness
- [ ] Deviated septum
- [ ] Retinitis Pigmentosa
- [ ] Any other sight/sound/smell disorder

For any conditions above that you selected - the describe each as well as you can

Have or Your Family Member Suffered from the following Skin Conditions (Select All that Apply)

- [ ] Acne
- [ ] Eczema
- [ ] Skin cancer
- [ ] Pigmentation disorder
- [ ] Neurofibromatosis
- [ ] Other disorders of the skin
- [ ] Other Blood Disorder

For any conditions above that you selected - the describe each as well as you can

Have or Your Family Member Suffered from the following Other Conditions (Select All that Apply)

- [ ] Alcoholism
- [ ] Drug abuse, misuse or addiction
- [ ] Breast cancer
- [ ] Early death, Before age 50
- [ ] Any other cancer not mentioned
- [ ] Congenital hip problems
- [ ] Club feet
- [ ] Any other condition not mentioned

For any conditions above that you selected - the describe each as well as you can

DONOR CONSENT

I have answered all the questions to the best of my ability and the answers to my knowledge are correct.

I am aware that all information on the preceding pages (except for identifying information on page one) can be released to the potential recipient of my donated oocytes.

Signed

Date Signed

Submit