Egg Donor Questionnaire

Please include photos of yourself and your child/ren (if applicable) with this questionnaire.
We encourage you to provide accurate and thorough responses
so that we can match you appropriately with Recipient Parents.
Use your TAB key to navigate through this form.

General Information

Date:

First name initial (or Nickname):

What state do you live in?

Closest major airport:

Would you be willing to travel out of state for the donation? Yes No

Physical Information

Age: Birth date:

Height: Weight:

Vision: normal 20/20 far sighted near sighted

Eye color: brown green hazel blue other

Eye shape: round oval almond

Hair color as a young child:

Hair (natural): straight wavy curly

Dental: none braces retainer other

Reason: cosmetic accident disease other

Mouth size: small average large

Lip size: thin average full

Dimple (s): Yes No if yes, where:

Freckles: Yes No if yes, where:

Body frame/bone structure: (please circle) small medium large

Right handed Left handed Ambidextrous

Race (s):

Ethnic background (s):

Athletic activity: high average below average

Have you excelled in any athletic activity? Yes No

If yes, please describe:

Are you musically talented? Yes No

If yes, please describe:

Sexual orientation: heterosexual homosexual bi-sexual

Personal Information

Religious affiliation:

Do you drive? Yes No

Do you own a car? Yes No

Do you have auto insurance? Yes No

Are you a U.S. Citizen? Yes No

If you have ever lived in another country, where?

When? From: To:

What languages do you speak / write?

Marital status:

Are you employed? Yes No

If yes, what is your current occupation/position?

Educational Information

Highest level of education completed:
(You must have graduated high school or obtained a GED to qualify as an Egg Donor)

Do you have any college background? Yes No

If yes, please state when & location:

What was (were) your college degree (s) and major (s)?

Please list any degrees you are currently pursuing:

Other licenses/certificates/areas of training:

Grade Point Average: High School College

SAT ACT MCAT

Your favorite subject: Least Favorite:

Reproductive Information

Have you ever been pregnant? Yes No If yes, how many times?

How many children (natural) do you have? # Males # Females

Have you ever gone through fertility treatment to become pregnant? Yes No

If yes, please explain:

Have you ever had any pregnancy and/or delivery complications Yes No
(i.e. pre-term labor, high blood pressure, gestational diabetes, placenta previa, etc.)?

If yes, please explain:

Do any of your biological children have physical health problems? Yes No

If yes, please explain:

Do any of your biological children have psychological or behavioral problems? Yes No

If yes, please explain:

Have you ever placed a child for adoption? Yes No

If yes, please explain and include date (s)

Do you have any deceased children? Yes No

If yes, please explain:

Do you have regular menstrual cycles? Yes No

Has anyone in your family had multiple births? Yes No

If yes, please explain:

What method of birth control are you using at this time?

Birth control pills	Depo Provera	Norplant	Vasectomy
Condoms	Diaphragm	Patch	Other
Contraceptive gel	IUD	Tubal ligation	not sexually active

How long have you been on this form of birth control?

Personal Health and Medical Information

Overall Health Condition:

When did you last see your general practitioner/family doctor?

When was your last pap smear?

What were the results of your last pap smear?

If you have ever had an abnormal pap smear result, please explain (include date/s and course of treatment):

What is your blood type? (If known)

Do you have any allergies? Yes No

If yes, explain:

Do you currently take any prescription or over-the-counter medications? Yes No

If yes, please medications & reason:

Have you ever been tested for HIV/AIDS? Yes No

If yes, please provide dates & results:

Have you ever suffered from severe depression? Yes No

If yes, please list dates & explain:

Have you ever been to see a psychiatrist, psychologist, or any other mental health professional? Yes No If yes, please explain:

Have you ever been prescribed psychiatric medication(s)? Yes No

If yes, please list dates and explain:

Have you ever been hospitalized due to a psychiatric issue? Yes No

If yes, please list dates and explain:

Do you exercise? Yes No How often?

Have you ever had surgery (minor or major)? Yes No

If yes, please explain:

Do you have any chronic medical conditions/problems? Yes No

If yes, please explain:

Do you have any siblings who died in infancy or in early childhood? Yes No

If yes, please explain:

Do you smoke cigarettes? Yes No

If yes, how often:

Do you drink alcohol? Yes No

If yes, how often:

Do you or anyone in your family have a history of alcohol or drug abuse? Yes No

If yes, please explain:

Please check either "Yes" or "No" below accordingly:

Have either you or your spouse/partner ever been diagnosed with any of the following STD's:

Gonorrhea	Yes	No	Hepatitis B	Yes	No
Hepatitis C	Yes	No	Herpes	Yes	No
HIV	Yes	No	Genital warts/sores	Yes	No
Syphilis	Yes	No			

<u>Other conditions/illnesses:</u>

Anemia	Yes	No	Kidney disease/infection	Yes	No
Asthma	Yes	No	Kidney stones	Yes	No
Back or neck problems	Yes	No	Liver disease/infection	Yes	No
Beta strep	Yes	No	Migraine	Yes	No
Cancer	Yes	No	Ovarian cysts	Yes	No
Diabetes	Yes	No	PID	Yes	No
Head injury	Yes	No	Seizures	Yes	No
Heart problems	Yes	No	Thyroid problem	Yes	No
Hemorrhoids	Yes	No	Tuberculosis	Yes	No
High blood pressure	Yes	No	Uterine fibroid	Yes	No
Irregular heartbeat	Yes	No	Vaginal discharge	Yes	No
			Varicose veins	Yes	No

OTHER: If you answered "yes" to any of the above, please explain in detail:

Genetic Information

Have you, any of your children (if applicable) or any of your biological family members (including parents, siblings, aunts, uncles and cousins) been diagnosed or experienced any of the below? *Please check all that apply. Also, please list relationship (self, or specific family member) and age of diagnosis.*

		Relationship and age diagnosed
Alcohol or drug addiction		
Blindness		
Canavan		
Cancer		
Congenital heart defect		
Cystic fibrosis		
Deafness		
Depression		
Down’s syndrome		
Dwarfism		
Epilepsy		
Heart problems		
Hemophilia		
Hyperactivity – ADD/ADHD		
Insanity		
Learning disabilities		
Major birth defect		
Mental retardation		
Multiple miscarriages		
Muscular dystrophy		
Nervous breakdown		
Schizophrenia		
Seizures		
Skin conditions (i.e. psoriasis)		
Stillbirth or childhood death		
Stroke		
Suicide or attempted suicide		
Tay Sachs		
Thalassemia		

Please tell us some basic details about the genetic relatives listed below. If any of the mentioned family members are deceased, please fill in the section to follow which asks you to specify age and cause of death.

Mother

Age:	Hair Color:	Eye Color:	Height:	Weight:
Career/Hobbies/interests:				
Health (physical and mental):				

Father

Age:	Hair Color:	Eye Color:	Height:	Weight:
Career/Hobbies/interests:				
Health (physical and mental):				

Siblings*

**If you have more than 3 siblings, please add additional information at the bottom of this section of the questionnaire.*

Age: Sex: M F	Hair Color:	Eye Color:	Height:	Weight:
Career/Hobbies/interests:				
Health (physical and mental):				

Age: Sex: M F	Hair Color:	Eye Color:	Height:	Weight:
Career/Hobbies/interests:				
Health (physical and mental):				

Age: Sex: M F	Hair Color:	Eye Color:	Height:	Weight:
Career/Hobbies/interests:				
Health (physical and mental):				

Age: Sex: M F	Hair Color:	Eye Color:	Height:	Weight:
Career/Hobbies/interests:				
Health (physical and mental):				

Children*

If you have more than 4 children, please add additional information at the bottom of this section of the questionnaire.

Age: Sex: M F	Hair Color:	Eye Color:	Height:	Weight:
Career/Hobbies/interests:				
Health (physical and mental):				

Age: Sex: M F	Hair Color:	Eye Color:	Height:	Weight:
Career/Hobbies/interests:				
Health (physical and mental):				

Age: Sex: M F	Hair Color:	Eye Color:	Height:	Weight:
Career/Hobbies/interests:				
Health (physical and mental):				

Age: Sex: M F	Hair Color:	Eye Color:	Height:	Weight:
Career/Hobbies/interests:				
Health (physical and mental):				

Maternal Grandmother

Age:	Hair Color:	Eye Color:	Height:	Weight:
Career/Hobbies/interests:				
Health (physical and mental):				

Maternal Grandfather

Age:	Hair Color:	Eye Color:	Height:	Weight:
Career/Hobbies/interests:				
Health (physical and mental):				

Paternal Grandmother

Age:	Hair Color:	Eye Color:	Height:	Weight:
Career/Hobbies/interests:				
Health (physical and mental):				

Paternal Grandfather

Age:	Hair Color:	Eye Color:	Height:	Weight:
Career/Hobbies/interests:				
Health (physical and mental):				

If any of the above are deceased, please specify the genetic relative to which you are referring as well as his or her age and cause of death:

Family Member	Age	Cause of Death

Any additional comments about family history:

Legal Information

Have you ever been arrested or had any conflicts with the law? Yes No

If yes, please explain:

Has there been any criminal history in your family? Yes No

If yes, please explain:

Information about becoming an Egg Donor

Have you ever been an Egg Donor? Yes No

If yes, please list number of donations and dates:

Do you know if the donation was successful? Yes No

Please describe your feelings towards your past Egg Donation(s):

Do you have any concerns about sharing your Egg Donation information with your children?
Yes No

If yes, please explain:

Please describe the "ideal" couple/individual for whom you would like to become an Egg Donor:

Please list any circumstances which would cause you to **NOT** want to donate for a couple or individual?

Why would you like to be an Egg Donor? (Please explain in as much detail as possible.)

Please tell us about yourself! Describe your personality, character, interests and hobbies:

Level of Egg Donation: anonymous semi-open open

If you have chosen to do semi-open donation, how much contact would you like with the child (ren) and parent/s after the pregnancy/delivery? *(Please be specific in describing what you have in mind, as we want to make sure you are matched accordingly.)*

Please write a note to your future Recipient Parent/s:

Please write a note to any children that may be born via your Egg Donation:

Please email, mail or fax this completed Donor application to our office for review.
Beginning Families will be in contact with you shortly after receiving your information.
Thank You!

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