

# ADVANCED REPRODUCTIVE MEDICINE

## AT UNIVERSITY OF COLORADO HOSPITAL

ANSCHUTZ OUTPATIENT PAVILION  
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AURORA, COLORADO 80045

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### OOCYTE (EGG) DONOR QUESTIONNAIRE

#### I. CONFIDENTIAL INFORMATION

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

Unit/Apt. Number: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

You may send letters to my home:  NO  YES

An alternative address that would allow mail to get to me is:

\_\_\_\_\_  
\_\_\_\_\_

Email address: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_

Social Security Number: *(required for donor fee payment)* \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Do you have health care insurance?  NO  YES

Do you own a car? \_\_\_\_\_ Do you have a valid driver's license? \_\_\_\_\_

Do you have adequate and reliable transportation? \_\_\_\_\_

Marital status: *(circle)* Married Single with relationship Single without relationship

Partner's Name: *(if applicable)* \_\_\_\_\_

Duration of relationship with partner: \_\_\_\_\_

Date of current marriage: *(if applicable)* \_\_\_\_\_

Date(s) of previous marriage(s): *(if applicable)* \_\_\_\_\_

Date(s) of divorce(s): *(if applicable)* \_\_\_\_\_

Number of children living in the home with you: \_\_\_\_\_

DONOR # \_\_\_\_\_

***It is essential that we be able to contact you regarding test results, return appointments, or schedule changes. Please check all of the following acceptable means of communicating with you.***

\_\_\_\_\_ You may phone me at home and leave messages. My home phone # is: \_\_\_\_\_

\_\_\_\_\_ You may phone me at home, but leave **no messages**. My home phone # is: \_\_\_\_\_

\_\_\_\_\_ You may phone me at work and leave messages. My work phone # is: \_\_\_\_\_

\_\_\_\_\_ You may phone me at work, but leave **no messages**. My work phone # is: \_\_\_\_\_

\_\_\_\_\_ You may phone me on my cell phone and leave messages. Cell #: \_\_\_\_\_

\_\_\_\_\_ You may phone my cell phone, but leave **no messages**. Cell #: \_\_\_\_\_

\_\_\_\_\_ You may phone me at a number other than home, work, or cell; that # is: \_\_\_\_\_

May we leave messages at this number?     NO     YES

Whose number is this? \_\_\_\_\_

The best time and place to call is: \_\_\_\_\_

How did you learn of our donor egg program? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Verification of accuracy of responses on the Egg Donor Questionnaire:**

I understand that I can be held legally responsible for providing false information on this questionnaire. I certify that the preceding and following responses are truthful and accurate to the best of my knowledge and that I have included all pertinent information.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_



Please describe any honors courses, specialty training in your educational background: \_\_\_\_\_

Current occupation: \_\_\_\_\_

Please describe your mother's occupation/career and talents: \_\_\_\_\_

What was your mother's level or type of educational training? \_\_\_\_\_

Please describe your father's occupation/career and talents: \_\_\_\_\_

What was your father's level or type of educational training? \_\_\_\_\_

**Do you have special abilities or talents?** (Check all that apply.)

Ability	None	Some talent	Very Talented	Explain, give examples
English language and writing				
Foreign language(s)				
Mathematics				
Physical sciences				
Social sciences				
Business				
Organization				
Manual dexterity				
Music				
Singing Voice				
Artistic				
Athletic				

What other skills, talents, interests and hobbies do you have (i.e., reading, ability to do games, crossword puzzles, handicrafts, etc.)? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PERSONAL HEALTH HISTORY** *(circle the answer that best fits or completes sentence)*

**Vision:**            normal            far-sighted            near-sighted            astigmatism

**Glasses/contacts:** none            single            bifocal            trifocal            age began wearing: \_\_\_\_\_

**Hearing:**            poor            fair            good            excellent

Describe problems: *(if applicable)* \_\_\_\_\_

**Dental:**                            poor                            fair                            good                            excellent                            orthodontic work

**Dental device:** none            braces            retainer            other: \_\_\_\_\_

**Reason for braces:** cosmetic            accident            disease            other: \_\_\_\_\_

**Current Smoking:**     NO     YES (number per day \_\_\_\_\_)

**Past Smoking:** Approximate dates of smoking were: \_\_\_\_\_

How many alcoholic beverages do you consume?    \_\_\_\_\_ per day    \_\_\_\_\_ per week    \_\_\_\_\_ per month

Do you drink substances containing caffeine *(coffee, tea, soft drinks)*?     NO     YES

If YES, how many drinks per day? \_\_\_\_\_

How much exercise do you get?            none                            occasional                            regular

Have you been exposed to radiation or toxic chemicals in your work or personal life? \_\_\_\_\_

**ALLERGIES:**     NO     YES

***If YES, describe specific substance, reaction, and age first noticed.***

Substance (allergen)	Reaction(s)

Your general health: *(circle)*    excellent            good            fair            poor

Childhood illnesses and dates: \_\_\_\_\_

**PERSONAL FAMILY HISTORY**How many blood siblings are in your immediate family (*including yourself*)?

# of males \_\_\_\_\_ # of females \_\_\_\_\_

Are you adopted?  NO  YES

If YES, please complete the following histories if you know your birth family history. If you do not know your birth family history, complete the history for yourself and your children and known biological relatives only.

***Please describe your family members by the following characteristics:***

Relation	Eye Color	Hair Color	Ht	Wt	Ethnic Origin	Age if Living	Age at Death	Cause of Death
Mother								
Father								
Maternal Grandmother								
Maternal Grandfather								
Paternal Grandmother								
Paternal Grandfather								
Brothers	1.	1.	1.	1.	1.	1.	1.	1.
	2.	2.	2.	2.	2.	2.	2.	2.
	3.	3.	3.	3.	3.	3.	3.	3.
	4.	4.	4.	4.	4.	4.	4.	4.
Sisters	1.	1.	1.	1.	1.	1.	1.	1.
	2.	2.	2.	2.	2.	2.	2.	2.
	3.	3.	3.	3.	3.	3.	3.	3.
	4.	4.	4.	4.	4.	4.	4.	4.
Your children	1.	1.	1.	1.	1.	1.	1.	1.
	2.	2.	2.	2.	2.	2.	2.	2.
	3.	3.	3.	3.	3.	3.	3.	3.
	4.	4.	4.	4.	4.	4.	4.	4.

Have twins or multiple births occurred in your family?  NO  YES

Describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Carefully review the following list of medical problems and identify which are present in the listed family members. If applicable, please indicate age of onset.**

*\*MGM=maternal grandmother, MGF=maternal grandfather, PGM=paternal grandmother, PGF=paternal grandfather*

Body System	You	Your Children	Mother	Father	Sibling	MGM/MGF PGM/PGF*	Aunt/Uncle
<b>CONGENITAL ANOMALIES</b>							
Cleft lip/palate							
Heart defect							
Hip problems							
Club foot							
Other birth defects							
<b>CHROMOSOMAL ABNORMALITIES</b>							
Down's syndrome (trisomy 21)							
Fragile X syndrome							
Turner's syndrome							
Other chromosomal abnormalities (describe)							
<b>CANCERS</b>							
Breast							
Colon							
Intestinal							
Lung							
Ovarian							
Cervix							
Uterus							
Prostate							
Skin							
Stomach							
Testicular							
Thyroid							
Any other cancers							
<b>CARDIOVASCULAR</b>							
Stroke							
Heart attack							
Heart disease							
Hardening of the arteries							
High blood pressure							
High cholesterol level							
Heart murmur							
Other							
<b>BLOOD</b>							
Anemia							
Sickle-cell anemia							

Body System	You	Your Children	Mother	Father	Sibling	MGM/MGF PGM/PGF*	Aunt/Uncle
Hemophilia/ bleeding disorder							
Leukemia							
Immune deficiency							
Lymphoma							
Blood clot ( <i>in lungs, brain or heart</i> )							
Other blood disorder							
<b>GASTRO- INTESTINAL</b>							
Ulcers							
Gallstones							
Hepatitis A, B, C							
Cirrhosis							
Other liver disease							
Ulcerative colitis							
Crohn's disease							
Developmental disorders of stomach and intestine							
Pyloric stenosis							
Rectal disorder							
Any other cancer or problem of digestive system							
<b>GENITAL/ REPRODUCTIVE</b>							
Lumps or cysts in breasts							
Endometriosis							
Uterine fibroids							
Ovarian cysts							
Undescended testicle							
Hypospadias							
Premature menopause							
Infertility							
Multiple miscarriages							
Stillborn							
Death of a newborn infant							
Neonatal jaundice							
Other genital/reproductive problems							
<b>URINARY</b>							
Kidney disease							
Other disease of urinary tract (bladder, urethra, ureters); multiple urinary tract infections							

Body System	You	Your Children	Mother	Father	Sibling	MGM/MGF PGM/PGF*	Aunt/Uncle
<b>METABOLIC/ ENDOCRINE</b>							
Diabetes							
PKU ( <i>phenylketonuria</i> )							
Hypocalcemia							
Thyroid disease							
Goiter							
Adrenal problems							
Other metabolic or hormonal problems							
<b>MUSCLE/BONE JOINTS</b>							
Muscular dystrophy							
Other chronic muscle disease							
Loss of muscle coordination							
Lupus							
Osteoporosis							
Dwarfism							
Arthritis							
Scoliosis							
Gout							
Other diseases of muscle/bone/joints							
<b>RESPIRATORY</b>							
Hay fever/ environmental allergy							
Asthma							
Tuberculosis							
Emphysema							
Pneumonia							
Cystic fibrosis							
Other lung disease							
<b>SIGHT/SOUND SMELL</b>							
Deafness before age 60							
Cataracts before age 50							
Blindness							
Color blindness							
Problems with sense of smell							
Glaucoma							
Other							
<b>SKIN</b>							
Acne							
Eczema							
Pigmentation disorder							

Body System	You	Your Children	Mother	Father	Sibling	MGM/MGF PGM/PGF*	Aunt/Uncle
Excessive hair growth							
Other skin disorders							
<b>NEUROLOGICAL</b>							
Migraines							
Mental retardation							
Senility before age 50							
Multiple sclerosis							
Cerebral palsy							
Epilepsy/seizures							
Hydrocephalus							
Spina bifida/neural tube defect							
Huntington's disease							
Gaucher's disease							
Wilson's disease							
Creutzfeldt-Jacob Disease							
Parkinson's disease							
Tourette's syndrome							
Other diseases of nervous system							
<b>MENTAL HEALTH</b>							
Schizophrenia							
Manic depressive or bipolar disorder							
Anxiety/panic attacks							
Depression							
Hyperactivity or attention deficit disorder							
Eating disorders (anorexia/ bulimia)							
Obsessive/ compulsive disorders							
Suicide attempts							
Any other mental health problem (describe)							
<b>OTHER</b>							
Alcoholism							
Drug abuse, misuse, or addiction							
Any autoimmune disorder not mentioned							
Learning disabilities or learning styles							
Any other problems not mentioned							

DONOR # \_\_\_\_\_

If you are of Black ancestry, have you been tested as a carrier of Sickle Cell Disease?  NO  YES

If you are of Jewish ancestry, have you been tested as a carrier of Tay Sachs Disease?  NO  YES

Canavan Disease?  NO  YES      Gaucher's Disease?  NO  YES

If you are of Mediterranean (*Greek or Italian*), African or Asian ancestry, have you been tested as a carrier of thalassemia?  NO  YES

Regardless of your ethnicity, have you been tested as a carrier of cystic fibrosis?  NO  YES

### **YOU AS A PERSON**

Please list and explain your reasons for wanting to participate as an egg donor.

1. Interest in procedure:

2. Financial:

3. I know someone who is infertile:

4. To help someone else:

5. Other:

**In general, are you:** (*check all that apply*)

- |  |  |  |  |   |                                     |
|--|--|--|--|---|-------------------------------------|
| <input type="checkbox"/> shy             | <input type="checkbox"/> introverted         | <input type="checkbox"/> sociable      | <input type="checkbox"/> extroverted   | <input type="checkbox"/> extremely outgoing |                                     |
| <input type="checkbox"/> low maintenance | <input type="checkbox"/> somewhat demanding  | <input type="checkbox"/> perfectionist | <input type="checkbox"/> very cautious |   |                                     |
| <input type="checkbox"/> planner         | <input type="checkbox"/> take-it-as-it-comes | <input type="checkbox"/> passive       | <input type="checkbox"/> assertive     | <input type="checkbox"/> aggressive         | <input type="checkbox"/> risk-taker |
| <input type="checkbox"/> intuitive       | <input type="checkbox"/> logical             | <input type="checkbox"/> analytical    | <input type="checkbox"/> emotional     | <input type="checkbox"/> rational           |                                     |

How else would you describe your personality and temperament?

Describe yourself as a child (temperament, social relationships, activities, school experiences).

What are your overall career and/or personal goals in life?

What message would you like passed on to the recipient of your donated eggs and/or resulting offspring?

**SUPPLEMENTARY QUESTIONNAIRE**  
(NOT TO BE GIVEN TO THE RECIPIENTS OF DONATED EGGS.)

**MEDICAL HISTORY**

**IN THE PAST 12 MONTHS, HAVE YOU ENGAGED IN ANY OF THE FOLLOWING:**

- No     Yes    Gotten a tattoo or ear/skin piercing, acupuncture, needle stick, or come into contact with someone else's blood
- No     Yes    Shared any IV drug needles or syringes to use any drug (including steroids)
- No     Yes    Taken money or drugs for sex
- No     Yes    Had a positive test for syphilis, gonorrhea or chlamydia
- No     Yes    Had sex with any person (male or female) other than your current partner

**HAVE YOU EVER EXPERIENCED THE FOLLOWING:**

- No     Yes    Received blood or blood products
- No     Yes    Had an organ or tissue transplant
- No     Yes    Ever had treatment with pituitary-derived human growth hormone or received any other human extracts

***Current medication, including prescription, over-the-counter, herbs and vitamins:***

Medication	Started	Through	Amount	Indications

**IMMUNITY HISTORY**

***Approximate dates of your last vaccination or immunity test:***

Infectious disease	Vaccination? (yes or no)	Date received vaccine	Test showing immunity (yes or no)	Date of immunity test
Tetanus				
Rubella or MMR ( <i>measles, mumps, rubella</i> )				
Varicella ( <i>chicken pox</i> )				
TB skin test				
Influenza				
Hepatitis B				
Other:				

***Have you had surgery?***

Procedure	Date	Indication

Have you had any major illnesses such as hepatitis, pneumonia, mononucleosis, etc.? NO YES

If YES, explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you ever been in a serious accident or had a serious injury? NO YES

If YES, explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### **DETAILED COMMUNICABLE (INFECTIOUS) DISEASE HISTORY**

- yes  no 1. Have you had any hospitalizations in the past year?
- yes  no 2. Do you take any medications (prescription or nonprescription)? If yes, please indicate medications: \_\_\_\_\_
- yes  no 3. Have you injected drugs for a non-medical reason in the preceding five years, including intravenous, intramuscular, or subcutaneous injections?
- yes  no 4. Do you have hemophilia? If yes, do you use human-derived clotting factor?  yes  no
- yes  no 5. Have you engaged in sex in exchange for money or drugs in the preceding five years?
- yes  no 6. Have you had sex in the preceding 12 months with any person described in the previous 4 items of this section or with any person known or suspected to have HIV infection, clinically active hepatitis B infection, or hepatitis C infection?
- yes  no 7. Have you been exposed in the preceding 12 months to known or suspected HIV, HBV, and/or HCV-infected blood through percutaneous inoculation (e.g., needle-stick) or through contact with an open wound, non-intact skin, or mucus membrane?
- yes  no 8. Have you been incarcerated for more than 72 consecutive hours during the previous 12 months?
- yes  no 9. Have you had close contact within 12 months preceding donation with another person having clinically active viral hepatitis (e.g., living in the same household where sharing of kitchen and bathroom facilities occurs regularly)?
- yes  no 10. Have you had a tattoo, ear piercing, or body piercing in the last 12 months in which instruments were shared?
- yes  no 11. Have you been diagnosed with viral hepatitis after age 11? Unless evidence from the time of illness documents that the hepatitis was identified as hepatitis A (e.g., a reactive IgM anti-HAV test)?
- yes  no 12. Have you been exposed to smallpox or a person getting the smallpox vaccine in the past 60 days?
- yes  no 13. Have you had a recent smallpox vaccination (vaccinia virus) in the last 60 days? If less than 60 days, did the scab separate by some other means than spontaneously?
- yes  no 14. Do you have a clinically recognizable vaccinia virus infection contracted by close contact with someone who received the smallpox vaccine? The physical assessment should also check for this. **If the answer is yes to this question, defer donation for 90 days or 14 days after all complications have resolved whichever is the later date.**

- yes  no 15. Have you had a medical diagnosis of WNV infection? **If the answer is yes to this question, defer donation for 28 days from onset of symptoms or 14 days after condition has resolved whichever is the later date.**
- yes  no 16. Have you had both a fever and a headache (simultaneously) during the 7 days prior to donation? **If yes, defer donation for 28 days.**
- yes  no 17. Are you or any close contacts a recipient of a transplanted organ, tissue, or cells from an animal of different species such as a domestic swine? Have you, your sexual partner, or any member of his/her household ever had a medical procedure that involved being exposed to live cells, tissues, or organs from an animal?
- yes  no 18. Have you had a transfusion or received blood or blood products in the last 48 hours?
- yes  no 19. Have you been diagnosed with or treated for chlamydia?
- yes  no 20. Have you been diagnosed with or treated for gonorrhea?
- yes  no 21. Have you ever been diagnosed with Creutzfeldt-Jakob Disease (CJD) or any other form of CJD?
- yes  no 22. Have you ever had a diagnosis of dementia or any degenerative or demyelinating disease of the central nervous system (CNS) or other neurological disease of unknown etiology?
- yes  no 23. Have you ever had a blood relative diagnosed with CJD?
- yes  no 24. Have you ever taken human pituitary-derived growth hormone or other human extracts?
- yes  no 25. Have you ever received a dura mater transplant?
- yes  no 26. Have you spent three months or more cumulatively in the U.K. from the beginning of 1980 through the end of 1996?
- yes  no 27. Are you a current or former U.S. military member, civilian military employee, or dependent of a military member or civilian employee who resided at U.S. military bases in Northern Europe (Germany, U.K., Belgium, and the Netherlands) for 6 months or more from 1980 through 1990, or elsewhere in Europe (Greece, Turkey, Spain, Portugal, and Italy) for 6 months or more from 1980 through 1996?
- yes  no 28. Have you lived cumulatively for 5 years or more in Europe from 1980 until the present (note this criterion includes time spent in the U.K. from 1980 through 1996)?
- yes  no 29. Have you received any transfusion of blood or blood components in the U.K. between 1980 and the present?
- yes  no 30. Have you injected bovine insulin since 1980, unless you can confirm that the product was not manufactured after 1980 from cattle in the U.K.?
- yes  no 31. Have there been any illnesses or deaths in your family in the past year? If yes, please specify illness and/or cause of death and individual's relationship to you: \_\_\_\_\_
- yes  no 32. **If this is a repeat donation within 6 months of your last full medical history interview, have the answers to the above questions changed?**

The following questions need only be asked if there is a SARS outbreak in the world. Contact the CDC website (<http://www.cdc.gov/ncidod/sars/index.htm>) or call CDC (888-246-2675) to obtain the up-to-date information concerning areas affected by SARS. If there are cases of SARS, ask the following questions, otherwise note N/A.

- yes  no 33. Have you traveled to or resided in (the areas affected) in the last 14 days?
- yes  no 34. Have you had close contact with someone who has traveled to or resided in (the areas affected) in the last 14 days?
- yes  no 35. Have you been treated for SARS or suspected you had SARS in the last 28 days?
- yes  no 36. Have you had close contact within the previous 14 days with persons with SARS or suspected SARS?

**DETAILED PERSONAL REPRODUCTIVE HISTORY**Have you ever been treated for infertility?  NO  YES***Please give a history of all pregnancies:***

Number	Year	Infertility therapy needed?	Months to conceive?	Length of pregnancy in months	LOSSES: indicate miscarriage, ectopic, abortion, stillbirth	Vaginal or C-section delivery	Baby's sex & weight	Complications
1 <sup>st</sup>								
2 <sup>nd</sup>								
3 <sup>rd</sup>								
4 <sup>th</sup>								
5 <sup>th</sup>								

**Have you or any of your sexual partners had:**

	Self	Partner	When	Treatment
Non-specific urethritis				
Syphilis				
Gonorrhea				
Chlamydia				
Venereal warts				
Herpes				
Trichomoniasis				
Hepatitis				
Pelvic inflammatory disease				
Other sexually transmitted disease				

Are you in a monogamous relationship?  NO  YES

If YES, how long? \_\_\_\_\_

Number of sex partners in the last 12 months: \_\_\_\_\_

My sex partner has had other sex partners in the last 6 months?

 NO  YES  DON'T KNOW  NOT APPLICABLEAre you now, or have you ever been in a relationship with someone who is bisexual?  NO  YES**MENSTRUAL HISTORY**

What were the dates of your last 2 menstrual periods? \_\_\_\_\_

Have you ever gone more than 3 months without having a period?  NO  YES

If YES, how long? (*months/years*) \_\_\_\_\_

Approximate date(s) when this occurred: \_\_\_\_\_

Was a cause found? \_\_\_\_\_

Are your menstrual cycles normally: (*circle*)                      Regular                      Irregular

If irregular, please describe: \_\_\_\_\_

Has the average length of your menstrual cycle changed since puberty?  NO  YES

If YES, please explain: \_\_\_\_\_

How many days does your period last? \_\_\_\_\_

Is your flow: (*circle*)      light      medium      heavy

Does this vary?       NO       YES

If YES, please explain: \_\_\_\_\_

Do you have pain between periods?                       NO       YES

If YES, please describe: \_\_\_\_\_

Do you bleed between periods or after intercourse?                       NO       YES

If YES, describe frequency and amount of blood loss: \_\_\_\_\_

Do you have any noticeable vaginal discharge?                       NO       YES

If YES, describe your discharge color, consistency, presence of odor, itching, etc.: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you had regular gynecologic exams?                       NO       YES

Date of last exam: \_\_\_\_\_

Date and result of last Pap smear: \_\_\_\_\_

Have you had regular breast examinations?                       NO       YES

Date of last exam: \_\_\_\_\_

Date and findings of last abnormal exam: \_\_\_\_\_

Date and findings of last mammogram: \_\_\_\_\_

Have you ever had a milky discharge from one or both breasts?                       NO       YES

If YES, when? \_\_\_\_\_

Did your mother take DES while she was pregnant with you?                       NO       YES

**CONTRACEPTION**

Please check any of the following methods of contraception you are currently using and/or have used in the past:

√ if yes	Method	Type (if applicable)	Dates of usage
	Birth control pills or patches		
	IUD (intrauterine device)	Mirena or Paragard	
	Depoprovera injections		
	Norplant		
	Diaphragm		
	Condom		
	Jellies/Foam		
	Withdrawal		
	Partner had vasectomy		
	Tubal sterilization		
	Rhythm		
	Other		

**PSYCHIATRIC AND COUNSELING HISTORY**

Have you ever been treated for substance abuse, depression, or any other psychological problem?

NO  YES (If YES, please list dates and diagnoses.)

Dates	Diagnosis

Have you ever been in counseling or psychotherapy?

NO  YES (If YES, please list dates and diagnoses or reasons.)

Dates	Diagnosis or reason

Have you ever had psychotropic medications (i.e., antidepressants, anxiolytics/anti-anxiety, antipsychotic, etc.) prescribed by any physician?  NO  YES

If YES, please list dates: \_\_\_\_\_  
 \_\_\_\_\_

**Have you been exposed to the following in your living or work environment?**

Exposed to	Year	How often	Type
Toxic chemicals			
Sprays			
Fumes/exhaust			
Radiation			
Insecticides			
Lead/lead products			
Asbestos/asbestos products			
Cleaning solutions/solvents			
Other			

**SOCIAL HISTORY****Have you ever used or do you currently use any of the following drugs?**

√ if yes	Drug	Frequency/years	How used
	Marijuana or hashish		
	Cocaine or crack		
	Barbiturates		
	Ecstasy		
	Narcotics/opiates ( <i>heroin, methadone, morphine, codeine, opium</i> )		
	Amphetamines		
	Hallucinogens		
	Tranquilizers		
	PCP		
	Inhalants ( <i>amyl or butyl nitrate, aerosol propellants</i> )		
	Over-the-counter "recreational" drugs ( <i>which ones</i> )		
	Other "recreational" drugs ( <i>which ones</i> )		

**PERSONAL HISTORY AND OPINIONS**

Have you ever been arrested or convicted of any crime (other than minor traffic offenses)?  NO  YES

Have you ever had children removed from your custody?  NO  YES

Are you currently involved in any lawsuits?  NO  YES

What do you think is the biggest stress in your life at present?

What is your earliest childhood memory?

With whom have you discussed your intentions about becoming an ovum donor? What were their reactions?

Person	Reactions

How do you think you will feel about not knowing if a baby was conceived with your donated eggs?

Describe the couple for whom you would like to donate:

What do you anticipate your feelings and reactions will be to becoming an egg donor? What difficulties do you anticipate? Do you anticipate having children in the future?

**Have you had any personal experience with a traumatic event?**

DONOR # \_\_\_\_\_

	YES	NO	In the last 6 months
At any time in your life, were you ever physically abused? <i>(This includes hitting, spanking, punching, or restraining you with ropes or locking you up.)</i>			
Have you ever witnessed anyone else being abused?			
Has a close friend or family member of yours been seriously injured or murdered?			
Before you were 14 years of age, were you ever sexually threatened? <i>(This includes being touched, grabbed, or kissed against your wishes or performing any kind of sexual act against your wishes.)</i>			
After you turned 14, were you ever sexually threatened? <i>(Again, this includes being touched, grabbed, or kissed against your wishes or performing any kind of sexual act against your wishes, or being threatened to perform any of these.)</i>			
At any time in your life, have you ever been a victim of any other crime? <i>(This includes robbery, burglary, mugging, physical attack.)</i>			
At any time in your life were you psychologically abused? <i>(This includes being insulted, humiliated, or ridiculed by someone at least five years older, or witnessing someone being insulted, humiliated, or ridiculed.)</i>			
Have you ever had an accident at work, in a car, etc.?			
Have you ever been in a natural or manmade disaster? <i>(This includes a tornado, hurricane, flood, earthquake, riot, traffic crash, building collapse, fire, or robbery.)</i>			
Have you ever been exposed to dangerous chemicals or radioactivity that might have threatened your health or home?			
Have you ever been in any other situation in which you were seriously injured or in which you feared you might be seriously injured or killed?			
Have you ever seen someone seriously injured or killed?			
Except at a funeral, have you ever seen someone who has died?			
Have you had a spouse, romantic partner, sibling, or parent die? <i>(please circle who)</i>			
Have you had a serious life-threatening illness?			
Have you ever been in combat?			
Have you ever lost your home or had to live on the street?			
Have you lost a child through abortion, miscarriage, death, divorce, or adoption? <i>(please circle which)</i>			
Have you experienced parental divorce or personal divorce? <i>(please circle which)</i>			
Has anyone in your family had a drug/alcohol problem?			
Have you ever experienced any other stressful life event not mentioned above? <i>(Please describe on the back of this sheet.)</i>			

Have you been a donor before?     NO     YES

If YES, indicate what type (*i.e., ovum, blood, bone marrow, etc.*)

If you have previously donated eggs, please describe what you know about the results from your other donation(s), including the name of the clinic, number of eggs, medication used, dose of medication, and dates:

Would you like to meet any children who may result from your egg donation once they reach 18 years of age if it were possible? (*Check all that apply.*)

- Would definitely NOT like to meet.
- Would like to meet the child(ren).
- Would like to share a picture with child(ren).
- Would not object if child(ren) wished to meet but I would not seek a meeting.

Would you consider donating your eggs on more than one occasion?  NO  YES

If YES, how many times do you anticipate donating your eggs? \_\_\_\_\_

**Verification of accuracy of responses on the Oocyte Donor Questionnaire:**

I understand that I can be held legally responsible for providing false information on this questionnaire. I certify that the preceding responses are truthful and accurate to the best of my knowledge and that I have included all pertinent information.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_