



Georgia Center for Reproductive Medicine
5354 Reynolds Street, Suite 510
Savannah, GA 31405
(912)352-8588

Egg Donor Questionnaire

Application #: _____

Donor ID: _____

Date: _____

Interviewed by: _____

1. Name: _____

2. How did you hear about us? _____

3. Address:

Current: _____ How Long? _____

Previous: _____ How Long? _____

Email: Home: _____ Work: _____

4. Phone Contacts

1st _____ 2nd _____ 3rd _____

5. Social Security #: _____

Physical Characteristics

6. DOB: _____ Age Today: _____ Place of Birth _____

Height: _____ Weight: _____

7. Race: _____

8. Complexion: fair medium dark olive freckles

9. Hair: balding thin average curly wavy straight

10. Natural Hair Color: _____ Natural Eye Color: _____

11. Acne: none mild moderate severe

12. Bone type/Bone structure: small medium large

13. Dexterity: Right handed Left handed Ambidextrous

14. Blood type and RH (if known): _____



Georgia Center for Reproductive Medicine
5354 Reynolds Street, Suite 510
Savannah, GA 31405
(912)352-8588

Personal Information

15. Religion born into: _____ Current Religion: _____
Marital Status: Single Married Divorced In a Relationship
16. Sexual orientation: heterosexual homosexual bisexual
17. Ethnic origin/ Ancestry (Irish, German, African, etc.): _____
18. Do you smoke? **No** **Yes:** *how many packs a day?* _____
19. Have you ever smoked? **No** **Yes:** *how long ago did you quit?* _____ (must be > 6 months)
20. How much alcohol do you drink? _____
21. How much caffeine do you drink? _____
22. What recreational drugs do you use? _____
23. How much do you exercise? _____
24. Current weight: _____ Recent changes: _____ Ideal weight: _____
25. Briefly describe your diet: _____
26. Number of children: _____
27. What kind of work do you do? _____
28. Are you currently under significant stress? _____

29. Are your family/friends supportive of your decision to donate your eggs? _____

30. Who is the most supportive person in your life? _____
31. Tell me everything you know in detail regarding the egg donation process:
- Self-injections
 - Frequent blood testing
 - Vaginal ultrasounds
 - Early morning availability
 - Use of condoms
 - 2 Visits to center: 1st visit for screening (1-2 days.)
 - 2nd visit for egg-retrieval (if long distance, anticipate 3 or more day stay.)



Georgia Center for Reproductive Medicine
5354 Reynolds Street, Suite 510
Savannah, GA 31405
(912)352-8588

Committed time frame once in cycle

32. Prior egg donations: _____

Education

33. Completed high school: Year: _____ GPA: _____

34. College entrance exam scores: SAT: _____ ACT: _____

35. Currently in college, pursuing degree in: _____

36. Completed college: Year: _____ Degree: _____ GPA: _____

37. Currently pursuing advanced degree in: _____

Completed advanced degree: Year: _____ Degree: _____

GPA: _____

Personality Information

38. List subjects you enjoyed most: _____

39. Did you like school? _____

40. What would you like to do in the future? _____

41. What do you like to do in your spare time? _____

42. Do you have any special talents (musical, artistic, sporting ability, creative skills)?

43. How would you describe yourself (outgoing, moody, passive, sensitive, humorous, quiet, extroverted, introverted, etc.)? _____

44. How do you get along with people (parents, friends, boss, etc.)? _____

45. How do you solve your personal problems and make decisions (quickly, after carefully exploring all points of view, with deliberations, etc.)? _____



Georgia Center for Reproductive Medicine
5354 Reynolds Street, Suite 510
Savannah, GA 31405
(912)352-8588

46. What is important to you? _____

47. Why are you considering becoming a donor? _____

General Information

48. Do you have normal hearing? Yes No If no, explain: _____

49. Condition of teeth? Poor Fair Good

50. Do you (or did you ever) need corrective lens for vision? Yes No
Farsighted Nearsighted Other (explain) _____
Do you wear glasses/lenses all the time? Yes No
Do you need glasses/lenses only to read? Yes No

51. Does any member of your family require vision correction? Yes No
For what purpose? To read only Farsighted Nearsighted
Other (explain): _____

52. Did you or any member of your family have to wear eyeglasses at an early age (from birth to pre-teen years)? Yes No Who? _____

53. Do you sleep well? Yes No If no, do you know why? _____

54. Your diet: Vegetarian Non-Vegetarian

55. Your diet: Poor Average Excellent

56. How much exercise do you get? None Occasionally Regularly
Please explain type and frequency of exercise: _____

57. Have you ever had surgery? Yes No If yes, please list and explain: _____

58. Have you had any hospitalization not already mentioned? Yes No If yes, please explain: _____

59. Have you had any major radiation exposure or X-Ray exposure? Yes No If yes please explain: _____



Georgia Center for Reproductive Medicine
5354 Reynolds Street, Suite 510
Savannah, GA 31405
(912)352-8588

60. Have you had any vaccinations (shots) or immunizations in the last year? Yes
No If yes, please list: _____
61. Have you ever taken street drugs by needle, even once? Yes No
62. Have you injected drugs for a non-medical reason in the last 5 yrs, including intravenous, intramuscular, or subcutaneous injection? Yes No
63. In the last twelve months, have you been a sex partner of anyone who has ever taken street drugs by needle? Yes No
64. In the last twelve months have you received blood transfusions, blood injections, tattoos, organ or tissue transplants? Yes No
65. In the last twelve months, have you been exposed to anyone with yellow jaundice or hepatitis? Yes No
66. Have you to your knowledge, had a positive test for HIV (any AIDS) tests? Yes
No
67. In the past 12 months, have you given money or drugs to anyone to have sex with you? Yes No
68. Have you had sex for drugs or money in the past 5 years? Yes No
69. Have you ever taken clotting factor concentrates for a bleeding disorder such as hemophilia? Yes No
70. In the last twelve months, have you been exposed to or had sex with anyone with AIDS or with a positive test for HIV (the AIDS antibody)? Yes No
71. In the past twelve months, have you has sex with a person known or suspected to have active hepatitis B or C? Yes No
72. In the last twelve months, have you been exposed to known or suspected HIV, hepatitis B, and/or hepatitis C infected blood through percutaneous inoculation, contact with an open wound, non-intact skin, or mucous membrane? Yes No
73. In the last twelve months, have you been in close contact (i.e. sharing kitchen and bathroom) with a person having active viral hepatitis? Yes No
74. In the last twelve months, have you had sex with someone who has taken clotting factor concentrates for a bleeding disorder such as hemophilia? Yes No



Georgia Center for Reproductive Medicine
5354 Reynolds Street, Suite 510
Savannah, GA 31405
(912)352-8588

75. In the last twelve months, have you had sex, even once, with a man who has had sex with another man since 1977? Yes No
76. In the last twelve months, have you had sex with a male or female prostitute? Yes No
77. In the last twelve months, have you been in jail for more than 72 consecutive hours? Yes No
78. Have you yourself received or had intimate contact (i.e. exchanged body fluids, including sharing toothbrushes and razors) with someone who has received organs or cells from non-human sources? Yes No
79. In the last twelve months, have you ever been raped? Yes No
80. Have you ever been treated for syphilis or gonorrhea? Yes No If yes, how many times and when? _____
81. In the last twelve months, have you ever had acupuncture, electrolysis, ear and/or body piercing, or tattooing in which sterile procedures may not have been used? Yes No If yes, please describe: _____
82. In the last 12 months, have you had any accidental needle stick, sharp instrument injury, contact w/human blood serum or plasma in the eye, mucus membranes (lips, interior of nose) or sores. Yes No
83. After the age of 11, have you ever had viral hepatitis (Hepatitis A excluded: IgM anti-HAV test)? Yes No
84. Have you had more than one sexual partner in the last 6 months? Yes No
85. Have you ever been treated for Chlamydia? Yes No If yes, how many times and when? _____
86. Have you ever been treated for pelvic inflammatory disease (PID)? Yes No If yes, how many times and when? _____
87. Please check if you or any of your sexual partners have ever had:
(Please ask if any of these terms are unfamiliar to you)

_____ Nonspecific urethritis (NSU)
_____ Chlamydia
_____ Venereal Warts

When? _____
When? _____
When? _____



Georgia Center for Reproductive Medicine
5354 Reynolds Street, Suite 510
Savannah, GA 31405
(912)352-8588

_____ Herpes When? _____
_____ Other sexually transmitted diseases When? _____

88. Have you ever had any major infectious illnesses, such as hepatitis, pneumonia, etc.?
Yes No Please explain: _____
89. Have you ever served overseas in the military? Yes No If yes, please describe when and where: _____
90. From 1980 through 1996, were you a member of the US military, a civilian military employee or a dependent of a member of the US military? Yes No
91. Did you spend a total time of 6 months or more associated with a military base in any of the following countries: Belgium, The Netherlands, Germany, Spain, Portugal, Turkey, Italy, or Greece? Yes No
92. Since 1980, have you ever lived in or traveled to Europe? (Includes: England, Ireland, Scotland, Wales, the Isle of Man, the Channel Islands, Gibraltar, or the Falkland Islands) Yes No
93. Between 1980 and 1996 did you spend time that adds up to more than 3 months or more in the UK? Yes No
94. Since 1980 have you received a transfusion of blood, platelets, plasma, cryoprecipitate, or granulocytes in the UK? Yes No
95. Since 1980 have you spent time that adds up to 5 years or more in Europe (including time spent in the UK between 1980 and 1996)? Yes No
96. Have you been in a place affected by SARS or with an affected person with in the past 14 days? Yes No
97. Have you been treated for SARS in the last 28 days? Yes No
98. Were you born, lived in, or traveled to any African country since 1977? Yes No
99. When you traveled to _____, did you received a blood transfusion or any other medical treatment with a product made from blood? Yes No
100. Have you had sexual contact with anyone who was born in or lived in any African country since 1977? Yes No



Georgia Center for Reproductive Medicine
5354 Reynolds Street, Suite 510
Savannah, GA 31405
(912)352-8588

101. Have you ever been exposed to “agent orange” or any other herbicides or chemicals in Vietnam or elsewhere (forest service, highway maintenance, etc.)?
Yes No If yes, what substances and where exposed? _____
-
102. Have you been diagnosed with West Nile Virus? Yes No
103. Have you had a headache and fever within the last 7 days? Yes No
104. Have you had a blood transfusion or infusion within the past 48 hrs before your blood test for eligibility? Yes No
105. Have you ever received growth hormone made from human pituitary glands?
Yes No
106. Have you ever received a dura mater (brain covering graft)? Yes No
107. Have any of your blood relatives ever had Creutzfeldt-Jakob disease? Yes
No
108. In the past twelve months, have you had a positive syphilis test? Yes No
109. In the past 4 weeks have you had any shots or vaccinations?
Vaccines with no waiting period
- | | | |
|--|------------------------------|-----------------------------|
| • Allergy desensitization shots | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • Cholera | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • Diphtheria | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • DPT-Diphtheria pertussis tetanus | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • DT-Diphtheria tetanus | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • Hepatitis A (HAVRIX) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • Influenza | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • Lyme Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • Paratyphoid | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • Pertussis (Whooping Cough) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • Plague | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • Polio (injection) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • Rocky Mountain Spotted Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • Typhoid (injection) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • Typhus | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <i>Conditional Vaccines:</i> | | |
| • Hepatitis B(Heptavax B, recombivax, or Engergix B): 12m deferral if for HBV exposure | <input type="checkbox"/> Yes | <input type="checkbox"/> No |



Georgia Center for Reproductive Medicine
 5354 Reynolds Street, Suite 510
 Savannah, GA 31405
 (912)352-8588

- Rabies: 12m deferral if animal bite broke the skin Yes No
 - Tetanus: 3w deferral if for exposure Yes No
 - TB: If a skin test (PPD test) was performed temporary deferral until results are negative. If positive, defer to a Medical Director Review. Yes No
- Vaccines requiring 2w waiting period:*
- Measles (rubeola) Yes No
 - Mumps Yes No
 - Typhoid Yes No
 - Polio (oral) Yes No
 - Yellow Fever Yes No
- Vaccines requiring 4w waiting period:*
- German Measles (rubella) Yes No
 - MMR (measles, mumps, and rubella) Yes No
 - Chicken Pox (varicella vaccine) Yes No

Personal Health History

110. Do you currently have any allergies? Yes No

If yes, check applicable allergies: Food Drugs Environmental Animals
 Other

Please list the substances and reactions produced:

<u>Substances</u>	<u>Reactions</u>
_____	_____
_____	_____

111. Please describe any childhood allergies you may have outgrown: _____

112. What medications are you currently taking (please include prescriptions, over the counter medications, and supplements)? _____



Georgia Center for Reproductive Medicine
5354 Reynolds Street, Suite 510
Savannah, GA 31405
(912)352-8588

General Health

Please mark if you are now or have recently experienced any of the following:

<u>Problem</u>	<u>Yes</u>	<u>No</u>	<u>Explain</u> _____
Problems with your vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Problems with your hearing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ringing in your ears	<input type="checkbox"/>	<input type="checkbox"/>	_____
Earache	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of balance	<input type="checkbox"/>	<input type="checkbox"/>	_____
Problems with your sense of smell	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent sinus pain, congestion, or drainage	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent or severe headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sores in your mouth or gums	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding from your gums	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pain in any of your teeth	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lumps or bumps in your neck	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any pain with exertion	<input type="checkbox"/>	<input type="checkbox"/>	_____
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty sleeping at night	<input type="checkbox"/>	<input type="checkbox"/>	_____
A need to be propped up with pillows to sleep	<input type="checkbox"/>	<input type="checkbox"/>	_____
Waking up in the middle of night short of breath	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fever or chills	<input type="checkbox"/>	<input type="checkbox"/>	_____
Waking up at night soaked in sweat	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rapid heart beat	<input type="checkbox"/>	<input type="checkbox"/>	_____
Breast pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
A persistent lump in your breast	<input type="checkbox"/>	<input type="checkbox"/>	_____
Discharge of any kind from your breast	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stomach pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pelvic pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bloating	<input type="checkbox"/>	<input type="checkbox"/>	_____
Back pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Swelling of your feet	<input type="checkbox"/>	<input type="checkbox"/>	_____
Painful or enlarged veins in your legs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Feel hot or cold when others are comfortable	<input type="checkbox"/>	<input type="checkbox"/>	_____



Georgia Center for Reproductive Medicine
 5354 Reynolds Street, Suite 510
 Savannah, GA 31405
 (912)352-8588

Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Irritability	<input type="checkbox"/>	<input type="checkbox"/>	_____
Persistent unexplained fatigue	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you depressed?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Constipation or diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urinating more frequently than every two hours	<input type="checkbox"/>	<input type="checkbox"/>	_____
Waking up in the middle of the night to urinate	<input type="checkbox"/>	<input type="checkbox"/>	_____
Painful urination	<input type="checkbox"/>	<input type="checkbox"/>	_____
Change in the amount or distribution of hair	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin marking (moles, etc.) that concern you	<input type="checkbox"/>	<input type="checkbox"/>	_____
Change in your skin texture (more moist or dry)	<input type="checkbox"/>	<input type="checkbox"/>	_____

Physical Characteristics of the Family

113. Please describe your family members by the following characteristics:

Family Member	Age	Eye Color	Hair Color	Complexion	Height	Weight	Ethnic Origin
Children:							
1.							
2.							
3.							
Father							
Mother							
Brothers:							
1.							
2.							
3.							
Sisters:							
1.							
2.							
3.							
Grandfathers:							
Paternal							
Maternal							



Georgia Center for Reproductive Medicine
 5354 Reynolds Street, Suite 510
 Savannah, GA 31405
 (912)352-8588

Family Member	Age	Eye Color	Hair Color	Complexion	Height	Weight	Ethnic Origin
Grandmothers: Paternal							
Maternal							

Past Gynecologic History

114. What was the first day of your last menstrual cycle? _____
115. How old were you when you first noticed breast development? _____
116. How old were you when you first noticed pubic hair growth? _____
117. How old were you when you had your first period? _____
118. Do you have regular periods? _____ Length of cycle: _____ Always regular?
 _____ LMP: _____
119. How old were you when you began to have regular periods? _____
120. How many days are there from the first day of bleeding of one period to the first day of bleeding of the next period? _____
121. How many total days of menstrual flow do you have? _____
122. How many "heavy flow" days do you have during your period? _____
123. How many pads/tampons do you use for protection? _____
124. Describe any discomfort you have associated with your period: _____

125. When does this discomfort start and how long does it last? _____

126. Have you ever been on oral contraceptive pills? _____ How long? _____

<u>Date Started</u>	<u>Date Stopped</u>	<u>Type</u>	<u>Reason for Stopping</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____



Georgia Center for Reproductive Medicine
5354 Reynolds Street, Suite 510
Savannah, GA 31405
(912)352-8588

127. Method of Birth Control: _____ Would you be willing to change or temporarily stop? _____
128. Describe any discomfort with intercourse? _____
129. Do you use any kind of lubrication during intercourse? _____
130. How many times a month do you have intercourse? _____
131. How long have you been in your current relationship? _____
132. How many partners have you had within the last 6 months? _____
133. What, if any, changes have you noticed in your sexual drive? _____
134. Have you ever been pregnant? _____ Number of pregnancies: _____
Number of spontaneous miscarriages: _____
Number of elective abortions: _____
Number of ectopic pregnancies: _____
135. List any PAP smear abnormalities you have had in the past: _____

When was your last PAP smear? _____ Result: _____
When was your last mammogram? _____ Result: _____
136. List any past imperfections/irritations in your pelvic organs: _____

137. How old was your mother when she went through menopause? _____
138. How many total times have you been pregnant? _____
139. If you have conceived, how many months of trying did it take? _____
140. If never pregnant, have you ever tried? _____ How long? _____
141. List each pregnancy in chronological order:

<u>Date</u>	<u>Duration</u>	<u>Delivery Type</u>	<u>Problems</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____



Georgia Center for Reproductive Medicine
5354 Reynolds Street, Suite 510
Savannah, GA 31405
(912)352-8588

Ancestry

142. Do you have any Jewish ancestors? Yes No Unknown
If yes, have you been tested as a carrier of Tay Sachs, Cystic Fibrosis, or
Gaucher's disease? Yes No If yes, Result: _____
143. Do you have any African ancestors? Yes No Unknown
If yes, have been tested as a carrier of sickle cell disease? Yes No
If yes, Result: _____
144. Do you have any Mediterranean (Greek or Italian) ancestors? Yes No
Unknown
If yes, have you been tested as a carrier of Thalassemia? Yes No
If yes, Result: _____
145. Do you have any Oriental ancestors? Yes No Unknown
If yes, have you been tested as a carrier of Thalassemia? Yes No
If yes, Result: _____
146. What level of schooling did your mother reach? _____
What is her occupation? _____
147. What level of schooling did your father reach? _____
What is his occupation? _____
148. Are you adopted? Yes No
149. Have twins or multiple births ever occurred in your family? Yes No
If yes, what relation to you? _____

Family Medical History

150. Has any member of your family, including yourself, had a **problem at birth** or **birth defect** of any of the following body systems? Please include first cousins and great grandparents.

Bones, muscles, joints, limbs	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Gastrointestinal system	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Nervous system, brain, spinal cord	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood circulation	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Respiratory system	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Organ (heart, lung, kidney, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Genital/urinary	<input type="checkbox"/> Yes	<input type="checkbox"/> No



Georgia Center for Reproductive Medicine
 5354 Reynolds Street, Suite 510
 Savannah, GA 31405
 (912)352-8588

Metabolic (hormones, enzymes, etc.) Yes No

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

Birth Defect	Who	When did this occur	Seriousness

151. Do you have any brothers, sisters, or children that died in infancy or childhood?
 Yes No If yes, what was the cause? _____

152. Are there any known genetic diseases or conditions that run in your family?
 Yes No If yes, what are they? _____

153. Has anyone in your family, including yourself and your first cousins, 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: _____

154. Look very carefully through the following list of medical problems and place an "X" in the applicable boxes to indicate problems you or one of your relatives has had. Please consider each condition carefully for each family member. If you have any questions as to the definition of a condition please call our office to verify.

Medical Problems	Self	Children	Mother	Father	Siblings	Grand-parents	Aunts/Uncles	First Cousins
1. Heart								
Stroke								
Heart attack								
From birth								
other								
Hardening of the arteries								
Congenital heart defects								
High Blood pressure								



Georgia Center for Reproductive Medicine
 5354 Reynolds Street, Suite 510
 Savannah, GA 31405
 (912)352-8588

Medical Problems	Self	Children	Mother	Father	Siblings	Grand-parents	Aunts/Uncles	First Cousins
Aneurysm								
2. Blood								
Anemia								
Sickle-cell anemia								
Hemophilia or other bleeding problem								
Leukemia								
Immune Deficiency								
Other blood disorder								
Clots								
3. Respiratory (lungs)								
Hay Fever								
Asthma								
Emphysema								
Tuberculosis								
Lung Cancer								
Pneumonia								
Other lung disease								
4. Gastro-intestinal								
Ulcer of the stomach/duodenum								
Gallstones								
Hepatitis A (infectious)								
Hepatitis B (serum/blood)								
Other liver diseases								
Colon Cancer								
Ulcerative Colitis								
Crohn's disease								
Cystic Fibrosis								
Jaundice								
Intestinal Cancer								
Any other cancer/problem of the digestive system								
5. Metabolic/Endocrine								
Diabetes mellitus (specify type 1 or 2)								



Georgia Center for Reproductive Medicine
 5354 Reynolds Street, Suite 510
 Savannah, GA 31405
 (912)352-8588

Medical Problems	Self	Children	Mother	Father	Siblings	Grand-parents	Aunts/Uncles	First Cousins
Low blood sugar								
Thyroid Cancer								
Goiter								
Other thyroid disease								
Adrenal dysfunction or disorders								
Hyperactivity								
6. Urinary								
Kidney disease								
Other diseases of the urinary tract (urethra, bladder, ureter)								
7. Genital/Reproductive								
Undescended testicle(s)								
Malformed Penis								
Prostate Cancer								
Miscarriages (2 or more)								
Stillborns (2 or more)								
Unclear sex at birth								
Uterine Fibroids								
Ovarian Cysts								
Cancer of the cervix, ovaries, or uterus								
Other conditions								
8. Neurological								
Migraines								
Mental Retardation								
Senility before age 50								
Multiple sclerosis								
Cerebral Palsy								
Epilepsy/Seizures								
Hydrocephalus (water on the brain)								
Disorders of the spinal cord								



Georgia Center for Reproductive Medicine
 5354 Reynolds Street, Suite 510
 Savannah, GA 31405
 (912)352-8588

Medical Problems	Self	Children	Mother	Father	Siblings	Grand-parents	Aunts/Uncles	First Cousins
Parkinson's disease								
Myasthenia gravis								
Spina Bifida (open spine)								
Paralysis/ paraplegia								
Huntington's disease								
Gaucher's disease								
Wilson's disease								
Other diseases of the nervous system								
9. Mental Health								
Schizophrenia								
Manic depression (Bipolar)								
Depression of any other kind								
Attention deficit disorder								
10. Muscles/Bones/Joints								
Muscular Dystrophy								
Other chronic muscle disease								
Lupus								
Deformity of the spine								
Osteoporosis								
Dwarfism								
Heredity of low back disease								
Arthritis								
Congenital hip problems								
Gout								
Club Foot								
Tourette's Syndrome								
Other								
11. Sight/Sound/ Smell								
Deafness before age 60								



Georgia Center for Reproductive Medicine
 5354 Reynolds Street, Suite 510
 Savannah, GA 31405
 (912)352-8588

Medical Problems	Self	Children	Mother	Father	Siblings	Grand-parents	Aunts/Uncles	First Cousins
Deformity of the ear								
Cataracts before age 60								
Blindness								
Color Blindness								
Glaucoma								
Deviated Septum								
Any other sight/sound/smell disorder								
12. Skin								
Acne								
Eczema								
Edema (Swelling)								
Coffee-colored skin spots								
Skin cancer								
Pigmentation disorders								
Other disorders of the skin								
13. Other								
Early death (<50 years)								
Chromosome problems								
Inguinal Hernia								
Cystic Fibrosis								
Down's Syndrome								
Lymphedema								
Alcoholism/cirrhosis								
Drug abuse, misuse, or addiction								
Breast cancer								
Other cancers not mentioned above								
Obesity								
Cleft lip and/or palate								
Any other condition not listed above								

155. Carefully review the preceding tables and boxes selected. Use your answers to complete the table below and be sure to explain all the conditions that you



Georgia Center for Reproductive Medicine
 5354 Reynolds Street, Suite 510
 Savannah, GA 31405
 (912)352-8588

marked. If the relative indicated below is healthy and has not been treated for anything, please mark “healthy”. Do not use phrases such as “not applicable” and “natural causes” or “old age”. (At the very least, please comment on yourself, children, parents, siblings, and grandparents.)

Relationship	Current age or age of death	Health Problems	Age Diagnosed	Living	Deceased	Comments
Self						
Child						
Child						
Sister						
Sister						
Brother						
Brother						
Mother’s side of family						
Mother						
Grandmother						
GG mother						
GG father						
Grandfather						
GG mother						
GG father						
Aunt						
Aunt						
Uncle						
Uncle						
First Cousin						
First Cousin						
Father’s side of the family						
Father						
Grandmother						
GG mother						
GG father						
Grandfather						
GG mother						
GG father						
Aunt						
Aunt						
Uncle						
Uncle						
First Cousin						
First Cousin						

If you need additional space to explain any of the conditions, you may use the following space:



Georgia Center for Reproductive Medicine
5354 Reynolds Street, Suite 510
Savannah, GA 31405
(912)352-8588

Exposed to	When	How often
Asbestos/Asbestos products		
Cleaning solutions/solvents		



Georgia Center for Reproductive Medicine
5354 Reynolds Street, Suite 510
Savannah, GA 31405
(912)352-8588

DONOR ACKNOWLEDGMENT:
HUMAN PITUITARY-DERIVED GROWTH HORMONE

The undersigned acknowledges that, to the best of her knowledge, she has not received injections of the human pituitary-derived growth hormone (pit-hGH) between 1963 and 1985. The undersigned further states that she has not used this drug non-therapeutically, that is, during rigorous physical training

The donor has been made aware of the commercial sources of pit-hGH available between 1978 and 1985, which were Asellacrinn (Serono) and Cresorman (KabiVitrum). She has been made aware of Creutzfeldt-Jakob disease (CJD) which is associated with pit-hGH.

Signature of Donor

Signature of Witness

Date

Date



Georgia Center for Reproductive Medicine
5354 Reynolds Street, Suite 510
Savannah, GA 31405
(912)352-8588

DONOR MEDICAL AND GENETIC HISTORY CERTIFICATION

I certify that the above information is, to the best of my knowledge, true and complete, and I have not intentionally omitted/withheld any information required to be given in this questionnaire. I also acknowledge that I have asked the meaning of any term that I was not familiar with.

Signature of Donor

Signature of Witness

Date

Date