Heartfelt Egg Donation

DONOR APPLICANT FIRST NAME: ***DONOR ID#***

(Office Use Only)

PHYSICAL & PERSONAL CHARACTERISTICS

Date of Birth	
Age	
Height	
Weight	
Blood Type	
Are you adopted?	Yes No If so, do you know the medical history of your birth family? Yes No If so, do you have contact with your: biological mother Yes No biological father: Yes No
Are either of your parents adopted?	Mother: Yes No Father: Yes No
Race	Asian Black Caucasian Hispanic Other: *Please choose all that apply and expand on Ethnicity below*
Mother's Ethnicity	
Maternal Grandmother's Ethnicity	
Maternal Grandfather's Ethnicity	
Father's Ethnicity	
Paternal Grandmother's Ethnicity	
Paternal Grandfather's Ethnicity	
Body Type	Very Small Small Medium Large Very Large
Natural Hair Color	Blonde Brown Black Auburn Red Strawberry Blonde
Childhood Hair Color	Blonde Brown Black Auburn Red Strawberry Blonde
Hair Shade	Light Medium Dark
Hair Fullness	Thin Medium Thick Very Thick
Hair Texture	Very Fine Fine Medium Coarse
Eye Color	Black Blue Brown Green Hazel
Complexion	Fair Medium Dark
Manual Dexterity:	Left Handed Right Handed Ambidextrous Clumsy Dexterous Average
Religious Background	Practicing? Yes No
Are you willing to travel for the egg retrieval process?	Yes No
What type of arrangement would you like to have with the Intended Parents?	Anonymous (not willing to meet) Open (Full Disclosure) Semi-Open (willing to meet each other on first name basis)
Are you willing to speak to the Intended Parent on the telephone?	Yes No

Are you willing to exchange e-mail with the Intended Parent?	Yes No
Do you want to know the outcome of the donation?	Yes No
Would you be willing to meet the child if they wanted to meet you?	Yes No
If you are comfortable with a Semi-Open arrangement, would you be willing to provide a 3rd party name and their contact information should the Intended Parent need to reach you in the future?	Yes No
Are you willing to provide address changes to Heartfelt Egg Donation?	Yes No
Will you be out of town in the next 6 months?	Yes No Where and for how long?
Do you own an insured vehicle?	Yes No
Have you ever applied to donate eggs before?	Yes No If yes, when and where?
Have you ever donated eggs?	Yes No If yes, when and through which agency? How many eggs were retrieved? If known, what were the pregnancy results?

EDUCATION

Education Level	High School Diploma Trade/Vocational School Some College Attending College College Degree Attending Graduate School Graduate Degree Other:
What College or other Academic Institution did you attend or are you attending?	
What was your Major? (if applicable)	
What type of Degree did you receive (if applicable)?	
Grade Point Average	In High School: In College:
Testing Scores	SAT: GRE: MCAT: ACT: Other: Not applicable
Honors & Awards	
Extracurricular Activities	

EDUCATION CONTINUED…

What Academic areas did you most enjoy?	
What Academic areas did you enjoy least?	
Societies & Organizations	
Educational Goals	
Linguistic Ability	Language: ______________ Speak Read Write Language: ______________ Speak Read Write Language: ______________ Speak Read Write
Artistic Talents	None Average Artistic Very Artistic Please expand:
Musical	Voice: Soprano Alto Tenor Baritone Bass Instrument:
Athletic Ability	None Average Athletic Very Athletic
What other skills, hobbies, activities or talents do you have or enjoy?	

EMPLOYMENT HISTORY

Current Occupation *(do not list place of employment)*	
Past Occupations	*(List most recent first)* 1. 2. 3. 4.
What are your career goals?	
Volunteer Work	

PERSONALITY

Please check all that apply

Extrovert	Introvert	Outgoing	Shy
Leader	Follower	Sensitive	Emotional
Forthright	Reserved	Insightful	Quiet
Responsible	Creative	Organized	Melancholy
Optimistic	Pessimistic	Serious	Sarcastic
Vivacious	Stubborn	Funny	Calm
People-oriented	Anti-social	Ambitious	Goal-oriented
Intelligent	Cheerful	Active	Relaxed
Artisan	Guardian	Rational	Idealist
Loyal	Faithful	Risk Taker	Analytical

FAVORITES

Favorite Book	
Favorite Type of Music	
Favorite Color	
Favorite Sport	
Favorite Food	
Favorite Animal	
Favorite Movie	
Other Favorites	

PERSONAL HEALTH & REPRODUCTIVE HISTORY

Describe your current health	Excellent Good Fair Poor
Date of your last physical exam	
Describe your eating habits?	Excellent Good Fair Poor
What best describes your diet?	Vegetarian Non-Vegetarian Other *(please describe):*
Have you ever had an eating disorder?	Yes No If yes, please describe:

How often do you use the following?

	Never	Seldom	Once per week	Several times per week	Several times per day	Once per day	Last time used
Coffee							
Beer							
Liquor							
Cigarettes							
Cigars							
Pipe Tobacco							
Marijuana							
Cocaine							
Barbiturates							
Heroin							
Amphetamines							
Hallucinogens							
Tranquilizers							
Anti-depressants							
PCP							
Inhalants							

Have you ever had plastic surgery?	Yes No If yes, please describe:
Does your current partner smoke cigarettes or use any other forms of tobacco?	Yes No Not applicable If yes, include type and frequency:
Do your current roommates smoke cigarettes or use any other forms of tobacco?	Yes No Not applicable If yes, include type and frequency:
Have you ever had any surgeries?	Yes No If yes, include type of surgery and dates:
Have you been hospitalized for any reason other than surgery listed above?	Yes No If yes, include the reasons and dates:
Level of Physical Activity	Inactive Average Active Very Active
How much and what type of exercise do you do?	
Eyesight	Without glasses: Poor Fair Good Excellent Vision: Normal Far-sighted Near-sighted Both
Do you wear corrective lenses?	Yes No Glasses Contacts Bi-focal Tri-focal Other: What is your prescription?

Describe the condition of your teeth?	Poor Fair Good Excellent
Have you ever worn braces or another dental device?	Device None Braces Retainer Other: Reason Cosmetic Accident Disease Other:
Skin Tone	Fair Medium Dark
Tanning Ability	None Slight Medium Easy Very Easy
Skin Type	Oily Medium Dry Combination
Do you or did you have acne?	Yes No If so, Slight Moderate Severe At what age? For how long? Medications?
Facial Features	Freckles None Several Moderate Numerous Location of Freckles: Moles None One Several Moderate Numerous Location of Moles: Dimples None One Several Numerous Location of Dimples:
Do you have any birth or beauty marks?	Yes No If yes, what type and their location:
Do you have any body art? (*tattoos, body piercing)*	Yes No If yes, what type and their location:
Have you had acupuncture in the last 12 months where sterile procedures were not used?	Yes No
Have you donated blood?	Yes No
Have you ever been denied as a blood donor?	Yes No If yes, please state date and reason/s:
Have you ever fainted during or after a blood draw?	Yes No
Have you ever had a blood transfusion?	Yes No If yes, include dates:
Have you ever had major radiation or x-ray exposure?	Yes No If yes, include dates:
Have you ever given yourself injections?	Yes No If yes, please describe:
Are you currently taking any Medications, Dietary Supplements (prescriptions, vitamins, herbs, etc.)?	Yes No If yes, please explain:

MENSTRUAL & SEXUAL HISTORY

Age at your first menstrual period?	
Average Number of days between menstrual cycles when not on birth control	
Are your menstrual cycles regular?	Yes No If no, please describe:
How long do you bleed for?	
Is your flow?	Light Medium Heavy Very Heavy
Do you have severe cramping?	Yes No If so, what relieves your cramps?
Have you ever been treated for menstrual related problems?	Yes No If yes, please describe
Date of your last pap and results	Date: Results:
Have you ever had an abnormal pap?	Yes No If yes, when and what was the diagnosis and outcome?
Did your mother take DES while she was pregnant with you?	Yes No
Past forms of contraception	Type/s: How long did you use it?
Current form of contraception	Type: How long have you been using it?
Are you monogamous? (having only one sexual partner at a time)	Yes No If yes, how long?
Are you celibate? (not sexually active)	Yes No If yes, how long?
How many sexual partners have you had in the past 6 months?	
How many sexual partners have you had in the past 3 years?	
Have you engaged in sex for money or drugs?	Yes No
Have you or any of your sexual partners (past/present) ever had sex with gay/bisexual men or IV drug users?	Yes No
Have you had sex with any person with known or suspected HIV (AIDS) or hepatitis infection?	Yes No

Have you been exposed to HIV or hepatitis-infected blood through needle sticks, an open wound, non-intact skin, or mucous membranes in the past 12 months?	Yes No
Have you ever been forced to have sexual relations against your will as a child or an adult?	Yes No If yes, did you receive help or counseling?

Have you or any of your sexual partners ever had one of the following?

		Dates	Form of Treatment
Clamydia	No Self Partner		
Gonorrhea	No Self Partner		
Herpes	No Self Partner		
Syphilis	No Self Partner		
Hepatitis B/C	No Self Partner		
HIV/AIDS	No Self Partner		
NSU *(Non-specific Urethritis)*	No Self Partner		
Other:	No Self Partner		

PREGNANCY HISTORY

Have you ever been pregnant?	Yes No

If applicable, please list any and all pregnancies below:

	Pregnancy Type	Year	Gender (M/F)	Delivery Type Vaginal/Cesarean	Born at # of weeks
1.	Live Birth Miscarriage Abortion Tubal				
2.	Live Birth Miscarriage Abortion Tubal				
3.	Live Birth Miscarriage Abortion Tubal				
4.	Live Birth Miscarriage Abortion Tubal				
5.	Live Birth Miscarriage Abortion Tubal				

List any pregnancy complications	
Have any of your children died in infancy?	Yes No Not applicable
Have you ever had trouble conceiving?	Yes No Not applicable
Have you ever been treated for infertility?	Yes No
Has anyone in your family ever had fertility problems?	Yes No If yes, please describe:
Do natural multiple births (twins, triplets, etc.) run in your family?	Yes No If so, who had them?

FAMILY MEDICAL HISTORY

Are there any known genetic diseases or conditions that run in your family?	Yes No If so, please explain:
How many siblings are in your immediate family? *(do not include step-family members)*	#of Females (including yourself): # of Males:
Do you or anyone in your family experience recurring and/or chronic physical symptoms that have not been evaluated by a physician?	Yes No If so, please explain:
Have you ever had genetic testing?	Yes No If so, please explain:
Have you ever had genetic counseling?	Yes No If so, please explain:

Have you ever been tested as a carrier of:

Tay-Sach's Disease	Not Tested	Carrier	Non-carrier
Sickle Cell Disease	Not Tested	Carrier	Non-carrier
Thalassemia	Not Tested	Carrier	Non-carrier
Cystic Fibrosis	Not Tested	Carrier	Non-carrier

	Eye Color	Hair Color	Height	Weight	Skin Tone	Year of Birth (If Living)	Age at Death	Cause of death
Sample	Blue	Black	5'10"	185	Light	1945	60	Heart Disease
Father								
Mother								
PGF								
PGM								
MGF								
MGM								
Brothers								
1.								
2.								
3.								
4.								
Sisters								
1.								
2.								
3.								
4.								
Your Children								
1.								
2.								
3.								
4.								

	Education	**Occupation**	**Distinguishing Physical Characteristics**	**Achievements**	**Type of Personality**
Sample	College	Retail Manager	Tall/Dimples	Volunteers	Quiet/Funny
Father					
Mother					
PGF					
PGM					
MGF					
MGM					
Brothers					
1.					
2.					
3.					
4.					
Sisters					
1.					
2.					
3.					
4.					
Your Children					
1.					
2.					
3.					
4.					

Please use the following abbreviations on the tables below
MGM = maternal grandmother MGF= maternal grandfather MA/MU= maternal aunt/uncle
PGM = paternal grandmother PGF = paternal grandfather PA/PU = paternal aunt/uncle
Please do not include step-family members

	You	Mother	Father	Sister/Brother	MGM/MGF PGM/PGF	PA/PU MA/PU
BLOOD						
Anemia						
Leukemia						
Lymphoma						
Immune deficiency						
Hemophilia						
Clotting disorder						
Thalassemia						
Sickle Cell Disease						
Other bleeding disorders						
HEART						
Heart disease (from birth)						
Irregular heart beat (arrhythmia)						
Heart valve disease						
Heart attack						
High blood pressure						
High cholesterol						
Stroke						
Aneurysm						
Other						
RESPIRATORY						
Asthma						
Emphysema						
Hay fever						
Lung cancer						
Pneumonia						
Tuberculosis						
Cystic fibrosis						
Other lung disease						
GASTRO-INTESTINAL						
Ulcer of stomach/duodenum						
Gallstones						
Cirrhosis						
Hepatitis A (infection)						
Hepatitis B (serum)						
Hepatitis C						
Ulcerative colitis						
Colon cancer						
Crohn’s disease						
Intestinal cancer						

	You	Mother	Father	Sister/Brother	MGM/MGF PGM/PGF	PA/PU MA/PU
GASTRO-INTESTINAL CONT…						
Rectal disorder						
Pyloric stenosis						
Irritable bowel syndrome						
Other Gastro-intestinal						
METABOLIC/ ENDOCRINE						
Tay-Sach's Disease						
Diabetes – Type 1 (juvenile onset)						
Diabetes – Type II (adult onset)						
Hypoglycemia						
Thyroid disease						
Thyroid cancer						
Thyroid nodules						
Goiter						
Adrenal dysfunction or disorder						
Hyperactivity						
Other						
URINARY						
Kidney disease						
Kidney stones						
Kidney or bladder infection						
Other						
REPRODUCTIVE						
Birth defects of genitals						
Undescended testicle (s)						
Hermaphroditism/ ambiguous genitals						
Hypospadius						
Prostrate cancer						
Testicular cancer						
Uterine fibroids						
Ovarian cysts						
Cancer of cervix/ovaries/uterus						
Endometriosis						
Breast disorders						
Breast cancer						
Recurrent miscarriage						
Still birth						
Death of a newborn						
Neonatal jaundice						
Infertility						
Other						

	You	Mother	Father	Sister/Brother	MGM/MGF PGM/PGF	PA/PU MA/PU
CONGENITAL ANOMALIES						
Congenital hip problems						
Cleft lip/palate						
Chromosome problems						
Down's Syndrome						
Trisomy 13 or 18						
Fragile X syndrome						
Turner's Syndrome						
Kleinfelter Syndrome						
Other						
MUSCLE/BONES/ JOINTS						
Muscular dystrophy						
Other chronic muscle disease						
Loss of coordination						
Lupus						
Osteoporosis						
Dwarfism						
Arthritis (rheumatoid or degenerative?)						
Gout						
Deformity of spine						
Other						
NEUROLOGICAL						
Migraines						
Mental retardation						
Senility before age 50						
Multiple sclerosis						
Cerebral palsy						
Epilepsy/seizures						
Hydrocephalus						
Spina bifida/neural tube defects						
Parkinson's disease						
Huntington's disease						
Myasthenia gravis						
Paralysis/paraplegia						
Gaucher's disease						
Wilson's disease						
Tourette's Syndrome						
Scoliosis						
Creutzfeldt-Jakob disease						
Alzheimer's disease						
Other						

	You	Mother	Father	Sister/Brother	MGM/MGF PGM/PGF	PA/PU MA/PU
MENTAL HEALTH						
Schizophrenia						
Depression						
Manic depression						
Bipolar disorder						
Postpartum depression						
ADHD – Attention deficit hyperactivity disorder						
ADD – Attention deficit disorder						
SENSES						
Deformity of the ear						
Deafness before age 60						
Cataracts before age 50						
Blindness						
Color blindness						
Glaucoma						
Deviated septum						
Other						
SKIN						
Acne						
Eczema						
Skin cancer						
Pigmentation disorders						
Neorufibromatosis						
Other						
OTHER						
Alcoholism						
Drug abuse or addiction						
Obesity						
Other						

PERSONAL & MOTIVATIONAL

Please take time to contemplate your answers and to be as thorough and neat as possible.

What are your goals in life?

My best physical characteristics are:

I've been told I look like…

Some of the things I like most about myself are…

Describe yourself as a child.

What do you have in common with your parents?

What would you do with your life if money were no object?

Describe yourself as your friends and family would.

What is your most favorite memory of your childhood? ______________________________

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How do you like to spend your spare time?______________________________

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If you could change one thing about yourself what would it be?______________________________

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____

Who has been the most influential person in your life and why? ______________________________

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Are your family and friends supportive of your decision to be an egg donor?______________________________

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____

I would like to become an egg donor because: ______________________________

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____

What special message would you like to pass on to the Intended Parents?______________________________

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____

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Is there anything else you would like the Intended Parent to know about you?______________________________

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Feel free to include additional pages if you need more space