



Seattle Reproductive Medicine[®]

A N I N T E G R A M E D[®] A F F I L I A T E

EGG DONATION APPLICATION FORM

Date filled out: ____/____/____

Last name: _____ First name: _____ Middle Initial: _____

Age: _____ Date of Birth: ____/____/____ Place of Birth: _____

Soc. Security #: _____-_____-_____ Are you a US citizen or permanent resident? Yes No

Marital Status: ____single ____married ____divorced ____widowed Length of Relationship: _____ years

PARTNER:

Last name: _____ First name: _____ Middle Initial: _____

Day phone: () _____-_____ (best number to call) Date of Birth: ____/____/____

MAILING ADDRESS:

Street: _____ City: _____

State/Province: _____ Zip/ Postal code: _____ Country: _____

OK to leave message?

Home Phone Number: () _____-_____ Yes No

Work Phone Number: () _____-_____ Yes No

Cell Phone Number: () _____-_____ Yes No

Email Address: _____

How did you hear about our program?

- Radio (which station) _____ Friend (name) _____
 Newspaper (which one) _____ Magazine (which one) _____
 Website (which one) _____ Other (specify) _____

I hereby attest that all information disclosed in this application is accurate, true, and up-to-date to the best of my knowledge. _____

(Signature of Applicant)

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FORM NUMBER: DE-F2	EFFECTIVITY DATE: 6/28/2006

PERSONAL HEALTH HISTORY (continued)

Have you had any hospitalization(s) not mentioned above?: _____

Have you ever had any broken bones? Yes No If yes, please explain: _____

How many days in the preceding 12 months could you not work because of illness, etc. (colds, flu, accidents, surgery, etc.)? _____

Have you ever had any major illnesses such as amoebic dysentery, pneumonia, mononucleosis, etc.? ____Yes ____No

If yes, please explain: _____

Are you currently under a physicians care for any reason? Yes No

If yes, please explain: _____

Has anyone in your family, including yourself, 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

Exercise Habits: ____None ____Occasional ____Regular

Type of Exercise: _____

Do you smoke cigarettes? ____Yes ____No If yes, how many per day? _____

Do you drink alcohol? ____Yes ____No If yes, how many drinks/week? _____

Have you ever used recreational drugs (cocaine, marijuana, heroin, etc.)? ____Yes ____No

List all drugs that you have taken in the proceeding 12 months (prescription, nonprescription, herbal & sports supplements, recreational):

Medication	How Often	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all current medications (include vitamins, aspirin, antacids, laxatives, herbal & sports supplements, etc.)

Medication	How Often	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever taken anti-malarial drugs or had malaria? ____Yes ____No

Have you had a blood transfusion? ____Yes ____No

Have you had major radiation exposure or x-ray exposure? ____Yes ____No

If yes, please explain: _____

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PERSONAL HEALTH HISTORY (continued)

Have you ever had any problems with the law? ____ Yes ____ No

If yes, please explain _____

Please list any arrests, convictions, sentences, etc.: _____

Within the past 6 months have you been exposed to UV rays in a tanning booth? ____ Yes ____ No

To your knowledge, have you or any of your sexual partners been in contact with anyone or have you been personally tested or treated for any of the following:

	Self	Partner	If yes, when:	How many times?	When was the last time?
HIV (AIDS)					
NSU (non specific urethritis)					
Syphilis					
Gonorrhea					
Chlamydia					
Venereal Warts					
Herpes, Genital					
Viral Hepatitis B or C					
Other sexually transmissible Diseases					

PERSONAL FERTILITY/ SOCIAL HISTORY

Age at onset of menses: _____ Are your menstrual periods regular: ____ Yes ____ No

Are you periods regular when you are not on any type of hormonal birth control such as the pill, etc.? ____ Yes ____ No

Date of Last Menstrual Period: _____ How many days does your period usually last? _____ days

How long is your monthly cycle (first day of one period to first day of the next)? _____ days

Date of last Pap Smear: _____ Result: _____

Have you ever had an abnormal PAP: _____ If yes, when & why: _____

Have you ever been told you were infertile: _____ If yes, when & why: _____

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PERSONAL FERTILITY/ SOCIAL HISTORY (continued)

Number of current sexual partners: _____ Number of sexual partners during the last six months: _____

Number of total past sexual partners: _____

Have you had unprotected sex with a new partner within the last 6 months? ____Yes ____No

Sexual Preference: Homosexual Heterosexual Both Neither

Have you or your partner engaged in sexual relations with a partner of the same sex during the last 5 years? Yes No

FERTILITY HISTORY:

Number of pregnancies: _____ Dates of pregnancies: _____

Number of miscarriages: _____ Dates of miscarriages: _____

Number of abortions: _____ Dates of abortions: _____

Number of stillbirths: _____ Dates of each stillbirth: _____

Number of children: _____ Are you Currently Breastfeeding? ____Yes ____No

Pregnancy # Male /Female	Delivery Date	Complications	Height / Weight
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Length of time on took you to get pregnant. Shortest _____ Longest _____

CONTRACEPTIVE HISTORY:

Currently use: IUD ____ Diaphragm ____ Condom ____ Birth Control Pills ____

Rhythm ____ Spermicide ____ Depo-Provera ____

If Birth Control Pills, _____ (name)

How long on Birth Control Pills? _____

Why did you start taking Birth Control Pills? _____

If Depo-Provera, when was your last injection? _____

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PERSONAL FERTILITY/ SOCIAL HISTORY (continued)

EGG DONATION HISTORY:

Have you applied or been screened to be an egg donor before? ___ Yes ___ No

If yes, list name and location of egg donor program (s): _____

Where you accepted as an egg donor? ___ Yes ___ No

If yes, how many times did you cycle? _____

Are you currently enrolled as an egg donor in another program? ___ Yes ___ No

PERSONAL CHARACTERISTICS

Religion Born Into: _____ Religion Practiced: _____

Education: _____
 _____ Completed high school Grade Point Average (GPA): _____
 _____ Currently in college, pursuing degree in _____
 _____ Completed college, degree in _____ GPA: _____
 _____ Currently pursuing an advanced degree in _____
 _____ Completed advanced degree in _____

Academic Strengths (i.e. math, language): _____

Musical Talent: _____

Artistic Talent: _____

Athletic Skills / Favorite Sports: _____

Current Occupation: _____

List jobs held in the past five years and your possible exposure to chemicals, drugs and gases. Please consider carefully.

Jobs/Duties	Year Began	Year End	Any exposure to toxic chemicals, drugs or gases?

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PERSONAL CHARACTERISTICS (continued)

Have you ever been exposed to "agent orange" or any other herbicides or chemicals in military action or elsewhere? (forest service, highway maintenance, etc.) _____Yes _____No

Which substance(s)? _____

If yes, when: _____ Where? _____

In the preceding six months, were you exposed to excessive amounts of the following in your living environment or while involved in hobbies? If yes to any of these, give dates and how often you have been exposed. Please consider carefully.

Exposed to:	Response		When?	How Often?
Toxic Chemicals or Substances	Yes	No		
Sprays	Yes	No		
Fumes/Exhaust	Yes	No		
Radiation	Yes	No		
Flea Powder/Sprays	Yes	No		
Lead/Lead products	Yes	No		
Asbestos/Asbestos products	Yes	No		
Cleaning solutions/solvents	Yes	No		

FAMILY HEALTH HISTORY

YOUR CHILDREN	1	2	3	4
Age				
Sex				
Eye color				
Hair Color				
Frame size				
Grade in school				
Wears eye glasses				
Discipline problems				
Any medication				
Dyslexia				
Reading difficulties				
Speech difficulties				
Any special services at school				
Seen by Social worker/ psychiatrist				
Grade functional level: Normal / Above/ Below Average				

How many blood siblings are in your immediate family (including yourself)? _____

Number of Brothers _____

Number of Sisters _____

Number of Maternal Aunts _____

Number of Maternal Uncles _____

Number of Paternal Aunts _____

Number of Paternal Uncles _____

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FAMILY HEALTH HISTORY (continued)

Do you have any brothers or sisters that died in infancy or childhood? ____ Yes ____ No

If yes, what was the cause? _____

Describe biological family members according to the following characteristics. Use natural eye and hair color; fair/dark, etc. complexion. If they are deceased, please list cause of death:

	Eye Color	Hair Color	Complexion	Height	Weight	Profession	Age if living	Age at time of death	Cause of death
Sister(s)									
Brother(s)									
Mother									
Father									
MGM									
MGF									
PGM									
PGF									

(MGM = Maternal Grandmother, MGF = Maternal Grandfather, PGM = Paternal Grandmother, PGF = Paternal Grandfather)

Please list below any family members who experienced miscarriages:

Family Member (Sister, Aunt, Etc.)	Paternal or Maternal	Age	# of Miscarriages
1.			
2.			
3.			
4.			

Are there any members of your family with a history of learning disabilities? ____ Yes ____ No

If yes, please explain _____

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FAMILY HEALTH HISTORY (continued)

Carefully review the following list of medical problems and identify which ones you or one of your biological relatives have had. Please consider each condition carefully for each family member. Explain any conditions you check below, indicating which side of the family (maternal or paternal), the age at the time of onset, and any other pertinent information. If you and none of your indicated family members have a history of the specific medical condition, please indicate none.

	None	Self	Mother	Father	Sibling	Grand- parents	Aunt/ Uncle	Cousin	Explanation (which side of family, age of onset, etc.)
HEART									
Stroke									
Heart Attack									
Congenital Heart Disease									
Heart Disease or Defect									
Hardening of the Arteries									
High Blood Pressure									
Hereditary Hypercholesterolemia									
High cholesterol level									
BLOOD									
Anemia									
Sickle-cell anemia									
Hemophilia or other bleeding disorder									
Immune deficiency									
Leukemia									
Polyarteritis nodosa									
Other blood disorder									

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FAMILY HEALTH HISTORY (continued)

	None	Self	Mother	Father	Sibling	Grand- parents	Aunt/ Uncle	Cousin	Explanation (which side of family, age of onset, etc.)
RESPIRATORY									
Asthma									
Hay fever									
Lung cancer									
Emphysema									
Tuberculosis									
Pneumonia									
Alpha-1 antitrypain disorder									
Other lung disease									
GASTRO- INTESTINAL									
Ulcer of stomach or duodenum									
Gallstones									
Hepatitis (all types)									
Cirrhosis									
Other liver disease									
Ulcerative colitis									
Crohn's disease									
Cystic fibrosis									
Pyloric stenosis									
Multiple polyposis of the colon									

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FAMILY HEALTH HISTORY (continued)

	None	Self	Mother	Father	Sibling	Grand- parents	Aunt/ Uncle	Cousin	Explanation (which side of family, age of onset, etc.)
Rectal disorder									
Inflammatory bowel disease									
Any other cancer/ problem of the digestive system									
METABOLIC/ ENDOCRINE									
Diabetes mellitus requiring insulin therapy									
Diabetes not requiring insulin therapy									
Thyroid disease									
Thyroid cancer									
Goiter									
Hypoglycemia									
Hyperactivity									
Adrenal dysfunction or disorder									
Phenyl Ketonuria (PKU) or inherited metabolism disorder									
Dwarfism									
URINARY									
Kidney disease									
Polycystic kidney disease									
Other disease/ defect of urinary tract (urethra, bladder, ureter)									

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FAMILY HEALTH HISTORY (continued)

	None	Self	Mother	Father	Sibling	Grand- parents	Aunt/ Uncle	Cousin	Explanation (which side of family, age of onset, etc.)
GENITAL/ REPRODUCTIVE									
Hermaphroditism/ ambiguous genitals									
Hypospadias									
Uterine fibroids									
Ovarian cysts									
Endometriosis									
Cancer of cervix, ovaries or uterus									
REPRODUCTIVE OUTCOMES									
2 or more miscarriages									
Stillborn									
Death of a newborn infant									
Birth defects									
Infertility									
NEUROLOGICAL									
Migraines									
Mental retardation									
Senility or mental deterioration before age 50									
Multiple Sclerosis									
Cerebral Palsy									
Epilepsy/seizure									

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FAMILY HEALTH HISTORY (continued)

	None	Self	Mother	Father	Sibling	Grand- parents	Aunt/ Uncle	Cousin	Explanation (which side of family, age of onset, etc.)
Hydrocephalus									
Spina bifida neural tube defect									
Tuberous Sclerosis									
Parkinsonism									
Creutzfeldt-Jakob Disease									
Scoliosis									
Myasthenia Gravis									
Other diseases of the nervous system									
MENTAL HEALTH									
Depression									
Schizophrenia									
Manic depressive or bipolar disorder									
Huntington's disease									
Other mental health disorder requiring hospitalization									
MUSCLE/BONE/ JOINTS									
Muscular dystrophy									
Other chronic muscle disease									
Loss of muscle coordination									
Osteoporosis									
Marfan Syndrome									
Arthritis									

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FAMILY HEALTH HISTORY (continued)

	None	Self	Mother	Father	Sibling	Grand- parents	Aunt/ Uncle	Cousin	Explanation (which side of family, age of onset, etc.)
Spinal muscular atrophy									
Hereditary low back disorder									
Reiter's disease									
Gout									
Metabolic bone disease									
SIGHT/SOUND/ SMELL									
Deafness before age 60									
Deformity of the ear									
Cataracts before age 50									
Blindness									
Color blindness									
Severe Myopia									
Glaucoma									
Retinoblastoma									
Retinitis Pigmentosa									
Deviated septum									
Any other sight/sound/smell disorder									
SKIN									
Acne									
Albinism									
Eczema									
Pigmentation disorders									
Psoriasis									
Neurofibromatosis									

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FAMILY HEALTH HISTORY (continued)

	None	Self	Mother	Father	Sibling	Grand- parents	Aunt/ Uncle	Cousin	Explanation (which side of family, age of onset, etc.)
Other disorders of the skin									
Infectious skin disease									
More than 5 purple- or coffee- colored spots on skin (size of quarter or larger)									
CONGENITAL ABNORMALITIES									
Cleft lip/palate									
Congenital hip problems									
Club feet									
Other									
CHROMOSOMAL ABNORMALITIES									
Down Syndrome									
Other (i.e. Turner, Fragile X, etc.)									
OTHER									
Alcoholism									
Drug abuse, misuse or addiction									
Any Cancer not mentioned above									
Premature degeneration of any organ system									
Any other condition not mentioned above									

Explain: _____

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GENETIC HISTORY

Are there any known genetic diseases or conditions that run in your family? Yes No

If yes, please identify: _____

Is your ancestry:

- African American? Yes No
- Eastern European (Ashkenazi) Jewish? Yes No
- Mediterranean (Greek, Italian)? Yes No
- Southeast Asian (Laotian, Vietnamese, Cambodian)? Yes No
- French Canadian? Yes No
- Cajun? Yes No

Have you been tested as a carrier of any of the following diseases:

- | | | | | | |
|--------------------------|----|---------|----------------------------------|--------------------------------------|----------------------------------|
| Tay-Sachs: | No | If yes: | <input type="checkbox"/> carrier | <input type="checkbox"/> non-carrier | <input type="checkbox"/> unknown |
| Gaucher: | No | If yes: | <input type="checkbox"/> carrier | <input type="checkbox"/> non-carrier | <input type="checkbox"/> unknown |
| Canavan: | No | If yes: | <input type="checkbox"/> carrier | <input type="checkbox"/> non-carrier | <input type="checkbox"/> unknown |
| Fanconi Anemia Grp. C: | No | If yes: | <input type="checkbox"/> carrier | <input type="checkbox"/> non-carrier | <input type="checkbox"/> unknown |
| Niemann-Pick type A: | No | If yes: | <input type="checkbox"/> carrier | <input type="checkbox"/> non-carrier | <input type="checkbox"/> unknown |
| Mucopolipidosis type IV: | No | If yes: | <input type="checkbox"/> carrier | <input type="checkbox"/> non-carrier | <input type="checkbox"/> unknown |
| Familial Dysautonomia: | No | If yes: | <input type="checkbox"/> carrier | <input type="checkbox"/> non-carrier | <input type="checkbox"/> unknown |
| Blooms Syndrome: | No | If yes: | <input type="checkbox"/> carrier | <input type="checkbox"/> non-carrier | <input type="checkbox"/> unknown |
| Sickle Cell | No | If yes: | <input type="checkbox"/> carrier | <input type="checkbox"/> non-carrier | <input type="checkbox"/> unknown |
| Thalassemia | No | If yes: | <input type="checkbox"/> carrier | <input type="checkbox"/> non-carrier | <input type="checkbox"/> unknown |
| Cystic Fibrosis | No | If yes: | <input type="checkbox"/> carrier | <input type="checkbox"/> non-carrier | <input type="checkbox"/> unknown |

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PERSONAL AND MOTIVATIONAL
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Reason for wanting to donate eggs/sperm/embryos: _____

In your own words, describe your personality and character: _____

What are your hobbies, interests, and talents: _____

What are your goals in life? _____

If you could pass on a message to the recipient(s) of your eggs/sperm/embryos, what would that message be:

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PERSONAL AND MOTIVATIONAL (continued)
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What is your favorite movie? _____

What is your favorite book? _____

What is your favorite color? _____

What is your favorite food? _____

What is one of your most memorable moments and why?

If you could change one thing about yourself, what would it be and why?

Is there a person alive or dead whom you admire and why?

What would you do on a "perfect" day if you could do anything you wanted?

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**Please attach several photographs of yourself as a child
(Ages 1 – 8 years, no adult photos please).
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