

REPRODUCTIVE MEDICINE & SURGERY CENTER OF VIRGINIA

EGG DONOR APPLICATION

Date:
Name:
Address:
City
State, Zip Code

Date of Birth ____/____/____

Phone Numbers: okay to leave a detailed message?
Cell# ___yes ___no
Home# ___yes ___no
Work# ___yes ___no

Email address: _____
okay to send a detailed message? ___yes ___no

Health Insurance Information

Health insurance company: _____
Policy Holder's name: _____
Group Number: _____

PERSONAL DESCRIPTION:

_____ HEIGHT Religion: _____
_____ WEIGHT

Eye color _____
Hair color _____
Race _____
Ethnic background (ex. French, Irish, African-American, Latino, Italian, Japanese, etc) _____

Skin tone (medium, dark, light, fair, olive, freckles, etc) _____

Hair type: (curly, straight, wavy, fine, thick, frizzy) _____

Years of completed education: _____
Colleges attended: _____
Degrees obtained/currently pursuing: _____

Current Occupation: _____
Previous Occupations: _____

SOCIAL HISTORY

Tobacco use currently:

yes no

If yes, how much? _____

If no, have you smoked in the past? How much? How long ago did you quit?

Alcohol use:

yes no

If yes, how much? _____

If no, did you drink in the past? How much?

Recreational/illegal drug use currently:

yes no

If yes, what specifically and how frequently?

If no, have you used in the past? If yes, what specifically and how frequently?
When was the last time?

Are you currently:

Single

Married

Living w/a partner

Does your significant other know of your interest in egg donation?

Yes

No

If no, do you plan to tell your partner?

Yes

No

Undecided

How many times have you been pregnant?

never

once

twice

three times or more

How many children do you have?

none

one

two

three or more

Have you ever been convicted of a crime (other than a traffic violation)?

yes no

If yes, how what specifically and when?

Have you ever been in jail/prison?

yes no

If yes, for what specifically, when and length of stay?

PERSONAL ABILITIES/TALENTS:

How would you rank your

Mathematical abilities:

- fair
- average
- good
- excellent

Literary skills:

- fair
- average
- good
- excellent

Scientific abilities:

- fair
- average
- good
- excellent

Athletic abilities:

- fair
- average
- good
- excellent

Artistic skills:

- fair
- average
- good
- excellent

Musical skills:

- fair
- average
- good

excellent

List any special talents, skills or hobbies:

Your favorite sport: _____

Your favorite type of music: _____

Your favorite color: _____

Your favorite food(s): _____

Personal Medical History

Do you have any medical conditions currently? yes no

If yes, please describe:

Were you born with any handicaps or genetic conditions? yes no

If yes, please describe:

Have you ever been hospitalized? yes no

If yes, please describe:

Have you ever had surgery? yes no

If yes, please describe:

Have you ever been diagnosed with any psychiatric illness? yes no

If yes, please describe, including treatment:

Have you ever been diagnosed with a STD (sexually transmitted disease)?

yes no

If yes, please describe:

Have you ever been pregnant before? ___yes ___no

If yes, how many times? _____

Please describe the outcome of each pregnancy with dates, including any complications w/pregnancy, labor and delivery (ex. Elective termination, spontaneous miscarriage, premature birth, full term live birth, stillborn, etc.):

Have you ever received a blood transfusion? ___yes ___no

If yes, why and when? _____

Please list all **prescribed** medications you take and the reason:

Please list all "over the counter" medications and herbal supplements you take and the reason:

Please list all tattoos and dates acquired:

Have you ever been excluded from blood donation?

___yes ___no

If yes, why and when? _____

Have you ever donated your eggs elsewhere? ___yes ___no

If yes, when and where? _____

If yes, how many eggs were retrieved? _____

Family Medical History:

Relative	Alive?	Current age or age of death	Occupation	Years of completed education	Health problems: detailed description
Mother					
Father					
Maternal grandmother					
Maternal grandfather					
Paternal Grandmother					
Paternal Grandfather					
Sibling 1					
Sibling 2					
Sibling 3					
Aunt					
Aunt					
Uncle					
Uncle					

Other relatives w/significant medical history: _____

If you have children, please complete the following:

Age Current Health Birth Problems Medical Problems

First child: _____

Second child: _____

Third child: _____

Fourth child: _____

Has anyone in your family had any of the following conditions?

	YES	NO
Down's Syndrome		
Mental retardation		
Seizure disorder		
Cleft lip and/or cleft palate		
Spina bifida (open spine)		
Hydrocephalus (water on the brain)		
Congenital heart defects		
Cystic fibrosis		
Mental illness (schizophrenia, bipolar, depression)		
Diabetes mellitus (onset prior to age 50)		
Club feet		
Congenital hip problems		
Thyroid disease		
Progressive kidney disease		
Skin disease		
Neurofibromatosis (lumps under the skin)		
Arthritis		
Alcoholism		
Colon cancer (before age 65)		
Hypertension		
Blood clotting disorder		
Breast cancer		
Ovarian cancer		
Huntington's disease		
Marfan's syndrome		
3 or more miscarriages or any stillbirths		
Blindness		
Deafness		
Cataracts		
Premature senility (before age 50)		
Muscle weakness/atrophy/dystrophy		
Light color patches on skin (tuberous sclerosis)		
Any other genetic conditions		

If yes is answered to any of the above questions, please explain:

Specific relation

Specific Condition

Age affected
