Donor Questionnaire
Choices

ID:

Personal Information

Age:

Marital Status: Married Divorced Single Widowed

Characteristics

Ethnic Origin/Nationality:

Natural Hair Color: Eye Color: Height: Weight:

Hair (circle one):	Balding	Thin	Average	Thick
Hair (circle one):	Kinky Curly	Curly	Wavy	Straight

Body Structure (circle one):		Small	Medium	Large
Skin Tone (circle one):		Light	Medium	Dark
Skin Marks (circle):	Freckled	Birth Mark	Moles	Dimples

Select One: Left Handed Right Handed Ambidextrous

Eye Sight (circle one):	Normal	Farsighted	Nearsighted	Stigmatism
Teeth (circle one):	Good	Excellent	Braces	
Hearing (circle one):	Poor	Good	Aide explain	

Diet: Vegetarian Non-vegetarian

Exercise what kind: None Some Regularly

Personality

Circle those that apply:

Introvert	Shy	Quiet	Warm
Moody	Lonely	Passive	Sensitive
Average	Dependent	Independent	Happy
Extrovert	Energetic	Aggressive	Assertive
Outgoing	Planner	Sociable	Unfazed
Risk Taker	Cautious	Demanding	Giving
Perfectionist	Personable	Takes it as it comes	

What do you like most about yourself as a person?

What is your favorite TV show? What is your favorite color?

What is your favorite food? What is your favorite number?

What is your favorite type of music? What is your favorite beverage?

What are you currently doing at this point in your life?

What are your future career and personal goals?

How would the people close to you describe you?

What motivated you to become an ovum donor?

Would you like to pass on a message to the couple of your ovum donation?

Education

Grade School: Completed Didn't Complete

High School: Completed Didn't Complete GED

GPA SAT Score ACT Score IQ Score

Attending College: Major Minor GPA

Attending Trade School: Major Minor GPA

Attending Postgraduate: Major Minor GPA

College Degree: Major Minor GPA

Postgraduate Degree: Major Minor GPA

Trade School: Major Minor GPA

Occupation: Current Past

Family Education

Mother: Education Occupation

Father: Education Occupation

Sibling: Education Occupation

Sibling: Education Occupation

Sibling: Education Occupation

Sibling: Education Occupation

Talents and Abilities

Athletic: Fair Good Excellent Explain:

Music: Fair Good Excellent Explain:

Singing: Fair Good Excellent Explain:

Artistic: Fair Good Excellent Explain:

Writing: Fair Good Excellent Explain

Organized: Fair Good Excellent Explain

Please list any talents, clubs, hobbies, special skills or activities you enjoy:

Ancestry

Are you from Jewish descent? Yes No Unknown

If yes, have you been tested for as a carrier of Tay Sachs, Cystic Fibrosis or Gaucher's Disease? Yes No

If yes, results:

Are you from African descent? Yes No Unknown

If yes, have you been tested as a carrier of Sickle Cell disease? Yes No

If yes, results:

Are you from Greek or Italian descent? Yes No Unknown

If yes, have you been tested as a carrier of Thalessemia? Yes No

If yes results:

Are you from any Asian descent? Yes No Unknown

If yes, have you been tested as a carrier of Thalassemia? Yes No

If yes, results:

Reproductive History

Age of first period: Regular Irregular

If irregular please explain:

Age of breast development:

Age of pubic hair growth:

Number of days between periods (count start of flow to start of next flow):

How many total days of menstrual flow do you have?

Do you have bleeding between periods? Yes No

If yes, explain:

Do you have menstrual cramps? Yes No

If yes, explain:

Do you have discharge from your breast? Yes No

If yes, explain:

When was your last pap smear? Results:

Pap smear needs to be within the last year and please send copy

Have you ever had an abnormal pap smear? Yes No
If yes, explain:

Pregnancy History

Have you ever been pregnant? Yes No If yes fill out the below

Date	Miscge	Stillborn	Abortion	Delivered	Birth Wgt	Weeks Gestation	Complications

Please fill out the below chart for each child:

Age	Sex of Child	Health Problems

Are you currently breastfeeding? Yes No

If yes, how long and when will you stop?

Have you ever had a fertility evaluation? Yes No

If yes, explain:

Have you previously been a donor? Yes No

If yes, when: Where: Results:

Were you adopted? Yes No

Family Pregnancy History

Please fill in:

Member	Age of Preg.	# of Children	Complications	Health Problems	Miscarriage	Stillborn

Is there any history of fertility problems in your family? Yes No

Did your mother have problems conceiving or fertility issues?

Did any of your sisters have problems conceiving or fertility issues?

Did any of your aunts have problems conceiving or fertility issues?

Did your mother take Diethylstilbestrol (DES) or any drug to prevent miscarriages when she was pregnant with you? Yes No If yes explain:

Do twins run in your family? Yes No If yes, relation to you?

Have you or a family member had a hermaphroditism pregnancy? Yes No

Sexual History

What type of contraceptives are you or have you used:

Type	Started	Stopped	Reason for stopping
Birth Control Pill			
IUD			
Diaphragm			
Condom			
Norplant			
Depo Provera			

Are you sexual active now? Yes No
How long have you been with your partner?
How many partners have you had in the last year?

Have you had sex with a man who has had sex with another man since 1977? Yes No

Have you ever been with a male or female prostitute? Yes No

Have you ever had sex with someone who has taken clotting factor concentrates for a bleeding disorder such as hemophilia? Yes No

In the last twelve months have you been with a sex partner or anyone who has ever taken street drugs by needle? Yes No

Have you ever been raped? Yes No

To your knowledge have you ever had a positive test for HIV (any AIDS tests) or been with anyone who has? Yes No

In the last twelve months have you been exposed to anyone with yellow jaundice or Hepatitis? Yes No

Have you had medical diagnosis of ZIKA virus? Yes No

Have you or you lived/traveled to an area of active ZIKA virus transmission within the last 6 months (refer to CDC for list of countries)? Yes No

Have you had sex with a male who is known to have either of the risk of the ZIKA? Yes No

Have you ever had Pelvic Inflammatory disease? Yes No

Have you or a sexual partner had any of the following:

Disease	Date	Age	Treatment
Gonorrhea			
Chlamydia			
Venereal Warts			
Syphilis			
Herpes			
Other			

Health

Do you have allergies? Yes No

If yes, are they to: Food Drugs Environmental Other

Please list specific substances and/or allergic reaction(s):

Substance **Reaction**

If you had allergies as a child please describe:

Have you ever had surgery? Yes No

If yes, please explain:

Have you been hospitalized not previously mentioned? Yes No

If yes, please explain:

Do you know your blood type: If yes, what type No

Have you had major radiation or x-ray exposure? Yes No

If yes, explain:

Have you ever had any complications resulting from surgery? Yes No

If yes, explain:

In the last twelve months have you had a blood transfusion, blood injections, organ or tissue transplants? Yes No

If yes, explain:

Have you ever had a major illness such as Amoebic Dysentery, Hepatitis, Pneumonia,

Mononucleosis, etc? Yes No
If yes, explain:

Have you ever been in jail for more than 72 consecutive hours? Yes No

Do you have or have you had body piercing or tattoos? Yes No

If yes, explain what body part: what year

Do you have any current chronic medical problems/conditions? Yes No

If yes, explain:

List all medication you are currently taking: none

Have you have had mental health counseling? Yes No

If yes, explain:

Are you now smoker? Yes No

age started number per day age quit how long

Do you drink alcohol? Yes No

If yes, what kind:

How many? per day per week per month

Do you drink coffee? Yes No If yes, how much per day?

Do you drink caffeinated soda? Yes No If yes, how much per day?

Do you drink caffeinated tea? Yes No If yes, how much per day?

Do you now or have you are ever used any of the following drugs?

Drug	How Often	How Long	How Used
Marijuana			
Cocaine			
Barbiturates			
Amphetamines			
Hallucinogens			
Tranquilizers			
Narcotics (heroin, codeine, opium)			
Inhalants			
PCP			
Over the counter type?			
Other?			

Are you exposed to cleaning products on a daily basis? Yes No

If yes, explain:

Are you exposed to paints, gases or oils on a daily basis? Yes No

If yes, explain:

Have you ever served in overseas in the military? Yes No

If yes, explain:

Family Characteristics

Member	Age	Height	Hair Color	Eye Color	Body	Complexion
Father						
Mother						
Brother						
Brother						
Brother						
Brother						
Brother						
Sister						
Sister						
Sister						
Sister						
Sister						
Paternal Grandfather						
Paternal Grandmother						
Maternal Grandfather						
Maternal Grandmother						

If any family member has died please fill in the chart below:

Family Member	Age of Death	Cause

Family Medical Background

Indicate if any family member has or has had any of the following conditions:

Medical Condition	You	Parent	Sibling	Grandparent	Uncle/Aunt Cousin
Heart					
Disease					
from birth					
Other					
Attack					
Stroke					
Heart murmur					
High blood pressure					
Harding of the arteries					
High Cholesterol					
Respiratory (Lungs)					
Lung cancer					
Emphysema					
Tuberculosis					
Pneumonia					
Asthma					
Hay fever					
Cystic Fibrosis					
Other lung disease					
Blood					
Leukemia					
Anemia					
Immune deficiency					
Thalassemia					
Other blood disorder					
Metabolic/Endocrine					
Thyroid disease					
Thyroid cancer					
Diabetes mellitus Type I or II					

Medical Condition	You	Parent	Sibling	Grandparent	Uncle/Aunt Cousin
Hypoglycemia					
Hyperactivity					
Adrenal dysfunction					
Goiter					
Gastro-Intestinal					
Hepatitis A (infectious)					
Hepatitis B (serum)					
Hepatitis C					
Gallstones					
Ulcer of stomach or duodenum					
Colon cancer					
Ulcerative colitis					
Crohn's disease					
Intestinal cancer					
Cirrhosis					
Pyloric Stenosis					
Rectal disorder					
Jaundice					
Other liver disease					
Genital/Reproductive					
Ovarian cancer					
Ovarian cysts					
Uterine cancer					
Uterine fibroids					
Cervical cancer					
Endometriosis					
Hysterectomy					
Breast cancer					
Premature menopause					
Undescended testicle					
Hypospadias					
Prostate cancer					
Ambiguous Genitals					
Urinary					
Kidney disease					

Medical Condition	You	Parent	Sibling	Grandparent	Uncle/Aunt Cousin
Kidney stones					
Kidney Infection					
Diseases of (Urethra or Utterer)					
Bladder problems					
Neurological					
Migraines					
Mental Retardation					
Down's syndrome					
Turner's syndrome					
Fragile X					
Multiple Sclerosis					
Cerebral Palsy					
Epilepsy/Seizures					
Hydrocephalus					
Disorders of Spinal Cord					
Huntington's chorea					
Gaucher's disease					
Canavan's disease					
Tays sach's					
Parkinson's disease					
Wilson's disease					
Alzheimer's disease					
Senility before 50					
Myasthenia Graves					
Paralysis/Paraplegia					
Neurofibromatosis					
Born without a brain					
Mental Health					
Manic depression					
Depression					
Schizophrenia					
Bi-Polar					
Suicide					
Hospitalized for Mental health					
Other Mental Health disorders					

Medical Condition	You	Parent	Sibling	Grandparent	Uncle/Aunt Cousin
Muscular/Joints/Bones					
Muscular dystrophy					
Scoliosis					
Other chronic Muscular disease					
Osteoporosis					
Lupus					
Deformity of Spine/Spina Bifida					
Dwarfism					
Rheumatoid Arthritis					
Malformed bones or many Broken bones					
Malformed hands (extra/missing webbed finger)					
Malformed feet (extra/missing webbed toes)					
Osteoarthritis					
Gout					
Club feet					
Congenital hip problems					
Vision/Hearing/Smell					
Blindness					
Color Blindness					
Cataracts before age 50					
Glaucoma					
Retinitis Pigmentosa					
Deafness before age 60					
Deformity of the ear					
Deviated Septum					
Other related conditions					
Skin					
Skin cancer					
Pigmentation disorder					
Varicose veins					
Edema					
Coffee colored skin spots					

Medical Condition	You	Parent	Sibling	Grandparent	Uncle/Aunt Cousin
Eczema					
Acne					
Other skin disorders					
Other					
Alcoholism					
Drug abuse, addiction or misuse					
Tourette's syndrome					
Chromosome problem					
Inguinal Hernia					
Lymph edema					
Obesity					
Cleft lip and/or palette					
Attention Deficit Disorder					
Any other cancer					
Any other condition					