# EGG DONOR PROFILE

Name _____

Maiden Name _____

Address _____

_____

Phone (home)_____(Work)_____

Email address _____

Date of Birth_____Place of birth _____

Religion_____Ancestry/Nationality _____

Race _____

Marital Status: Single ( ) Married ( ) Separated ( ) Divorced ( )

Husband's name _____

## Physical description

Height:_____ Weight: _____

Hair Color: _____ Eye Color : _____

Complexion: Fair ( ) Olive ( ) Medium ( ) Tan ( )

## Identification

Social Security No.: _____

Drivers License: _____

## Educational History

Number of years attended: Grade School ___ High School ___ College ___

Educational Achievements: _____

Educational Goals: _____

Vocational and /or other training: _____

## Occupational History

Date: _____

Present occupation: _____

Address of present employer: _____

Telephone number: _____ Hours: _____

Can you be called at work? Yes ( ) No ( )

Length of employment: _____

Do you plan to stop working? Yes ( ) No ( )

If so, when? _____

## Hobbies, Talents, Interest

_____

_____

_____

## Medical Information on Egg Donor

OUTLINE OF THE EGG DONOR'S HEALTH HISTORY INCLUDING ALL FAMILY MEMBERS

Place an "X" if the listed medical condition exists in your medical history or if any relatives or other family members have/had any of the conditions. If one of your relative's deaths was the result of a particular medical condition, note it on the line to the right of the condition and write the age at which they died.

| PLACE AN '**X**' | **CONGENITAL IMPAIRMENTS** | **List the member(s) from your maternal or paternal side of your family who have or had each impairment** |
|---|---|---|
| | Club foot or any orthopedic problem | |
| | Harelip (Cleft lip) or Cleft palate | |
| | Cerebral Palsy | |
| | Down's Syndrome | |
| | Hydrocephalus (Water on the brain) | |
| | Muscular dystrophy | |
| | Dwarfism | |
| | Spina Bifida | |
| | Congenital heart defect | |
| | Other | |

| PLACE AN '**X**' | **ALLERGIES** | **List the member(s) from your maternal or paternal side of your family who have or had each impairment** |
|---|---|---|
| | Eczema or other skin conditions | |
| | Hay fever | |
| | Milk allergy | |
| | Drug allergy(s) | |
| | Other | |
| PLACE AN '**X**' | **EYE, EAR, NOSE AND THROAT DISORDERS** | **List the member(s) from your maternal or paternal side of your family who have or had each impairment** |
| | Farsighted | |
| | Nearsighted | |
| | Different color eyes | |
| | Night blindness | |
| | Glaucoma | |
| | Blindness | |
| | Other visual problems | |
| | Sinus or nasal problems | |
| | Ear infections | |
| | Deafness | |
| | Other ear problems | |
| | Teeth problems | |
| | Gum disease | |
| | Other | |

| PLACE AN 'X' | **CIRCULATORY DISORDERS** | **List the member(s) from your maternal or paternal side of your family who have or had each impairment** |
|---|---|---|
| | Hypertension (high blood pressure) | |
| | Heart murmurs | |
| | Heart attack (coronary) | |
| | Hemophilia (free bleeder) | |
| | Leukemia | |
| | Stroke | |
| | Anemia | |
| | Sickle cell anemia or trait | |
| | Heart Surgery | |
| | Any other heart or circulatory problems | |

| PLACE AN '**X**' | **RESPIRATORY AND DIGESTIVE DISORDERS** | **List the member(s) from your maternal or paternal side of your family who have or had each impairment** |
|---|---|---|
| | Asthma | |
| | Bronchitis | |
| | Cystic fibrosis | |
| | Sudden infant death syndrome | |
| | Frequent pneumonia | |
| | Other respiratory disorders | |
| | Ulcers | |
| | Colitis | |
| | Gall bladder problem | |
| | High Cholesterol | |
| | Obesity | |
| | Anorexia/Bulimia | |
| | Colon Cancer | |
| | Other Digestive Disorders | |

| PLACE AN 'X' | **URINARY TRACT CONDITIONS** | **List the member(s) from your maternal or paternal side of your family who have or had each impairment** |
|---|---|---|
| | Bladder Problems | |
| | Kidney problems | |

| PLACE AN 'X' | **DEVELOPMENTAL DISORDERS, MENTAL, BEHAVIORAL, AND NERVOUS DISORDERS.** | **List the member(s) from your maternal or paternal side of your family who have or had each impairment** |
|---|---|---|
| | Speech problems | |
| | Learning disability | |
| | Retardation: mental or physical | |
| | Other developmental disorders | |
| | Diagnosed schizophrenia | |
| | Diagnosed manic depressive | |
| | Alcoholism or heavy drinking | |
| | Drug abuse | |
| | Other mental or behavioral disorders | |
| | Multiple sclerosis | |
| | Lou Gehrig's disease | |
| | Seizures or convulsions | |
| | Huntington's disease | |
| | Epilepsy | |
| | Migraine headaches | |
| | Other nervous system disorders | |

| PLACE AN '**X**' | **MISCELLANEOUS DISORDERS** | **List the member(s) from your maternal or paternal side of your family who have or had each impairment** |
|---|---|---|
| | Diabetes | |
| | Arthritis | |
| | Gouty arthritis | |
| | Rheumatoid arthritis | |
| | Hodgkin's disease | |
| | Cysts, lumps, or growths | |
| | Tumors | |
| | HIV/AIDS | |
| | Others | |

| PLACE AN '**X**' | **FEMININE DISORDERS** | **List the member(s) from your maternal or paternal side of your family who have or had each impairment** |
|---|---|---|
| | Endometriosis | |
| | Menstrual problems | |
| | Problem pregnancies | |
| | Other problems | |
| | What age did your period begin? | |

## CONFIDENTIAL DRUG USAGE

This is **STRICTLY CONFIDENTIAL**. Place an "X" in the "no" box, if you have never used that drug/alcohol.

| DRUG & ALCOHOL USAGE | **Use occasion-ally (1-5 times)** | **Use Daily** | **Use Weekly** | **Use monthly** | **NO** |
|---|---|---|---|---|---|
| CIGARETTES | | | | | |
| BEER | | | | | |
| WINE | | | | | |
| LIQUOR | | | | | |
| MARIJUANA | | | | | |
| COCAINE | | | | | |
| AMPHETAMINES | | | | | |
| HEROINE | | | | | |
| METHADONE | | | | | |
| QUAALUDES | | | | | |
| PCP | | | | | |
| LSD | | | | | |
| STIMULANTS | | | | | |
| DEPRESSANT | | | | | |
| DIET PILLS | | | | | |
| TRANQUILIZERS | | | | | |
| ANTI-CONVULSANTS | | | | | |
| PRESCRIPTION DRUGS | | | | | |

Please list any other medical issues that were not covered in the information above:

_____

_____

Please list any additional comments, concerns or questions you may have: _____

_____

_____

_____

_____

## EGG DONOR ACKNOWLEGEMENT

**I represent that the information contained in this Egg Donor Profile (including but not limited to the medical information) is true and accurate.**

**I acknowledge that the intended parents and other parties will rely on this information in making a determination to proceed. I hereby agree that the information contained in this form may be given to the intended parents, their physicians and specialists, and their attorney.**

**I further understand that any false statement herein may be viewed as perjury and in violation of the penal laws of my state and may subject me to criminal and/or civil penalties under the law.**

_____

STATE OF _____
COUNTY OF _____

The foregoing instrument was sworn to and subscribed before me this ___ day of _____, 2002, by_____, who is personally known to me or who has produced _____ as identification.

_____
Notary Public

_____
(Print, Type or Stamp Name)

**Please return with a photograph.**