NYU Langone MEDICAL CENTER

FERTILITY CENTER
660 First Avenue, 5th Floor ● New York, NY 10016
Phone: 212.263.8990 ● Fax: 212.263.7853

Egg Donor Application And Medical History Form

Date Applied:________________________________ **Donor #:**____________________________

Please put thought into your responses and write legibly. A copy of your application with identifying information deleted will be given to prospective recipients. Please mail your completed application to the address listed above (attention: DE Program) or fax to 212-263-0059.

Name:___________________________________ **Age:**_________ **Date of Birth:**________________

Address:____

City:__________________________________ **State:**______________ **Zip Code:**________________

Home Phone:________________ **Work Phone:**________________ **Cell Phone:**_________________

Email Address:_______________________________________ **Marital Status:**___________________

Provide your Social Security or T.I.N. Number :_____________________________________

Are you a U.S. Citizen? ☐Yes ☐No Country of Origin?____________________________

Are you a Resident Alien? ☐Yes ☐No If yes, provide your alien number: A_________________
Please include a copy of your social security card or TIN & green card along with the application

Are you a non-resident Alien? ☐Yes ☐No If yes, what type of VISA?________________________
Please include a copy of your visa & work permit information with the application

How did you hear about our program?

☐Magazine (name):
☐Friend (name):
☐Newspaper (name):
☐Internet
Did you see us on Facebook? ☐Yes ☐No

☐PATH train
☐Movie Ad (name & location of theatre):
☐Radio ad (name of station):
☐Craigslist

☐Directed Donor Name of Recipient:_______________________________

Although children born of my ovum donation cannot now contact me, should the laws change, I would be willing to be contacted when such children reach maturity (usually age 18-21).
This is not a binding decision, but merely my current inclination.

☐Yes ☐No ☐Undecided Any comments:____

____

Would you be willing to provide a childhood photo of yourself, (between age 2-8) for prospective recipients to view? (They will NOT be permitted to keep this photo).

☐Yes ☐No If yes, please attach a childhood photo of yourself (age 2-8)

Date Applied:_______________

Why are you interested in becoming an egg donor ?______________________________

____

____

____

Do your personal and/or religious beliefs prohibit you from receiving potentially necessary medical treatments (example - blood transfusions, IVF fluids, etc.) ☐Yes ☐No

Personal Information: Place of Birth: ________________________________

Race: ________________________________

Ethnic origin, (i.e.: Italian, Swedish, African, etc.)

Ethnic Origins of your Mother's Family	Ethnic Origins of your Father's Family

Your Religion:_____________ **Mother's Religion**:____________ **Father's Religion:**______________

If Jewish: ☐**Ashkenazi** ☐**Sephardic**

Physical Characteristics

Height:__________________ **Weight:**__________________ **(Please be accurate)** **Build:** ☐ Small ☐ Medium ☐ Large

Eye Color:________________________ **Natural Hair Color**:________________________

Hair Texture (Check all that apply):
☐Straight ☐Wavy ☐Thick ☐Thin ☐Fine ☐Curly ☐Coarse

Do you wear glasses or contact lenses? ☐Yes ☐No If yes, at what age were they prescribed?_____
Did you wear braces ? ☐Yes ☐No
Do you have any dental abnormalities ? Please describe:_________________________________

Complexion:
☐Fair ☐Rose ☐Medium ☐Olive ☐Light Brown ☐Medium Brown ☐Dark Brown ☐Ebony

Freckles?
☐None ☐Few ☐Numerous
Have you ever had Acne? ☐Yes ☐No If yes, at what age?________ Severity of your acne?__________

Are you: ☐Right Handed ☐Left Handed ☐Ambidextrous

Is your hearing normal ? ☐Yes ☐No
If no, please describe hearing trouble**:**____

Date Applied:_______________

Family Characteristics

(Please tell us about your family to the best of your ability)

Relative	Alive Yes or No	Present age or age at death	Height	Weight	Size of body frame	Hair color	Eye Color	Skin tone	Medical condition or cause of death?	Occupation	Birth Place
Mother											
Maternal Grandmother											
Maternal Grandfather											
Father											
Paternal Grandmother											
Paternal Grandfather											
Brother/sister 1 (Circle brother or sister)											
Brother/sister 2 (Circle brother or sister)											
Brother/sister 3 (Circle brother or sister)											
Brother/sister 4 (Circle brother or sister)											
Brother/sister 5 (Circle brother or sister)											
Brother/sister 6 (Circle brother or sister)											
Brother/sister 7 (Circle brother or sister)											
Your own Son/daughter 1 (Circle son or daughter)											
Your own Son/daughter 2 (Circle son or daughter)											
Your own Son/daughter 3 (Circle son or daughter)											

If you have additional siblings or children of your own please attach an additional sheet of paper and include their characteristics.

Date Applied:_______________

Education and Social History

High School (# years) 1 2 3 4 GPA ________ (Based upon ☐3 ☐4 point scale)
High School G.E.D. _______

College/University (# years) 1 2 3 4 GPA ________ (Based upon ☐3 ☐4 point scale)

Study Major :________________________________ Degree Obtained:_________________________

Post Graduate Major:____________________________ Post Graduate Degrees:____________________

____

Please list any Scholastic achievements or awards received: ___________________________________

____

Are you or have you been a member of any Honor Societies ?__________________________________

____

In which area(s) of study did you excel ? ____

____

Are you fluent in languages other than English? If so, which:___________________________________

Musical Ability

Have you studied music ? ☐Yes ☐No If yes, number of years studied?________________________
Musical Ability: ☐Gifted ☐Above Average ☐Average ☐Fair ☐Tone Deaf

Do you play an instrument ? ☐Yes ☐No If yes, what instrument(s) ___________________________

____

Athletic Activity

Are you athletic ? ☐Yes ☐No
What is your level of physical activity ? ☐Athletic ☐Active ☐Occasionally active ☐Inactive

Have you excelled in physical activities ? If so, please describe: _______________________________

____

____

Do you currently participate in sports or physical activities ? ___________________________________

____

Artistic Ability

Have you studied art or do you have any artistic ability ? ☐Yes ☐No

If yes, please describe your artistic ability: ____

____

____

Date Applied:_______________

Please list any volunteer activities or community service: ____

____

Please list your hobbies or any special talent you may have or things you enjoy doing in your spare time:

____

____

How would you describe your personality ? ____

____

Work/Occupation History (check all that currently apply)

☐I am not currently working.
☐I currently work part time.
☐I am currently working full time.
☐I currently work in the home.
☐I am currently a full time student.
☐I am currently a part time student.
☐Other: explain:____

Current Occupation:____

What type of work have you done in the past ? ____

____

____

What are your ambitions for yourself over the next five years ? _______________________________

____

____

Social History (Check all that currently apply)

Cigarettes/Tobacco

☐I don't smoke.
☐I currently smoke______________cigarettes per day.
☐I used to smoke, but no longer do.

Alcohol

☐I never drink alcohol. ☐I drink only occasionally. ☐I drink regularly.
What type of alcoholic beverages do you drink?____

How many drinks (beer, wine, or alcohol) do you consume Per day_____? Per week_____? Per month_____?

Drug Usage

☐I have never used illegal drugs.
☐I have tried drugs at least once in the past.
☐I used to use drugs regularly but don't anymore.
☐I currently inject illegal drugs or I have injected illegal drugs within the past 12 months.
☐Have you ever shared needles when injecting drugs ? ☐Yes ☐No
Have you ever used marijuana, heroin, cocaine, LSD, amphetamines, barbiturates…other? ☐Yes ☐No
If yes, please give details and date last used:____

Date Applied:_______________

Reproductive Health and Sexual History

How old were you when you first began to menstruate?___________________________________

How many days between one period to the next?_____ Is your menstrual cycle? ☐ Regular ☐ Irregular

Are you currently taking oral contraceptives? If yes, which brand and for how long?________________

Have you donated your eggs before? ☐Yes ☐No How many times? ☐1 ☐2 ☐3 ☐4 ☐5

Where did you donate your eggs? ____

Pregnancy History

- Have you been pregnant? ☐Yes ☐No
- If yes, how many times have you been pregnant ? ______________________________________
- Have you ever carried a pregnancy full term? ☐Yes ☐No
- If yes, were there any complications with gestation or delivery? ☐Yes ☐No
- What were the complications: ____
- How many times have you given birth? ☐1 ☐2 ☐3 ☐4 ☐5 ☐More
- Has every delivery resulted in a live birth? ☐Yes ☐No
- If no, please explain: ____

	Please answer ALL of the following questions: Please check "Yes" or "No". If you make a correction, initial and date next to the correction(s).	**Yes**	**No**
1	Did your mother take DES while she was pregnant with you?		
2	Have you ever been told you are infertile?		
3	Is there a history of infertility in your family?		
4	Have you ever used intravenous drugs or had a sexual partner that did so?		
5	Have you ever used an injectable drug or had a sexual partner that did so?		
6	Are you currently taking injectable medication or do you have a sexual partner that does so?		
7	Have you engaged in prostitution at any time since 1977?		
8	Have you been involved sexually with anyone during the past six months that has engaged in prostitution at any time since 1977?		
9	Have you been sexually active during the past six months?		
10	Are you currently sexually active?		
11	Are you in a monogamous relationship? If no, how many sexual partners have you had during the past six months? _________		
12	Have you had more than 10 sexual partners?		
13	Have you had sexual relations with a partner that is suspected or known to be HIV positive?		
14	Have you ever had sexual relations with a man that has engaged in anal intercourse or oral sex with another man? If yes, when was the last time? __________________		
15	Have you had sexual relations with a gay or bisexual man? If yes, when? _________________		
16	Have you ever received a blood transfusion? If yes, when? _________________		
17	Have you ever received factor VIII, factor IX concentrates or other human derived clotting factors (blood transfusion) that was not heat-treated or otherwise vial inactivated? If yes, when? _________________		
18	Do you have any tattoos? If yes, when did you receive the last one? _________________ Did you have your tattoos refreshed? If yes, when? _______________ Were sterile instruments used for the new or refreshed tattoos? Yes_____ No _____		
19	Do you have any piercings? If yes, when did you receive the last one? ________________ Were sterile instruments used for the piercing(s)? Yes _____ No _______		
20	Have you been exposed to known or suspected HIV, Hepatitis B or Hepatitis C Virus, infected blood through skin penetration or through contact with an open wound or mucous membrane? If yes, When? __________________		

Date Applied:_______________

	Please answer ALL of the following questions: Please check "Yes" or "No". If you make a correction, initial and date next to the correction(s).	Yes	No
21	Have you ever been diagnosed with Creuzfeldt-Jacob Disease or any other form of CJD?		
22	Have you ever had a diagnosis of dementia or any degenerative or demyelinating disease of the central nervous system (CNS) or other neurological disease of unknown etiology?		
23	Have you ever had a blood relative diagnosed with Creuzfeldt-Jacob Disease (CJD)?		
24	Have you ever received a dura mater (outermost of membranes covering the brain and spinal cord) transplant?		
25	Have you spent three months or more cumulatively in the United Kingdom (U.K.) from the beginning of 1980 through the end of 1996?		
26	Are you a current or former U.S. military member, civilian military employee, or dependent of a military or civilian employee who resided at U.S. military bases in Northern Europe (Germany, U.K., Belgium, Netherlands) for 6 months or more from 1980 through 1990 or elsewhere in Europe (Greece, Turkey, Spain, Portugal, Italy) for 6 months or more from 1980 through 1996?		
27	Have you lived cumulatively for 5 years or more in Europe from 1980 until the present (note this includes time spent in the U.K. from 1980-1996)?		
28	Have you received any transfusion of blood or blood components in the U.K. between 1980 and the present?		
29	Have you injected bovine insulin since 1980, unless you can confirm that the product was not manufactured after 1980 from cattle in the U.K.?		
30	Have you ever been refused as a blood donor? If yes, Why? ____		
31	Have you ever been immunized against Hepatitis B? If yes, When? ________________		
32	Have you had close contact, i.e. sexual intimacy, shared a bathroom or a kitchen, with someone suspected or known to be positive for Hepatitis B or Hepatitis C?		
33	Have you been immunized against small pox in the past five years?		
34	Have you had close contact with someone who has had a cell, tissue or organ transplant from an animal?		
35	Have you ever been diagnosed with or treated for West Nile virus? If yes, When? __________________		
36	Have you ever been diagnosed with or treated for Severe Acute Respiratory Syndrome (SARS)? If yes, When? ______________		
37	Have you been exposed to radiation or toxic chemicals in your work or personal life? i.e. lead, mercury and gold		
38	Have you been bitten by an animal suspected of having rabies within the past 12 months?		
39	Have you traveled outside the United States in the past two years? If yes, where and when? ____		

Have you ever experienced the following conditions? :

		Yes	No
	Have you experienced unexplained weight loss?		
	Have you ever had a fever of unexplained origin?		
	Have you ever had Kaposi Sarcoma?		
	Have you ever had Pneumocystic Pneumonia?		
	Have you ever had sexual relations with anyone that had the above symptoms or diseases? If Yes, Please specify: ____		

Date Applied:_______________

Medical History

Do you have any medical illnesses (i.e. asthma, diabetes, seizure disorders, tuberculosis, etc.) ?
____

List all Surgeries: ____

Do you have any allergies (food, pollen, bee stings, etc.)? Please list:

____

Do you have any allergies to medications? Please list:

____

Describe any childhood allergies you may have outgrown :

____

List medications including prescription, over the counter, vitamins or herbs that you are currently taking:

____

____

Are there medications you have taken in the past five years that are not listed above? If so, please list:

____

____

Have you ever sought psychological counseling? ☐Yes ☐No
Have you, or are you currently taking medication for a psychological condition? ☐Yes ☐No

If yes, what medications have you, or are you currently taking? _______________________________

Have you ever attempted suicide? ____

Please read through the following list of medical conditions. Indicate which (if any) condition(s) apply to you or your family members. Consider each condition carefully and note the age at which the condition appeared.

ALL sections must be completed. If not applicable, write "N/A" with a line through the section.

Medical Condition	Self	Mother	Father	Siblings	Grandparents	Other Family	Age of Onset
HEART							
Hardening of the Arteries							
Heart Attack							
Heart Disease							
High Blood Pressure							
High Cholesterol							
Mitral Valve Prolapse							
Stroke							
BLOOD							
Anemia							
Hemophilia or other Bleeding problem							

Date Applied:_______________

Medical Condition	Self	Mother	Father	Siblings	Grandparents	Other Family	Age of Onset
HIV/AIDS							
Immune Deficiency or disease							
Leukemia							
Other blood disorder							
Prolonged Fever							
Sickle-Cell Anemia							
RESPIRATORY							
Asthma							
Hay Fever							
Emphysema							
Lung Cancer							
Other Lung Disease							
Pneumonia							
Tuberculosis							
GASTROINTESTINAL							
Digestive system Cancer or Disease							
Colon Cancer							
Crohn's Disease							
Cystic Fibrosis							
Gall Stones							
Hepatitis A (infectious)							
Hepatitis B (Serum)							
Hepatitis C							
Other Liver Disease							
Ulcerative Colitis							
Ulcer of stomach or duodenum							
METABOLIC /ENDOCRINE							
Adrenal Dysfunction or disorder							
Diabetes mellitus							
Goiter							
Human Growth Hormone administration							
Hyperactivity							
Hypoglycemia							
Thyroid Cancer							
Thyroid Disease							
Rectal disorder							
GENITAL REPRODUCTIVE SYSTEM							
Breast Cancer							
Cervical Cancer							
Chlamydia							
Genital Warts							
Gonorrhea							
Hemophilus							
Herpes Simplex Type I or II							
Hypospodiasis							
Ovarian Cysts							

Date Applied:_______________

Medical Condition	Self	Mother	Father	Siblings	Grandparents	Other Family	Age of Onset
Pelvic Inflammatory Disease							
Testicular or Prostate Cancer							
Syphilis							
Trichomonas							
Undescended testicle							
Urogenital tuberculosis							
Uterine or Ovarian Cancer							
Uterine Fibroids							
Disease of Urinary tract, urethra or bladder							
Kidney Disease							
NEUROLOGICAL							
ADD or ADHD							
Autism							
Cerebral Palsy							
Degenerative neurologic disease							
Disorder of the spinal cord							
Epilepsy							
Gaucher's Disease							
Huntington's Disease							
Hydrocephalus							
Learning disabilities/disorders							
Mental retardation							
Migraines							
Multiple Sclerosis							
Senility before age 50							
Wilson's Disease							
Other nervous system diseases							
MENTAL HEALTH							
Alcoholism							
Anxiety Disorder							
Attempted Suicide							
Mania							
Bi-polar Disorder							
Depression							
Drug abuse/misuse or addiction							
Eating Disorders							
Panic Attacks							
Schizophrenia							
MUSCULAR/BONES/JOINTS							
Arthritis							
Cleft Lip or Cleft Palate							
Club Foot							
Deformity of the Spine							
Dwarfism							
Gout							
Hereditary lower back disease							
Lupus							
Muscular Dystrophy							
Osteoporosis							
Spinabifida							
Other Chronic muscle disease							

Date Applied:_______________

Medical Condition	Self	Mother	Father	Siblings	Grandparents	Other Family	Age of Onset
SIGHT/ SOUND/ SMELL							
Any disorder of sight, sound or smell							
Cataracts before age 50							
Color blindness							
Congenital Deafness before age 60							
Deformity of the ear							
Deviated Septum							
Glaucoma							
SKIN							
Acne							
Eczema							
Pigmentation Disorders							
Skin Cancer							
Other skin disorders							
OTHER BIRTH DEFECTS							
Any other birth defects:							
OTHER							
Any Conditions not mentioned:							

Do you have any siblings that died in infancy or childhood? If so, what was the cause?

____

____

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

If yes, please explain:____

Have you or any family member experienced recurring and/or chronic physical symptoms that have not yet been evaluated by a physician? Please include symptoms even if you don't consider them serious.

____

____

- **I, the undersigned, have read the oocyte donation information. I hereby acknowledge that all the information that I have provided on this oocyte donation personal history form has been entered fully and correctly, to the best of my knowledge.**

____ _____________________________

Signature Date

To be completed by the Oocyte Donation Program or Nursing Staff Member:

___________________________________ ___________________________

Name Date application was received