

Thank you for your interest in our egg donor program. Our goal is to facilitate the meeting of prospective parents with egg donors. We arrange and organize all of the complexities that are associated with the donation cycle. With your help and ours, we are creating the possibility for a couple to have a child. You, of course, are the key to their success. Without your selflessness and open heart, this possibility would not exist. Please know that we will do our part to guide you and educate you on the process of egg donation from start to finish. Always know that we keep your health and safety our #1 concern. Once again, thank you for offering a gift of a lifetime!

The first step in the process is **completing** this application and **sending us recent photos of yourself (a close up of your face as well as a full body shot)**. Once we have received your **COMPLETE** application and photos and it has been approved, we will contact you for an appointment.

The process of matching can sometimes happen right away or can take months; it just depends on what our patients are searching for. After the match is made, the entire donation can take 2-3 months depending on where you and the intended mother are in your cycles. You will receive compensation for your donation in the amount of \$3,000 for first time donors; second time donors who have a proven track record may request a higher compensation depending on her qualifications. Please also keep in mind that you are responsible for reporting this income to the IRS.

Please note that it is your responsibility to keep us updated if your phone number or address changes.

Thank you again, and we look forward to getting to know you.

Sincerely,

*Susan Nunn, BS*

Susan Nunn, BS  
Donor Egg Coordinator

## Donor Registration

<b>PATIENT REGISTRATION FORM</b>				
<b>PATIENT INFORMATION</b>				
First:	M.I.:	Last:	How would you like to be addressed:	
Address:		City:	State:	Zip:
Home Phone:	Work Phone:	Cell Phone:	SS#:	Religion:
Birth date:	Age:	Race:	Marital Status:	Spouse's Name:
Patient Employer:		Patient's Occupation:		
Address:		City:	State:	Zip:
Emergency Contact (not living with you):			Relationship to Emergency Contact:	
Emergency Contact Phone:		Home:	Work or Other:	
Is it okay to leave a detailed message for you at and/or with:				
<b>Home?</b>	Y or N	<b>Work?</b>	Y or N	<b>Cell?</b> Y or N
		<b>Family/Spouse?</b>	Y or N	
What is the best time and place to contact you?				

### **Acknowledgment of Receipt of Privacy Notice**

I have been presented with a copy of this provider's **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning my personal medical information:

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Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

**Signed:** \_\_\_\_\_

**Date:** \_\_\_\_\_

### **Donor Requirements**

Donors must be between the age of 21 and 32, a **non-smoker** and have an exceptional health history. All donors must be within 40 lbs of their "ideal" weight to ensure the health of the donor and her egg quality. If you have had children in the past, this is helpful but not a requirement. This sometimes will reassure the prospective parents of your proven fertility. We only allow up to 6 donations total whether it be at our center or elsewhere. Please be honest regarding this specification.

### **The Donation Process**

Depending on the circumstances you may be expected to sign a contract drawn up from the prospective parent's legal counsel. The Fertility Center of Colorado will help answer any questions you may have. Visits will entail a consultation, blood screening for communicable diseases and hormone levels, a urine drug analysis as well as a vaginal ultrasound; this takes place on day 2, 3 or 4 of your menstrual cycle so be sure to inform the clinic of the first day of your period. The first day is considered a full, bright red flow before 5:00 P.M; not spotting. You will need to be off any type of birth control for a month before testing your hormone levels. These tests consist of an estradiol and a follicle-stimulating hormone, which will help to determine egg quality.

Once hormone testing is done, you will be placed on a birth control pill along with the prospective mother to coordinate your cycle. You will remain on the pill for 2 to 3 weeks. Your first injection of Lupron will be overlapped with your pill for approximately 7 additional days. Once you have taken your last pill, you will remain on Lupron injections and expect a period to report to your clinic; these injections will last approximately 7-14 days. You will then have an additional blood test to check your suppression status; this is done with another estradiol level (blood draw).

After you have established suppression, you will typically cut your dose of Lupron in half and begin your stimulation agents to begin enhancing follicular growth. Most women will stimulate on average 10 days, some will be ready for egg retrieval sooner and some take additional time. The stimulation agents are a form of synthetic FSH or follicle-stimulating hormone to increase follicular growth on the ovaries. Some forms of FSH you may hear of are Gonal-F, Follistim, Menopur and Bravelle.

You can expect to make 4-6 monitoring visits to check the status of your follicular growth. This is done by vaginal ultrasound and blood draws. At the end of each monitoring visit, we will inform you of your dosage of medication; this may stay the same throughout the cycle or could be increased or decreased depending on your response. Once we feel you are at a stage deemed "ready" for egg retrieval, we will instruct you to take a shot of hCG (human Chorionic

Gonadotropin), which will give the follicles their final maturation. The injection of hCG is extremely time sensitive. You **MUST** take this injection at the exact time that it is instructed because your egg retrieval will be scheduled 36-38 hours later. If you fail to take this at the time instructed, this will cause you to ovulate prior to the retrieval and the entire cycle will be cancelled.

During the egg retrieval, you will be placed under "light" anesthesia. You will be breathing on your own, but you will be comfortably sleeping during the procedure. The egg retrieval or aspiration is done using a vaginal ultrasound with a needle guide. The entire procedure is monitored through ultrasound to ensure accuracy of placement. The physician will make a small puncture in each follicle on both ovaries until all of the follicles have been emptied. This is done using a small suction that is attached to the needle. You may be tender and bloated throughout your monitoring and after the egg retrieval. Making sure you stay well hydrated and rested will help decrease the water retention and bloating.

Once the procedure is complete, you will remain at the clinic for approximately 1 hour for recovery. This will vary depending on your individual retrieval. After the anesthesia has worn off, you will be discharged to your designated driver. You are not allowed to drive for 24 hours after anesthesia initiation and therefore must bring someone with you.

You can expect to return to normal work and activities a day or two after the retrieval. It is very important that you follow the post-op instructions. This will ensure that bloating is resolved in a timely manner. You should expect your period in approximately 2-4 weeks after the retrieval; this varies from each individual. **YOU ARE STONGLY ADVISED NOT TO HAVE SEXUAL INTERCOURSE UNTIL YOU HAVE HAD YOUR PERIOD!!**

Final compensation will be received within a week of the retrieval. Please remember you are responsible for reporting this income to the IRS, The Fertility Center of Colorado does not withhold for you and is not responsible for reporting this to the IRS.

During your entire donation, you will not be required to make any type of payments. Everything will be covered by the prospective parents. If you end up covering something, please keep all receipts for reimbursement.

Many donors will ask whether or not their donation was successful for the prospective parents. This will be individually based and each couple will decide if they are comfortable with you knowing the outcome of a pregnancy or not. Some donors do not want to know if the prospective mom achieved pregnancy or not, please make this clear ahead of time so we may respect your wishes as well.

#### **Potential Risk Factors**

As with any medication, there are potential side effects from both the Lupron and the stimulation agent. Two of the most common complaints of Lupron are headaches and insomnia (this drug has not been approved by the FDA for this protocol). You may take Tylenol **only** during this process. Ibuprofen is not allowed due to the anti-inflammatory response it creates. With each stimulation agent, you will experience bloating and tenderness in the pelvic region due to the enlargement of the ovaries. Some of the agents sting upon injection and could also leave slight swelling or bruising at the injection site. These will dissipate with time and are not

harmful. You can expect to gain a small amount of weight due to the bloating (2-7 lbs); this will also resolve itself in a couple of weeks after the egg retrieval.

The most common risk with ovarian stimulation is "hyperstimulation" of the ovaries. The goal is to "over" stimulate, not "hyperstimulate". If this occurs, you will possibly be required to repeat a visit back to the clinic to have the added fluid aspirated out of the ovaries. This is done similarly to the egg retrieval itself, although usually you are not given anesthesia for this process. It is a quick procedure that will help you rid of the excess fluid. If you are hyperstimulating during the monitoring process, the physician may be inclined to cancel the cycle due to health risks to yourself.

In severe cases, ovarian twisting could occur (less than 1%) in which the ovaries cut off their own blood supply. In this case, the ovary would have to be removed. There are also additional risks to surrounding organs such as nipping the bladder. Your risk factors should be discussed in detail with your physician before consenting to the procedure.

### **Do's and Don'ts During Your Donor Cycle**

#### **Do's**

- Eat a healthy well balanced diet.
- Take a daily prenatal or multivitamin.
- Maintain your regular exercise habits and decrease once ovaries enlarge with stimulation; you may do lower impact at this time.
- Use only Tylenol or Sudafed~ NO IBUPROFEN!
- Report fevers to your clinic.

#### **Don'ts**

- Do not try any weight loss programs.
- Do not use any diet or herbal pills/remedies.
- Do not drink alcohol.
- Keep pulse below 140 beats per minute.
- No intercourse after period starts.

Egg donation is a fairly new procedure and long-term risks are still being established. The number one concern is how it will affect the donor's ability to conceive later in life. This procedure has not shown any increased risks for infertility, many donors have had healthy, successful pregnancies of their own after a cycle. Cancer is another risk factor that is also being studied and thus far has not shown any increased risk to donors.

Thank you again, and we look forward to sharing this amazing experience with you!

**Donation Screening Form**  
**(Incomplete applications will not be accepted)**

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Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Social Security #: \_\_\_\_\_ Home #: \_\_\_\_\_

Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

May we leave a message at:      home      work      cell

Partner's Name (Last Name, First Name): \_\_\_\_\_

Relationship (circle):    married      single with relationship      single without relationship

Who may we contact in case of an emergency: \_\_\_\_\_

Phone: \_\_\_\_\_

Are you currently listed with any other clinics or agencies? \_\_\_\_\_ If yes, whom?

\_\_\_\_\_

Have you ever been denied entry into another egg donor program? \_\_\_\_\_ If yes, please explain  
in detail: \_\_\_\_\_

\_\_\_\_\_

If a match is not immediately available, how long are you willing to stay in TFCC's database?

0 – 3 months \_\_\_\_\_ 4 – 6 months \_\_\_\_\_ 7 – 9 months \_\_\_\_\_ indefinitely \_\_\_\_\_

**PHYSICAL CHARACTERISTICS**

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Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Eye Color: \_\_\_\_\_ Blood Type: \_\_\_\_\_

Measurements: Bust \_\_\_\_\_ Hips \_\_\_\_\_ Waist \_\_\_\_\_

Body Frame: \_\_\_\_\_ small \_\_\_\_\_ medium \_\_\_\_\_ large

Skin Color (circle): Fair Med Dark Olive Do you tan easily? \_\_\_\_\_ Burn? \_\_\_\_\_

Natural Hair Color: \_\_\_\_\_

Hair (check all that apply):

\_\_\_\_ curly/wavy (naturally) \_\_\_\_\_ curly/wavy (processed)

\_\_\_\_ straight (naturally) \_\_\_\_\_ straight (processed)

\_\_\_\_ average texture \_\_\_\_\_ thin texture

\_\_\_\_ premature graying (at what age \_\_\_\_\_)

Race (e.g. Caucasian, African American, Asian, Hispanic, etc.): \_\_\_\_\_

Ethnicity (e.g. Irish, German, French,....): \_\_\_\_\_

Mother's Side: \_\_\_\_\_

Father's Side: \_\_\_\_\_

**Personal Characteristics**

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Birthplace: \_\_\_\_\_

Religion Born Into: \_\_\_\_\_ Religion Practiced: \_\_\_\_\_

Marital Status: \_\_\_ single \_\_\_ married \_\_\_ divorced/separated \_\_\_ widowed

Education: \_\_\_ Completed grade school \_\_\_ Completed high school

\_\_\_ Currently in college, pursuing degree in \_\_\_\_\_

College attending: \_\_\_\_\_

\_\_\_ Completed college, degree in \_\_\_\_\_

What degree did you receive (circle one): Associate BS MS PhD

\_\_\_ Currently pursuing advanced degree in \_\_\_\_\_

\_\_\_ Completed advanced degree in \_\_\_\_\_

Current occupation: \_\_\_\_\_

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Vision (without corrective lenses): \_\_\_ Poor \_\_\_ Fair \_\_\_ Good \_\_\_ Excellent

Do you wear corrective lenses: \_\_\_ Yes \_\_\_ No

For what problem(s): \_\_\_ Nearsighted \_\_\_ Farsighted  
\_\_\_ Other (explain): \_\_\_\_\_

Hearing (without corrective aids): \_\_\_ Poor \_\_\_ Fair \_\_\_ Good \_\_\_ Excellent

Teeth: \_\_\_ Poor \_\_\_ Fair \_\_\_ Good \_\_\_ Excellent

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Do you smoke cigarettes: \_\_\_ Yes \_\_\_ No If yes, how many cigarettes per day? \_\_\_\_\_

Do you consume alcohol: \_\_\_ Yes \_\_\_ No If yes, what quantity/how often: \_\_\_\_\_

Diet: \_\_\_ Vegetarian \_\_\_ Non-Vegetarian

Diet (nutrition): \_\_\_ Poor \_\_\_ Average \_\_\_ Good

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**Personal Health History**

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Allergies:  Yes  No

If yes, are they to:  Foods  Medication(s)  Environment  Other

For each allergy, describe specific substance and reaction(s) and age first noticed:

Substance: \_\_\_\_\_ Reaction(s): \_\_\_\_\_ Age: \_\_\_\_\_

Substance: \_\_\_\_\_ Reaction(s): \_\_\_\_\_ Age: \_\_\_\_\_

Substance: \_\_\_\_\_ Reaction(s): \_\_\_\_\_ Age: \_\_\_\_\_

Explain allergies you have outgrown: \_\_\_\_\_

Exercise:  None  Occasional  Regular

Type of Exercise: \_\_\_\_\_

Have you had any surgery(ies)? If yes, please list: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you had any hospitalization(s) not mentioned above: \_\_\_\_\_

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Have you had a blood transfusion?  Yes  No

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

If yes, explain: \_\_\_\_\_

Are you currently taking any medications, prescribed or over the counter?  Yes  No

If yes, please list: \_\_\_\_\_

\_\_\_\_\_

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**PERSONAL HEALTH HISTORY (CONTINUED)**

Are you currently using any recreational drugs?  Yes  No

If yes, please list: \_\_\_\_\_

Have you ever misused prescription medication(s)?  Yes  No

If yes, please describe in detail the types of prescription medications, quantities and frequency:

\_\_\_\_\_

If yes, please state when the most recent misuse of any prescription medication(s) was, and what the specific agent was: \_\_\_\_\_

Have you ever participated in Mental Health Counseling?  Yes  No

If yes, please explain: \_\_\_\_\_

**Fertility History (female):**

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: \_\_\_\_\_

Age	Sex	Birth Date	Health/Problems
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are your menstrual periods regular:  Yes  No

How long is your monthly cycle: \_\_\_\_\_ days (count start of flow to start of next flow)

How many days does your menstrual flow usually last: \_\_\_\_\_ days

**PERSONAL HEALTH HISTORY (CONTINUED)**

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Have you ever been told you were infertile:  Yes  No

If yes, when: \_\_\_\_\_ On what basis: \_\_\_\_\_

Birth Control method used: \_\_\_\_\_

Is there any history of fertility problems in your family (difficulty conceiving or miscarriages):  
 Yes  No If yes, please explain: \_\_\_\_\_

Did your mother take diethylstilbestrol (DES) or any prescription drug while she was pregnant with you or any of your siblings?  Yes  No

If yes, please explain: \_\_\_\_\_

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Sexual History:

Sexual preference:  heterosexual  bisexual  homosexual

Please state the number of sexual partners you have had in the past 1 year: \_\_\_\_\_

Do you have a sexual partner now?  Yes  No

Is your relationship monogamous:  Yes  No  Not sure

Have you ever had sexual relations with someone who was diagnosed as having or suspected that he/she had AIDS or was infected with HIV?  Yes  No

**Have you or any of your sexual partners:**

- had sex in exchange for money or drugs in the preceding 5 years?  Yes  No
- been confined to a correctional facility or been incarcerated for more than 72 consecutive hours during the previous 12 months?  Yes  No
- within the past 12 months undergone tattooing, acupuncture, ear or body piercing in which shared instruments are known to be used?  Yes  No
- received injections of human pituitary-derived growth hormone (pit-hGH)?  Yes  No

**PERSONAL HEALTH HISTORY (CONTINUED)**

Have you or any of your sexual partners had or been contact with anyone who has had:

	<u>Self</u>	<u>Partner</u>	<u>When</u>	<u>How Often</u>
HIV				
NSU (non specific urethritis)				
Syphilis				
Gonorrhea				
Chlamydia				
Venereal Warts				
Herpes				
Viral Hepatitis B or C				
Hemophilia				
Received human-derived clotting factor concentrates				
IV (intravenous) drug use				
Other sexually transmitted diseases				

**PERSONAL HEALTH HISTORY (CONTINUED)**

Have you ever donated your eggs before? \_\_\_\_\_ If yes, please list dates and outcomes:

Mo/Year	# Eggs Retrieved	# Eggs Fertilized	Did a pregnancy occur?	Did a live birth occur?

Were there embryos left to cryopreserve (freeze)? \_\_\_\_\_ If yes, how many? \_\_\_\_\_

Have you been sexually active in the past 6 months? \_\_\_\_\_

Are you currently sexually active? \_\_\_\_\_ If yes, is it a monogamous relationship and for how long? \_\_\_\_\_

Have you or your partner ever had a sexually transmitted disease? \_\_\_\_\_ If yes, when and what was your treatment regimen? \_\_\_\_\_

Have you ever been diagnosed with any gynecological problems such as endometriosis, ovarian cysts, abnormal Pap smears, fibroids, polyps? \_\_\_\_\_ If yes, please explain treatment

Please mark any that apply to you within the last 12 months:

- Exposure to HIV
- Exposure to Hepatitis B or C
- Had sex in exchange for money or drugs
- Intravenous drug use
- Piercing or tattoos

**Personal Work History**

List jobs held in the past five years:

<u>Jobs/Duties</u>	<u>Year Began</u>	<u>Year End</u>

Have you been exposed to any toxic chemicals in your living or work environment?

\_\_\_\_\_ Yes    \_\_\_\_\_ No    If yes, please explain: \_\_\_\_\_

**Family Health History**

Describe biological family members according to the following characteristics:

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

(Use natural eye and hair color; fair/dark, etc. complexion; height, small frame, etc., body type; and vision with corrective lenses.)

	<u>Eye Color</u>	<u>Hair Color</u>	<u>Complexion</u>	<u>Height</u>	<u>Body Type</u>	<u>Vision</u>
Mother						
Father						
Brother(s)						
Sister(s)						
MGM						
MGF						
PGM						
PGF						

**FAMILY HEALTH HISTORY (CONTINUED)**

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

Number of Males: \_\_\_\_\_ Number of Females: \_\_\_\_\_

Are there any twins or triplets in your family? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, what relation are they to you? \_\_\_\_\_

List below the ages of the following biological members of your family; if they are deceased, please list cause of death.

	<u>Age if living</u>	<u>Age at time of death</u>	<u>Cause of death</u>
Mother			
Father			
Brother(s)			
Sister(s)			
MGM			
MGF			
PGM			
PGF			

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

If yes, please identify: \_\_\_\_\_

Have you ever been tested as a carrier of:

Tay-Sachs disease \_\_\_\_\_ carrier \_\_\_\_\_ non-carrier \_\_\_\_\_ unknown

Sickle Cell disease \_\_\_\_\_ carrier \_\_\_\_\_ non-carrier \_\_\_\_\_ unknown

Thalassemia \_\_\_\_\_ carrier \_\_\_\_\_ non-carrier \_\_\_\_\_ unknown

Cystic Fibrosis \_\_\_\_\_ carrier \_\_\_\_\_ non-carrier \_\_\_\_\_ unknown

Have you or any family members listed above had genetic counseling? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please describe: \_\_\_\_\_

**FAMILY HEALTH HISTORY (CONTINUED)**

Carefully review the following list of medical problems and identify any which are present in biological family members:

	<u>You</u>	<u>Mother</u>	<u>Father</u>	<u>Sibling</u>	<u>Grandparent</u>	<u>Aunt/Uncle</u>	<u>Cousins</u>
<b>HEART</b>							
Stroke							
Heart attack							
Heart disease or defect							
1. From birth							
2. Other							
Hardening of the arteries							
High blood pressure							
High cholesterol							
<b>BLOOD</b>							
Anemia							
Sickle-cell anemia							
Hemophilia or other bleeding disorder							
HIV/AIDS							
Leukemia							
Other blood disorder							
<b>RESPIRATORY</b>							
Asthma							
Emphysema							
Tuberculosis							
Cystic Fibrosis							

**FAMILY HEALTH HISTORY (CONTINUED)**

	<u>You</u>	<u>Mother</u>	<u>Father</u>	<u>Sibling</u>	<u>Grandparents</u>	<u>Aunt/Uncle</u>	<u>Cousins</u>
<b>GASTRO-INTESTINAL</b>							
Ulcer of stomach or duodenum							
Hepatitis (all types)							
Cirrhosis							
Other liver disease							
Ulcerative colitis							
Crohn's disease							
Pyloric stenosis							
Rectal disorder							
<b>METABOLIC/ ENDOCRINE</b>							
Diabetes (age of onset)							
Thyroid disease							
Goiter							
Hyperactivity							
Phenyl Ketonuria (PKU)							
Dwarfism							
<b>URINARY</b>							
Kidney disease							
Other disease defect of urinary tract (urethra, bladder, ureter)							
<b>GENITAL/ REPRODUCTIVE</b>							
Hermaphroditism/ Ambiguous Genitals							
Hypospadias							
Uterine fibroids							
Ovarian cysts							
Endometrioses							

**FAMILY HEALTH HISTORY (CONTINUED)**

	<u>You</u>	<u>Mother</u>	<u>Father</u>	<u>Sibling</u>	<u>Grandparents</u>	<u>Aunt/Uncle</u>	<u>Cousins</u>
<b>REPRODUCTIVE OUTCOMES</b>							
2 or more miscarriages							
Stillborn							
Death of a newborn infant							
Infertility							
<b>NEUROLOGICAL</b>							
Migraines							
Mental retardation							
Senility before age 50							
Multiple Sclerosis							
Cerebral Palsy							
Epilepsy/seizure							
Hydrocephalus							
Spina bifida / neural tube defect							
Parkinsonism							
Creutzfeldt-Jakob Disease							
Other diseases							
<b>MENTAL HEALTH</b>							
Depression							
Schizophrenia							
Manic depressive or bipolar disorder							
Huntington's disease							
Other mental health disorder requiring hospitalization (i.e., suicides, nervous breakdowns, etc.)							

**FAMILY HEALTH HISTORY (CONTINUED)**

	<u>You</u>	<u>Mother</u>	<u>Father</u>	<u>Sibling</u>	<u>Grandparents</u>	<u>Aunt/Uncle</u>	<u>Cousins</u>
<b>MUSCLE/BONE/ JOINTS</b>							
Scoliosis							
Muscular Dystrophy							
Other chronic muscle disease							
Loss of muscle coordination							
Lupus or other auto immune diseases							
Osteoporosis							
Marfan Syndrome							
Arthritis							
<b>SIGHT/SOUND/ SMELL</b>							
Deafness before age 60							
Deformity of the ear							
Cataracts before age 50							
Blindness							
Color blindness							
Glaucoma							
Retinitis Pigmentosa							
Any other sight/sound/smell disorder							
<b>SKIN</b>							
Acne							
Eczema							
Pigmentation disorders							
Neurofibromatosis							
Other disorders of the skin							

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**FAMILY HEALTH HISTORY (CONTINUED)**

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	<u>You</u>	<u>Mother</u>	<u>Father</u>	<u>Sibling</u>	<u>Grandparents</u>	<u>Aunt/Uncle</u>	<u>Cousins</u>
<b>CONGENITAL ABNORMALITIES</b>							
Cleft lip/palate							
Congenital hip problems							
Club feet							
Other							
<b>CHROMOSOMAL ABNORMALITIES</b>							
Down Syndrome							
Other (i.e. Turner, Fragile X, etc.)							
<b>CANCER</b>							
Breast							
Ovarian							
Colon							
Skin							
Thyroid							
Cervical							
Uterine							
Other							
<b>OTHER</b>							
Alcoholism							
Drug abuse, misuse or addiction							



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**PERSONAL AND MOTIVATIONAL**

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Reason for wanting to donate eggs: \_\_\_\_\_

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In your own words, describe your personality and character: \_\_\_\_\_

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What are your hobbies, interests, and talents: \_\_\_\_\_

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What do you think is your best physical quality? \_\_\_\_\_

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What do you like most about yourself? \_\_\_\_\_

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**Personal and Motivational (continued)**

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What do you like least about yourself? \_\_\_\_\_

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What is your best intellectual quality? \_\_\_\_\_

\_\_\_\_\_

Do you have any particular athletic abilities? \_\_\_\_\_

\_\_\_\_\_

What are your goals in life, personal and professional? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Once you are chosen as an egg donor, first morning appointments are mandatory. You are not able to choose the dates of your appointments, as they will coincide with the clinic's requirements and timing of your cycle. You will be required to attend 7-10 monitoring appointments prior to the actual egg retrieval. Morning appointments can be arranged as early as 8:30 -9:00 a.m. If your schedule cannot accommodate this criterion, you will not qualify for the egg donation process.**

I hereby certify that I have answered all the above questions honestly, and to the best of my knowledge and ability. I recognize that TFCC representatives, the reviewing health care team, and potential recipients, shall rely on this information in judging my suitability as a donor candidate.

I also have been informed that this form will be kept by TFCC and may be provided (with identifying information such as name, address, and social security number, removed) to potential recipients and/or to children ultimately born as a result of the donation cycle. I hereby consent to the delivery of such non-identifying information.

I also promise that, should I receive additional information, in the future years, which indicates that I suffer from an inherited disease or condition, I shall inform TFCC.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date