COOPER INSTITUTE FOR ADVANED REPRODUCTIVE MEDICINE
7500 BEECHNUT, SUITE 308
HOUSTON, TEXAS 77074
TEL. 713-771-9771 FAX. 713-771-9773

Egg Donor Application Form

Todayôs Date: _____/ _____/_____

Date of Birth:_____/ _____/ _____ Age:_____

Duration of Infertility:_____ years Days from beginning of one menstrual cycle to the next:_____

Infertility Type: [ ] Tubal factor [ ] Endometriosis [ ] Male factor [ ] Unexplained [ ]Non-Ovulation [ ] Cervical factor

[ ] Other: _____

Have you ever had a hysterosalpingogram (HSG) performed? [ ] Yes [ ] No If yes, please give dates and results:

Date	Performed by	Results

Have you had previous fertility treatment? [ ] Yes [ ] No EXCLUDING IVF, please list and describe:

_____

_____

_____

PREGNANCY DATA

Please list any pregnancies and detailed information below:

Date	Outcome	Infertility TX (Indicate type)	# of Months Needed to Conceive	Type of delivery	Sex	With Current Partner
		Y N			M F	Y N
		Y N			M F	Y N
		Y N			M F	Y N
		Y N			M F	Y N

IVF HISTORY or Previous Donations

Indicate the number of previous IVF and/or GIFT/ZIFT cycles:_____ Record detailed information regarding prior cycles

Date	Clinic	Medications	# Eggs	# Fertilized	ICSI?	# Transfer	Pregnancy Outcome
					Y N		Pos Neg
					Y N		Pos Neg
					Y N		Pos Neg
					Y N		Pos Neg

Do you take any medications of any kind? Please include any over-the-counter medications taken on a regular basis, vitamins, etc. Include dosage if known.

Name of Medication	Dosage	Reason Prescribed
1.		
2.		
3.		
4.		
5.		

CHARACTERISTICS

Height: _____ Weight at 21? _____ Current Weight: _____

Body Frame: [ ] Small [ ] Medium [ ] Large

Natural Hair Color: [ ] Black [ ] Lt. Brown [ ] Brown [ ] Dk. Brown [ ] Auburn [ ] Red
[ ] Lt. Blonde [ ] Blonde [ ] Dk. Blonde

Hair (All that apply): [ ] Wavy [ ] Straight [ ] Curly [ ] Thin texture [ ] Premature Gray (at what age_____)

Eye Color: [ ] Blue [ ] Gray [ ] Green [ ] Hazel [ ] Brown [ ] Black

Skin Tone: [ ] Fair [ ] Light [ ] Medium [ ] Dark [ ] Lt. Brown [ ] Dk. Brown [ ] Ebony
[ ] Freckled [ ] Rosy [ ] Olive [ ] Lt. Olive [ ] Dk. Olive [ ] Birthmarks

Race:_____ Mother: _____ Father: _____

Ethnicity: _____

Blood Type: [ ] A Pos [ ] A Neg [ ] B Pos [ ] B Neg [ ] AB Pos [ ] AB Neg [ ] O Pos
[ ] O Neg [ ] Unsure

Right Handed:_____ Left Handed: _____ Ambidextrous: _____

Marital Status: [ ] Single [ ] Married [ ] Separated [ ] Divorced [ ] Widowed

Duration of relationship with partner: _____

Education: Completed grade School: [ ] Y [ ] N Completed High School: [ ] Y [ ] N GPA_____

Currently in College, pursuing degree in _____ GPA_____
Completed College, degree in _____ GPA_____

Currently pursuing advanced degree in _____

Advanced Degree in _____

Occupation: _____

Vision (without corrective lenses): [ ] Poor [ ] Fair [ ] Good [ ] Excellent

Do you wear corrective lenses? [ ] Yes [ ] No

For What problems? [ ] Near sighted [ ] Far sighted [ ] Others_____

Hearing (without corrective device): [ ] Poor [ ] Fair [ ] Good [ ] Excellent

Teeth: [ ] Poor [ ] Fair [ ] Good [ ] Excellent

Diet: Vegetarian Non-Vegetarian Diet (nutrition): Poor Average Good

Drug allergies to drugs(prescription or over the counter: [ ] None known drug allergies [ ] Allergic to_____

Food allergies to food:

Milk	☐ Yes ☐ No
Eggs	☐ Yes ☐ No
Fish	☐ Yes ☐ No
Crustacean shellfish	☐ Yes ☐ No
Tree nuts	☐ Yes ☐ No
Peanuts	☐ Yes ☐ No
Wheat	☐ Yes ☐ No
Soybeans	☐ Yes ☐ No

Please describe your family membersô characteristics:

Relation	Eye Color	Hair Color	Height	Weight	Ethnic Origin	Age L/D	Cause of Death
Mother							
Father							
Maternal Grandmother							
Maternal Grandfather							
Paternal Grandmother							
Paternal Grandfather							
Siblings							

If you or anyone in your family has had any of the following conditions, check yes and describe below:

Yes	No		Yes	No	
__	__	1. Downôs syndrome or Known Chromosomal Disorder	__	__	21. Skin Disease: Eczema/ Psoriasis
			__	__	22. Coffeeð colored spots on the skin
__	__	2. Mental Retardation	__	__	23. Early Death (before age 50)
__	__	3. Seizure Disorder	__	__	24. Cystic Fibrosis
__	__	4. Muscular Dystrophy or Multiple Sclerosis	__	__	25. Arthritis (before age 50)
			__	__	26. Drug Addiction
__	__	5. Premature Senility (Before age 50)	__	__	27. Hemophilia
			__	__	28. Chronic Anemia
__	__	6. Deafness (before age 50)	__	__	29. Sickle Cell Anemia
__	__	7. Blindness	__	__	30. Elevated Cholesterol Levels
__	__	8. Cataracts (before age 40)	__	__	31. Early Heart Attack/ Stroke (before age 50)
__	__	9. Schizophrenia or Manic Depression	__	__	32. Alcoholism

__	__	10. Serious Birth Defects	__	__	33. Allergies
__	__	11. Minor Birth Defects	__	__	34. Asthma
__	__	12. Cleft Lip and/or Cleft Palate	__	__	35. Heart Disease
__	__	13. Club Foot	__	__	36. High Blood Pressure
__	__	14. Open Spine or Water on the Brain	__	__	37. Cancer: type and location
__	__	15. Congenital Heart Problems	__	__	38. Tay Sachs
__	__	16. Congenital Hip Problems	__	__	39. Sickle Cell Trait
__	__	17. Two or More Miscarriages or Stillborns	__	__	40. B-Thalassemia
__	__	18. Diabetes Mellitus	__	__	41. A- Thalassemia
__	__	19. Thyroid Disease			
__	__	20. Polycystic Kidney Disease			

If you answered YES to any of the above questions, please answer the following:

Question #	Specific Relation or Family Member	Condition	Age of onset
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

42. Do you or have you ever used recreational drugs? [ ] Yes [ ] No

If YES, please specify: [ ] Cigarettes/Cigars [ ] Alcohol [ ] Marijuana [ ] Cocaine
[ ] Heroin [ ] Crack [ ] IV Drugs [ ] Amphetamines
[ ] LSD [ ] Other_____

Indicate frequency: _____

If you or anyone in your family had any of the following conditions, check yes and describe below.

Yes	No		Yes	No	
___	___	43. Liver Disease	___	___	44. Lung Disease
___	___	45. Appendicitis	___	___	46. Crohnôs Disease
___	___	47. Color Blind	___	___	48. Huntingtonôs Chorea
___	___	49. Sarcoidosis	___	___	50. Lupus
___	___	51. Tuberculosis	___	___	52. Hepatitis A, B, or C
___	___	53. Ulcers	___	___	54. Colitis
___	___	55. Alzheimerôs	___	___	56. Osteoporosis
___	___	57. Gout	___	___	58. Cerebral Palsy
___	___	59. Dwarfism	___	___	60. Migraines
___	___	61. Wilsonôs Disease	___	___	62. Glaucoma
___	___	63. Goiter	___	___	64. Leukemia
___	___	65. Emphysema	___	___	66. Dyslexia
___	___	67. Skin Cancer: Melanoma	___	___	68. Kidney/ Gall Stones
___	___	69. Hodgkinôs Disease			

If you answered YES to any of the above questions, please answer the following:

Question #	Specific Relation or Family Member	Condition	Age of onset
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you had any surgery (ies)? [ ] Yes [ ] No If ñYESò please list surgeries performed and date:

1._____
2._____
3._____
4._____

Have you had any hospitalizations not mentioned above: _____
_____
_____
_____

Have you had major radiation or X-ray exposure? [ ] Yes [ ] No

If yes, explain: _____
_____
_____

Please indicate date of testing and results of the following, also, list any treatment:

Test	Date Performed	Results (circle one)	Treatments
Rubella Immunity		Immune Non-immune	Vaccinated?
Chlamydia Culture		Positive Negative	
Mycolplasma Culture		Positive Negative	
Pap Smear		Normal Abnormal	
Mammogram		Normal Abnormal	

HIGH RISK QUESTIONNAIRE

Have you ever donated blood or any blood products? [ ] Yes [ ] No
Have you ever had yellow jaundice, liver disease, and hepatitis? [ ] Yes [ ] No
Have you ever had a positive test for hepatitis? [ ] Yes [ ] No
Have you ever had radiation or chemotherapy? [ ] Yes [ ] No
Have you had a major illness or surgery in the last 12 months? [ ] Yes [ ] No
Have you ever had a blood transfusion? [ ] Yes [ ] No
Have you had an organ or tissue transplant? [ ] Yes [ ] No
Have you had an accidental needle stick? [ ] Yes [ ] No
Have you been in close contact with anyone with hepatitis? [ ] Yes [ ] No
Have you had a positive test for syphilis? [ ] Yes [ ] No
Have you been treated for syphilis or gonorrhea? [ ] Yes [ ] No
Have you had sex with anyone who has taken money for sex? [ ] Yes [ ] No
Since 1977, have you taken money or drugs for sex? [ ] Yes [ ] No
Have you had sex with anyone who has taken money for sex? [ ] Yes [ ] No
Have you had sex with a male who has had sex with another male? [ ] Yes [ ] No

Psycho-Social Questionnaire

What do you hope to achieve by volunteering in the egg donor program (emotionally, financially, etc.)? _____
_____
_____
_____
_____

What message would you like passed on the recipient of you eggs/their offspring? _____
_____
_____
_____
_____

What helped you decide to become an egg donor? _____
_____
_____
_____
_____

How would you describe yourself? Please include a description of your personality and temperament: _____
_____
_____
_____
_____
_____

Describe your philosophy of life: _____
_____
_____
_____
_____
_____

YOUR FAMILY:

Describe the following:

Family member	Education	Occupation	Intellectual Academic Achievements	Artistic Achievements
Mother				
Father				
Sister(s): _____ _____ _____	_____ _____ _____	_____ _____ _____	_____ _____ _____	_____ _____ _____

YOUR CHILDREN:

Describe the following:

Personality	Artistic Ability	Intelligence	Distinguishing Characteristic(s)
1.			
2.			
3.			
4.			

YOUR CHILDHOOD:

Describe yourself as a child (personality, health, happiness, etc.). _____
_____
_____
_____
_____

What was it like growing up in your family? _____
_____
_____
_____

What religion did you belong to as a child? _____
_____
_____
_____

What was your earliest memory as a child? _____
_____
_____
_____

What problems did you have as a child (health, allergies, learning, social, etc.)? _____
_____
_____
_____

WHEN I WAS A CHILD:

My favorite thing to do was: _____

At home I was expected to do: _____

My parents were strict about: _____

My parents taught me to value: _____

What I loved most about my father was: _____

What I loved most about my mother was: _____

My favorite relatives were: _____

I loved to visit: _____

In comparison to others I was: _____

YOUR TEENAGE YEARS:

Describe yourself as a teenager: _____
_____
_____
_____

Describe you achievements: _____
_____
_____
_____

Did you do poorly in anything: _____
_____
_____
_____

WHEN I WAS A TEENAGER:

My favorite subject(s) was: _____

My worst subject(s) was: _____

The activities I was involved in were: _____

The most important influence on me was: _____

In comparison to others I was: _____

I liked to go: _____

I traveled to: _____

I was talented in: _____

My ambition was to: _____

ADULTHOOD:

Religion:	How religious are you now?	[ ] Very	[ ] Moderately	[ ] Not at all
Are you an:	[ ] Atheist	[ ] Agnostic	[ ]	
Activities:	How athletic are you?	[ ] Very	[ ] Average	[ ] Not Athletic
	Do you exercise?	[ ] Regularly	[ ] Occasionally	[ ] Not at all

What types of exercise or physical activity do you enjoy? _____
_____
_____

Do you have musical ability? _____
_____
_____

What other skills or talents do you have (painting, writing, reading, ability at games, crossword puzzles, handicraft, etc)?
Please describe in detail. _____
_____
_____
_____
_____

Describe any special interests you have (Girl Scout leader, fund raiser, pet owner, volunteer activities, etc.). _____
_____
_____
_____

What physical, artistic, intellectual, or social abilities do you feel best about? _____
_____
_____
_____

What have been your achievements as an adult? _____
_____
_____
_____

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EGG DONOR PERSONAL INFORMATION

Today's Date: _____/_____/_____

Your Name: _____, _____ _____
Last First Middle

Partner's name: _____, _____ _____
Last First Middle

Address: _____

_____
City State Zip Code

Home #: _____-_____-_____ Work: _____-_____-_____

Cell #: _____-_____-_____ Partner's #:_____-_____-_____

E-mail address: _____

Date of Birth: _____/_____/_____ Age: _____ SS: _____-_____-_____

Current OB/GYN: _____ _____
Name Phone

Current Doctor (General): _____ _____
Name Phone

Check box that applies to you: [ ] I want to be a paid donor (Exclusive anonymous donor)

[ ] I want to participate in the egg sharing program (Iôm trying to get pregnant myself)

This page of the application will be kept in strict confidence and will not be posted as part of the application

AUTHORIZATION FORM

I, _____, have completed the physical profile, genetic/medical history, and psycho-social history forms. I have answered the above questions honestly and to the best of my knowledge and ability. I understand that this information will be used and relied on by the IVF Program and by its recipients. I have not knowingly nor intentionally given false or misleading information. I understand that knowingly or intentionally providing false information will not only be a cause for my disqualification as an egg donor, but will also allow the IVF program to bring lawsuit for a recipient in order to recover damages they might have incurred. I understand that by signing this application I give the IVF Program permission to have my photograph viewed by potential recipients.

PLEASE INCLUDE A RECENT PHOTOGRAPH OF YOURSELF; THIS IS FOR PROGRAM USE ONLY AND WILL ONLY BE VIEWED BY OUR STAFF AND THE POTENTIAL RECEIPENT. ALL PERSONAL INFORMATION (NAME, ADDRESS, TELEPHONE #, ETC.) WILL REMAIN ANNONYMOUS.

DATE: ____/____/_____ **SIGNATURE: _____**

DATE: ____/____/____ **PARTNER'S SIGNATURE: _____**