



## OVUM DONOR PERSONAL HISTORY

### Instructions:

This document will be completed entirely by you and will provide some personal history of yourself that will be given to the ovum recipients without identification. The recipients may some day give this document to any children that may result from your donated egg(s). Not all parents choose to disclose this information to the child(ren), but all parents want to be able to provide accurate medical information. If children are told that they are born through your donated egg, the information contained within this document may be very important to them for medical and psychological reasons. It is for these reasons that we ask you to answer each question as carefully and thoroughly as you are able.

All information requested is voluntary and will be anonymous. Any identifying information such as name, social security number, and address will be omitted from the packet given to the recipients. A copy of this history form will be given to the recipients but will exclude the top identifying sheet and the supplementary questionnaire.

Donating your eggs is a caring and generous act, given in spite of some risk and discomfort. Those couples who receive eggs feel deep gratitude and respect for the gift you give so willingly. Naturally, most recipients and their children want to know as much as possible about the medical history of the woman who made their family possible. Thank you for letting them get to know you a little better.

Chart #: \_\_\_\_\_

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

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

Home phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Please indicate the best number to leave a message: \_\_\_\_\_

Please print or type your responses.



## OVUM DONOR PERSONAL HISTORY

Date history was completed: \_\_\_/\_\_\_/\_\_\_

### PHYSICAL CHARACTERISTICS:

Month/Year of birth: \_\_\_/\_\_\_ Place of birth: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Age adult height was reached: \_\_\_\_\_ Weight at age 21: \_\_\_\_\_

Blood type: \_\_\_\_\_ Eye color: \_\_\_\_\_

Hair (check all that apply): \_\_\_\_\_ Natural hair color: \_\_\_\_\_

\_\_\_ curly/wavy (naturally)      \_\_\_ curly/wavy (processed)  
\_\_\_ straight (naturally)      \_\_\_ straight (processed)  
\_\_\_ average texture      \_\_\_ thin texture  
\_\_\_ thick texture      \_\_\_ premature graying (at age:\_\_\_)

Skin Color:

\_\_\_ fair    \_\_\_ medium    \_\_\_ olive    \_\_\_ lt. brown    \_\_\_ dk brown    \_\_\_ ebony  
\_\_\_ freckled    \_\_\_ rosy

Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

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

Right handed: \_\_\_      Left handed: \_\_\_      Ambidextrous: \_\_\_



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Religion born into: \_\_\_\_\_ Religion practiced: \_\_\_\_\_

Marital status: \_\_\_single \_\_\_married \_\_\_divorced \_\_\_separated \_\_\_widowed

Duration of relationship with partner: \_\_\_\_\_

Education: (check all that apply)

- \_\_\_ completed grade school
- \_\_\_ completed high school (GPA = \_\_\_)
- \_\_\_ currently in college, pursuing degree in \_\_\_\_\_ (GPA = \_\_\_)
- \_\_\_ currently in college, degree in \_\_\_\_\_ (GPA = \_\_\_)
- \_\_\_ currently pursuing advanced degree in \_\_\_\_\_ (GPA = \_\_\_)
- \_\_\_ advanced degree in \_\_\_\_\_ (GPA = \_\_\_)

Testing Scores:

SAT \_\_\_ GRE \_\_\_ LSAT \_\_\_ MCAT \_\_\_ Other: \_\_\_\_\_

Current Occupation: \_\_\_\_\_

Previous Employment: \_\_\_\_\_

Special Interests/hobbies: \_\_\_\_\_

Talents: \_\_\_\_\_



**PERSONAL HEALTH HISTORY**

Vision: Do you wear glasses/contacts? \_\_\_\_ Age first wore glasses: \_\_\_\_

If yes, are you : \_\_\_\_nearsighted \_\_\_\_farsighted

Hearing: \_\_\_\_Poor \_\_\_\_Fair \_\_\_\_Good \_\_\_\_Excellent

Describe any problems: \_\_\_\_\_

Dental: \_\_\_\_Poor \_\_\_\_Fair \_\_\_\_Good \_\_\_\_Excellent

\_\_\_\_Orthodontic work: \_\_\_\_\_

Smoking: \_\_\_\_No \_\_\_\_Yes (number/day\_\_\_\_) How Long \_\_\_\_\_  
\_\_\_\_Quit (date\_\_\_\_\_)

Diet: \_\_\_\_Vegetarian \_\_\_\_Non-vegetarian

\_\_\_\_Poor diet \_\_\_\_Average diet \_\_\_\_Excellent diet

Do you drink alcoholic beverages? \_\_\_\_ What kind? \_\_\_\_\_

How many alcoholic drinks do you consume:  
\_\_\_\_per day \_\_\_\_per week \_\_\_\_per month

How much exercise do you get? \_\_\_\_none \_\_\_\_occasional \_\_\_\_regular

Allergies: \_\_\_\_yes \_\_\_\_no

If yes, are they to: \_\_\_\_Food(s) \_\_\_\_Medication(s)  
\_\_\_\_Environmental \_\_\_\_Other

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

Substance Reaction Age

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List any medications (prescribed or over the counter) which you are currently taking:

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### **REPRODUCTIVE HISTORY**

Age of first period/menses: \_\_\_\_\_

Average length of cycle (from 1<sup>st</sup> day of period to start of next period): \_\_\_\_\_

Did you ever have trouble conceiving:      \_\_\_yes      \_\_\_no

Have you ever had irregular cycles:      \_\_\_yes      \_\_\_no

Explain: \_\_\_\_\_

Describe any treatment you have had for menstrual problems:

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Number of pregnancies:      \_\_\_\_\_

Number of living children:      \_\_\_\_\_

### **PERSONAL FAMILY HISTORY**

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

    \_\_\_# of males      \_\_\_# of females

Are you adopted?      \_\_\_Yes      \_\_\_No

Have twins or multiple births occurred in your family?      \_\_\_Yes      \_\_\_No



Please describe your family members by the following characteristics:

The following abbreviations in the table are:

MGM = Maternal Grandmother; MGF = Maternal Grandfather  
 PGM = Paternal Grandmother; PGF = Paternal Grandfather

Relation	Eye Color	Natural Hair Color	Height	Weight	Ethnic Origin	Age if Living	Age at Death/Cause of Death
Mother							
Father							
MGM*							
MGF*							
PGM*							
PGF*							
Sisters: 1. 2. 3. 4. 5.							
Brothers: 1. 2. 3. 4. 5.							



Carefully review the following list of medical problems and identify any that are present in the listed family members. Where applicable, please indicate age of onset, specify maternal or paternal side of the family and if living or deceased.

	You	Mother	Father	Sibling	MGM/MGF/ PGM/PGF	Aunt/ Uncle	Cousin
<b>BLOOD</b>							
Anemia							
sickle-cell anemia							
Hemophilia/bleeding disorder							
Leukemia							
HIV virus							
Lymphoma							
Other blood disorder							
<b>CONGENITAL ANOMALIES</b>							
Cleft lip/palate							
Hip problems							
Club feet							
Cri du chat							
Trisomy 18							
Trisomy 13							
Fragile x							
Other							
<b>GASTRO INTESTINAL</b>							
Ulcer of stomach or duodenum							
Gall stones							
Hepatitis A (infectious)							
Hepatitis B (serum)							
Cirrhosis							
Other liver disease							
Colon cancer							
Ulcerative colitis							
Crohns disease							
Intestinal cancer							



	You	Mother	Father	Sibling	MGM/MGF/ PGM/PGF	Aunt/ Uncle	Cousin
<b>DEVELOPMENTAL DISORDERS OF STOMACH AND INTESTINE</b>							
Pyloric stenosis							
Rectal disorder							
Any other cancer or problem of digestive system							
<b>GENITAL REPRODUCTIVE</b>							
Undescended testicle							
Hermaphroditism/ambiguous genitals							
Hypospadias							
Prostate cancer							
Testicular cancer							
Lumps or cysts in breasts							
Breast surgery							
2 or more miscarriages							
Stillborn							
Death of a newborn infant							
Neonatal jaundice							
<b>HEART</b>							
Stroke							
Heart attack							
Heart disease							
Hardening of the arteries							
High blood pressure							
High cholesterol level							
<b>MENTAL HEALTH</b>							
Schizophrenia							
Bipolar disorder							
Anxiety/panic attacks							
Mild depression							
Any other mental health problem							



	You	Mother	Father	Sibling	MGM/MGF/ PGM/PGF	Aunt/ Uncle	Cousin
<b>METABOLIC/ENDOCRINE</b>							
Diabetes mellitus							
Hypoglycemia							
Thyroid cancer							
Thyroid disease							
Goiter							
Adrenal dysfunction of disorder							
Hyperactivity							
<b>MUSCLE/BONE JOINTS</b>							
Muscular dystrophy							
Other chronic muscle disease							
Loss of muscle coordination							
Lupus							
Osteoporosis							
Dwarfism							
Arthritis							
Gout							
Myasthenia Gravis							
<b>NEUROLOGICAL</b>							
Migraines							
Mental retardation							
Downs syndrome							
Alzheimer's syndrome							
Senility before age 50							
Multiple sclerosis							
Cerebral palsy							
Epilepsy/seizures							
Hydrocephalus							
Spina bifida/neural tube defect							
Huntingtons disease							



	You	Mother	Father	Sibling	MGM/MGF/ PGM/PGF	Aunt/ Uncle	Cousin
Gauchers disease							
Wilson's disease							
Parkinson's disease							
Paraplegia							
Tourette's syndrome							
Scoliosis							
Other diseases of nervous system							
<b>RESPIRATORY</b>							
Hayfever/environmental allergy							
Asthma							
emphysema							
Tuberculosis							
Lung cancer							
Pneumonia							
Cystic fibrosis							
Other lung disease							
<b>SIGHT/SOUND/SMELL</b>							
Deafness before age 60							
Deformity of the ear							
Cataracts before age 50							
Blindness							
Color blindness							
Glaucoma							
Deviated septum							
Any other disorder sight/sound/smell							
<b>SKIN</b>							
Acne							
Eczema							
Skin cancer							
Pigmentation disorders							
Neurofibromatosis							
Any other disorders of the skin							



	You	Mother	Father	Sibling	MGM/MGF/ PGM/PGF	Aunt/ Uncle	Cousin
<b>THERMOSOMAL ABNORMALITIES</b>							
Turner syndrome							
Klinefelter syndrome							
<b>URINARY</b>							
Kidney disease							
Other disease of urinary tract (urethra, bladder, uterus)							
<b>OTHER</b>							
Alcoholism							
Drug abuse, misuse, or addiction							
Breast cancer							
Any other cancer not mentioned							
Any other condition not mentioned							

**PERSONAL HISTORY**

What are your academic/professional goals?

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What are your personal goals?

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What are your hobbies, interests, and talents?



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Are you athletic? \_\_\_\_\_

What sports do you enjoy playing/watching?

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What are your musical interests?

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How would you describe yourself?

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Which three adjectives would the people who know you the best use to describe you?

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Why do you want to be an egg donor?

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What is important to you?

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How did you learn of ovum (egg) donation?

Making  
**miracles**  
*happen*



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Who have you told about your decision to donate your ova and what was their reaction?

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What are the three most important characteristics to you that the recipient parents possess (e.g. health, religion, race, appearance, intelligence, personality, financial ability, family background, etc.)?

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If you could pass a message onto the recipient couple, what would that message be?

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**SUPPLEMENTARY QUESTIONNAIRE**

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

Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

How were you referred to the Egg Donor Program? \_\_\_\_\_

Years employed at present job: \_\_\_\_\_ Annual Income: \_\_\_\_\_

**Marital and Family History**

Date of current marriage: \_\_\_\_\_

Date(s) of previous marriages: \_\_\_\_\_

Date(s) of divorces: \_\_\_\_\_

Have you ever been a donor at another clinic?  Yes  No  
If yes, where? \_\_\_\_\_ How many times? \_\_\_\_\_

Date of last physical exam: \_\_\_\_\_ Physician: \_\_\_\_\_  
Any problems? \_\_\_\_\_

How many days in the past 12 months could you not work because of illness (colds, flu, surgery, etc.)? \_\_\_\_\_

Have you ever had any serious illness?  Yes  No  
If yes, please explain:  
\_\_\_\_\_  
\_\_\_\_\_

Date of last Pap smear and gynecological exam: \_\_\_\_\_ Doctor: \_\_\_\_\_  
Was it normal?  If not, please explain: \_\_\_\_\_

Please list all the physicians that you have seen in the last 5 years.



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Doctor	Address	Phone	Reason for visit
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you of Caucasian ancestry?  Yes  No  
If yes, have you ever been tested for Cystic Fibrosis?  Yes  No  Unknown  
Results: Carrier Not a carrier Unknown

Are you of Jewish ancestry?  Yes  No  
If yes, have you ever been tested for Tay-Sach's, Canavan's, and Gaucher's Disease?  
 Yes  No  Unknown  
Results: Carrier Not a carrier Unknown

Are you of African American ancestry?  Yes  No  
If yes, have you ever been tested for Sickle cell anemia?  Yes  No  Unknown  
Results: Carrier Not a carrier Unknown

Are you of Asian ancestry?  Yes  No  
If yes, have you ever been tested for thalassemia?  Yes  No  Unknown  
Results: Carrier Not a carrier Unknown

Are you of Mediterranean ancestry?  Yes  No  
If yes, have you ever been tested for thalassemia?  Yes  No  Unknown  
Results: Carrier Not a carrier Unknown

Do you use recreational drugs?  Yes  No

Have you ever used IV drugs?  Yes  No

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

Have you ever had a blood transfusion?  Yes  No

Have you ever had an accidental needle stick?  Yes  No

Have you ever been excluded from blood donation  Yes  No



If yes, why? \_\_\_\_\_

Have you ever received any organ for transplant?    \_\_\_Yes    \_\_\_No

Have you traveled outside the United States since 1977?    \_\_\_Yes    \_\_\_No

If yes, where and for how long?

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Have you ever been tested for HIV?    \_\_\_Yes    \_\_\_No

If yes, what were the results? \_\_\_\_\_

Have you ever been in trouble with the law, arrested, or convicted of a felony?

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

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### DETAILED PERSONAL REPRODUCTIVE HISTORY

- Please give a history of all pregnancies regardless of whether or not they were full term deliveries, and their outcome (e.g. birth, abortion, stillborn, adopted, etc.):

Dates	Outcome

- Have you ever been diagnosed as having AIDS or AIDS related complex?

\_\_\_Yes    \_\_\_No

- Have you or any of your sexual partners had:

	Self	Partner	When	How Often
NSU (non-specific urethritis)				
Syphilis				
Gonorrhea				



Chlamydia				
Venereal Warts				
Herpes				
Hepatitis				
Use of IV drugs				
Other sexually transmitted diseases				

Have you ever been tested as a carrier of:

Tay-Sach's disease (Jewish ancestry)      \_\_\_ carrier    \_\_\_ non carrier    \_\_\_ unknown  
 Sickle cell disease (African American)    \_\_\_ carrier    \_\_\_ non carrier    \_\_\_ unknown  
 Cystic fibrosis (Caucasian)                \_\_\_ carrier    \_\_\_ non carrier    \_\_\_ unknown  
 Thalessemia (Italian-Greek)                \_\_\_ carrier    \_\_\_ non carrier    \_\_\_ unknown

4. Method of contraception used? \_\_\_\_\_ For how long? \_\_\_\_\_
5. Number of sex partners in the last 12 months: \_\_\_\_\_  
 If applicable, my sex partner has had other sex partners in the last 6 months:  
 \_\_\_ Yes    \_\_\_ No

**PSYCHIATRIC AND COUNSELING HISTORY**

1. Have you ever been hospitalized for substance abuse, depression, or any other psychological problem?  
 \_\_\_ No    \_\_\_ Yes (If yes, please list dates and diagnosis):

Dates	Diagnosis/Reason

2. Have you ever been in counseling or psychotherapy?  
 \_\_\_ No    \_\_\_ Yes (If yes, please list dates and diagnosis):

Dates	Diagnosis/Reason



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**PERSONAL HEALTH: WORK HISTORY AND EXPOSURE TO TOXINS**

List jobs held in the past five years and any exposure as described:

Dates	Dates Began Employment	Date Ended Employment	Exposure to chemicals, drugs, gasses (describe)

Have you been exposed to the following in your living or work environment?

Exposed to	Year	How Often/Type
Toxic Chemicals		
Sprays		
Fumes/Exhaust		
Radiation		
Insecticides		
Lead/Lead Products		
Asbestos/Asbestos Products		
Cleaning Solutions		
Recreational Drugs		

Please list year and location of any body tattoos or piercings?

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**PERSONAL HISTORY AND OPINIONS**

1. Have you ever been arrested or convicted of any crime (other than minor traffic offenses):    \_\_\_ Yes    \_\_\_ No



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2. Have you ever had children removed from your custody:  
\_\_\_\_No \_\_\_\_Yes (Explain: \_\_\_\_\_)

3. Are you currently involved in any lawsuits? \_\_\_\_No \_\_\_\_Yes

4. Do you use any of the following:

Substance	Frequency Used
Alcohol	
Marijuana	
Cocaine	
Tobacco	
Caffeine	
Prescription Drugs	
Other	

5. Do you presently have any health problems? If yes, please describe:


6. What do you think is the biggest stress in your life at present?


7. What is a typical week like for you?


8. With whom have you discussed your intentions about becoming an ovum donor?  
What are their reactions?




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9. How do you think you will feel about not knowing if a baby was conceived with your donated egg(s)?

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10. Describe the couple for whom you would like to donate:

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11. What do you anticipate your feelings and reactions will be to becoming an egg donor? What difficulties do you anticipate?

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12. Have you had any personal experience with a traumatic event?

Event	Yes or No
Serious accident	
Rape or sexual assault	
Incest, sexual or physical abuse	
Victim of any crime	
Other	

13. Have you been a donor before? If yes, indicate what type (e.g. ovum, blood, bone marrow, etc.)

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14. If you had the choice, would you prefer to know if a pregnancy occurred?  
 Yes     No     Uncertain

15. Please check all in which you would participate and feel comfortable if we were to provide these options. If you wish to remain completely anonymous you may and we will make every effort to keep your identity anonymous.

<input type="checkbox"/>	Participate in annual follow-up for medical update and to explore reactions to ovum donation
<input type="checkbox"/>	Share your own baby picture
<input type="checkbox"/>	Speak by telephone with the recipients but not meet in person
<input type="checkbox"/>	Share non-identifying letters
<input type="checkbox"/>	Share a current picture of yourself
<input type="checkbox"/>	Meet in person with the recipients
<input type="checkbox"/>	Exchange identifying information

16. Would you like to meet any of the children who may result from your egg donation once they reach 18 years of age (if it is possible)?

Please check all that apply:

<input type="checkbox"/>	Would definitely not like to meet
<input type="checkbox"/>	Would like to meet the child(ren)
<input type="checkbox"/>	Would like to share picture with child(ren)
<input type="checkbox"/>	Would not object if child(ren) wished to meet but would not seek a meeting

17. Would you consider donating your eggs on more than one occasion:

Yes     No     Uncertain

If yes, how many times do you anticipate donating your eggs: \_\_\_\_\_

As part of our wish to stay informed about your wishes, we have a few questions below for you to answer. Please take your time and indicate your current thinking on the following subjects:

	Yes	No	Not Sure
Do we have your permission to contact you in the future for additional cycles should a recipient wish to cycle with you again to create a	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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sibling for a child conceived through your donation?			
Would you be willing to contact us if you or a close relative developed any significant health problems after the donation is completed?			
Do we have your permission to contact you with medical information about any offspring born through your donated eggs if it might have relevance to you/your children or other family members with regard to possible medical or genetic issues? If you indicate no, please be aware that we will respect your wish and withhold any medical information from any pregnancies or births from your donated eggs, even if it has significance for you.			

I have answered all the questions asked of me throughout this history form and verify that they are accurate to the best of my knowledge.

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

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_