## Donor Information

Date: _____

Donor's Name: _____

Donor's Maiden Name (if married): _____

Donor's Marital Status: ☐ Single ☐ Married ☐ Engaged ☐ Divorced ☐ Dating ☐ Other

Partner/Husband's Name: _____

Address: _____ Apartment Number: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Donor's Date of Birth: _____ Partner/Husband's Date of Birth: _____

Religion Born Into: _____

Complexion: _____ Eye Color: _____

Hair Color/Type: _____

Children/Ages: _____

Donor's Occupation: _____

Donor Weight: _____ Donor Height: _____

Highest Level of Education: _____

Donor's Medical Insurance Company: _____

Donor's SSN: _____ Partner/Husband's SSN: _____

Donor's Blood Type (if known): _____

Name of Primary Care Physician: _____

May we contact your physician? ☐ Yes ☐ No

Physician's Phone: _____

Physician's Address: _____

## Substance Use

Have you ever smoked? ☐ Yes ☐ No

If yes, for how many years? _____ How many cigarettes per day? _____

If you quit smoking, when did you quit? _____

Drug History? ☐ Yes ☐ No | ☐ Current ☐ Past

From when to when? _____

If yes, what types? _____ How often? _____

## Alcohol

Do you drink alcoholic beverages? ☐ Yes ☐ No

If yes, what kind? _____

How many drinks (beer, wine, alcohol) do you consume on average per day? _____

How many drinks (beer, wine, alcohol) do you consume on average per week? _____

How many drinks (beer, wine, alcohol) do you consume on average per month? _____

Have you ever sought help for an alcoholic problem? ☐ Yes ☐ No

If yes, please explain: _____

If you do not drink at all, what is your reason? _____

## Allergies

Current allergies? ☐Yes ☐No

If yes, to what? (include drug allergies)_____

How long?_____

Any treatment given?_____

## Medications

| Drug Name | Dosage | Frequency | Dates Taken | Reason | Current | Past |
|---|---|---|---|---|---|---|
| | | | | | ☐ | ☐ |
| | | | | | ☐ | ☐ |
| | | | | | ☐ | ☐ |
| | | | | | ☐ | ☐ |
| | | | | | ☐ | ☐ |
| | | | | | ☐ | ☐ |
| | | | | | ☐ | ☐ |

## Previous Surgery

| Date | Type of Surgery | Physician Name |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

## Menstrual History

Age of first menses:_____ Cycle Length:_____ ☐Regular ☐Irregular

Dates last 3 periods started: 1:_____ 2:_____ 3:_____

Describe any menstrual related difficulties since puberty:

How bad were your menstrual cramps as a teenager?_____ Now?_____

Premenstrual Syndrome (PMS)? ☐Yes ☐No

Symptoms, duration, and severity:_____

Describe any medical treatment for menstrual problems:

## Reproductive History

Have you ever been pregnant? ☐Yes ☐No

If yes, how many times?_____

If yes, how many stillbirths? _____

How many live births? _____

How many miscarriages? _____

How many abortions? _____

Is there a history of infertility in your family? Explain:

Describe any reproductive complications:

## Pregnancy History

| Child's Date of Birth | Infertility Therapy (if any) | Miscarriage (D&C done?) | Abortion | Ectopic Pregnancy | C-Section or Vaginal Delivery | Weight and Sex | Pregnancy Complications | Name of Child's Biological Father |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

## Children

| Age | Hair Color | Hair Type | Eye Color | Skin Tone |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Please be completely candid when answering the following questions. A “yes” response will not necessarily eliminate you as a potential donor. Many applicants have at least one of these conditions. Please answer all questions openly and honestly. The accuracy of the information you provide will have an impact on the future generations you may help to create.

If you are accepted as a donor, a portion of your statements will be made anonymous and then circulated amongst our patients. This information will remain a confidential part of your medical record unless you agree to allow us to share it. If you choose not to share this information with our patients, you will not be allowed to donate with our program.

Are you a citizen of the United States?

☐Yes ☐No

Some people cannot provide a complete family history (including grandparents). For example, if you are adopted, or do not know one side of your family, your ability to provide a complete family history may be compromised. Is there any reason you cannot complete a family history?

☐Yes ☐No
If yes, please explain:

How did you hear about our program? (Please be specific with the publication or website where you saw/ heard our ad, or with the name of the person who referred you.)

Have you ever been an egg donor before?

☐Yes ☐No
If yes, where and how many times?

Please describe any concerns or complications from prior donations:

## Personal History Recap

Today's Date: _____ Age: _____ Year of Birth: _____

Religion Born Into: _____ Place of Birth (Country/State): _____

Height: _____ Weight: _____ Race/Ethnicity: _____

Countries of Ancestry: _____

## Physical Characteristics

Body Type/ Bone Structure: ☐ Small ☐ Medium ☐ Large

Hands: ☐ Right-handed ☐ Left-handed ☐ Ambidextrous

## Eyes

| | | | | |
|---|---|---|---|---|
| Color: | ☐ Brown | ☐ Hazel | ☐ Green | ☐ Blue |
| Set: | ☐ Narrow | ☐ Average | ☐ Wide | |
| Size: | ☐ Small | ☐ Average | ☐ Large | |
| Shape: | ☐ Round | ☐ Oval | ☐ Almond | |
| Shade: | ☐ Light | ☐ Medium | ☐ Dark | |

## Hair

| | | | | | |
|---|---|---|---|---|---|
| Color as a Young Child: | ☐ Blonde | ☐ Brown | ☐ Black | ☐ Red | Other: _____ |
| Natural Color: | ☐ Blonde | ☐ Brown | ☐ Black | ☐ Red | Other: _____ |
| Shade: | ☐ Light | ☐ Medium | ☐ Dark | | |
| Type: | ☐ Straight | ☐ Wavy | ☐ Curly | | |
| Fullness: | ☐ Thin | ☐ Medium | ☐ Thick | | |
| Texture: | ☐ Fine | ☐ Medium | ☐ Coarse | | |

## Nose

| | | | |
|---|---|---|---|
| Size: | ☐ Small | ☐ Medium | ☐ Large |
| Width: | ☐ Narrow | ☐ Average | ☐ Wide |
| Length: | ☐ Short | ☐ Average | ☐ Long |
| Nostril Flare | ☐ Small | ☐ Average | ☐ Wide |

## Cheekbones

| | | | |
|---|---|---|---|
| Set: | ☐ Low | ☐ Average | ☐ High |
| Prominence: | ☐ Slight | ☐ Medium | ☐ Strong |

## Mouth

| | | | |
|---|---|---|---|
| Size: | ☐ Small | ☐ Average | ☐ Large |
| Lips: | ☐ Thin | ☐ Average | ☐ Full |

## Chin

Shape: ☐ Square ☐ Oval ☐ Round

Prominence: ☐ Slight ☐ Average ☐ Strong

Dimples: ☐ None ☐ Slight ☐ Medium ☐ Strong

## Skin

Skin Tone: ☐ Light ☐ Med-light ☐ Medium ☐ Med-dark ☐ Dark

Tanning Ability: ☐ Slight ☐ Medium ☐ Easy

Condition: ☐ Oily ☐ Medium ☐ Dry ☐ Combination

Acne: ☐ None ☐ Slight ☐ Medium ☐ Severe At What Age:_____

## Other Facial Features

Moles: ☐ None ☐ One ☐ Several ☐ Numerous Where:_____

Freckles: ☐ None ☐ Several ☐ Moderate ☐ Numerous Where:_____

Dimples: ☐ None ☐ Slight ☐ Medium ☐ Deep Where:_____

## Vision Aids

Vision: ☐ Normal ☐ Far-sighted ☐ Near-Sighted

Glasses/ Contacts: ☐ None ☐ Single ☐ Bifocal ☐ Trifocal Age Diagnosed:_____

Laser Corrective Surgery: ☐ Yes ☐ No When:_____

## Dental Devices

Device: ☐ None ☐ Braces ☐ Retainer Other:_____

Reason: ☐ Cosmetic ☐ Accident ☐ Disease Other:_____

Age During Use: _____ to _____ years of age

## Other Physical Aids

List:_____

Reason/Cause:_____

## Religion

Are you an atheist/agnostic? ☐ Yes ☐ No

Religion born into:_____ What religion did you belong to as a child?_____

As an adult?_____

How religious are you now?: ☐ Very ☐ Moderately ☐ Ocasionally Attend ☐ Not at All

## Education

Have you completed grade school? ☐Yes ☐No

Have you completed high school? ☐Yes ☐No

Currently in college, pursuing a degree in:_____

Completed college degree in:_____

Currently pursuing an advanced degree in:_____

Completed an advanced degree in:_____

## Languages

Speak:_____ Read:_____ Write:_____

## Athletic Activity

☐Athletic ☐Active ☐Average ☐Inactive

What physical activities do you engage in?_____

Have you excelled in any physical activities? ☐Yes ☐No

Please list them:_____

## Manual Dexterity

☐Dexterous ☐Average ☐Clumsy

What manual skills do you have?

What other skills or talents do you have (e.g., painting, writing, reading, ability to do games, crossword puzzles, handcrafts, etc.) Please describe:

## Musical Ability

☐Musical ☐Average ☐Tone Deaf

## Work/Occupational History

*(Please DO NOT list employers, or company names; only your occupation/job title)

What were your strengths in school?

What were your weaknesses in school?

Were you ever diagnosed with any learning disabilities?

What is your current or most recent occupation?

What other types of employment have you had?

Describe any weight problems you may have had:

Describe your dietary preferences and dislikes:

Have you ever been convicted of a crime, or at present, have any pending legal action?

☐Yes ☐No If yes, please describe:_____

Describe yourself as a child (e.g., personality, health, interests, activities, etc.):

What are your favorite foods?

What is your favorite color?

Do you like pets? If so, which animal is your favorite?

Where would you most like to travel and why?

How would you describe your personality?

What is your ultimate ambition or goal in life?

What were your reasons for becoming a donor?

What would you especially like your genetic offspring to know about you (if anything)?

Would you be willing to be contacted by RMA Long Island IVF in the future, if your genetic offspring needed further genetic or medical information?

☐Yes ☐No

## Family History

Please complete the chart below for each of your immediate family members. Please fill in each family member's current age (or age at death). Please list any medical problems they have currently (and/or their specific cause of death), AND any medical problems they may have had in the past. Be sure to list any brothers or sisters who may have died in infancy. Please ask your family members if you are unsure about their medical history.

| Family Member | Age (If Alive) | Medical Problems | Age at Death (If Applicable) | Cause of Death (If Applicable) |
|---|---|---|---|---|
| Mother | | | | |
| Father | | | | |
| Maternal Grandmother | | | | |
| Maternal Grandfather | | | | |
| Paternal Grandmother | | | | |
| Paternal Grandfather | | | | |
| ☐Brother<br>☐Sister | | | | |
| ☐Brother<br>☐Sister | | | | |
| ☐Brother<br>☐Sister | | | | |
| ☐Brother<br>☐Sister | | | | |

What is your ethnic background? (Please check all that apply. If none apply, please write in next to Other:)

☐Northern European (Ireland, Denmark, Finland, UK, etc.)
☐Western European (Austria, France, Germany, etc.)
☐Southern Europe (Italy, Spain, Portugal, etc.)
☐Southeast Asian (Cambodia, Vietnam, etc.)
☐Far East Asian (China, Japan, Philippines, etc.)
☐Middle Eastern (Iran, Israel, Syria, Egypt, etc.)
☐Ashkenazi Jewish / Sephardic Jewish
☐African
☐South American (Brazil, Peru, Argentina, etc)
☐West Indies / Caribbean
☐French Canadian / Cajun
☐Puerto Rican
☐Dominican Republic
☐Mexican
☐Native American
☐Indian
Other:_____

When completing the family history section on the following pages, please DO NOT write the names of your family members or the names of their places of employment (for Occupation: just list their job title/type of employment, for example: office clerk, bank manager, or school teacher, etc.). Please request additional page if needed.

## Mother

Place of Birth:_____

Racial Group:_____

Religion:_____

Age:_____ Height:_____ Weight:_____

Eye Color:_____ Natural Hair Color:_____ Complexion:_____

Body Type:_____ Bone Structure:_____

Other Distinguishing Features: _____

Occupation:_____

Education:_____

Special skills, characteristics, achievements:_____

Describe her personality:_____

## Father

Place of Birth:_____

Racial Group:_____

Religion:_____

Age:_____ Height:_____ Weight:_____

Eye Color:_____ Natural Hair Color:_____ Complexion:_____

Body Type:_____ Bone Structure:_____

Other Distinguishing Features: _____

Occupation:_____

Education:_____

Special skills, characteristics, achievements:_____

Describe his personality:_____

## Sibling 1

☐Brother ☐Sister

Place of Birth:_____

Racial Group:_____

Religion:_____

Age:_____ Height:_____ Weight:_____

Eye Color:_____ Natural Hair Color:_____ Complexion:_____

Body Type:_____ Bone Structure:_____

Other Distinguishing Features: _____

Occupation:_____

Education:_____

Special skills, characteristics, achievements:_____

Describe his/her personality:_____

## Sibling 2

☐Brother ☐Sister

Place of Birth:_____

Racial Group:_____

Religion:_____

Age:_____ Height:_____ Weight:_____

Eye Color:_____ Natural Hair Color:_____ Complexion:_____

Body Type:_____ Bone Structure:_____

Other Distinguishing Features: _____

Occupation:_____

Education:_____

Special skills, characteristics, achievements:_____

Describe his/her personality:_____

## Sibling 3

☐Brother ☐Sister

Place of Birth:_____

Racial Group:_____

Religion:_____

Age:_____ Height:_____ Weight:_____

Eye Color:_____ Natural Hair Color:_____ Complexion:_____

Body Type:_____ Bone Structure:_____

Other Distinguishing Features: _____

Occupation:_____

Education:_____

Special skills, characteristics, achievements:_____

Describe his/her personality:_____

## Sibling 4

☐Brother ☐Sister

Place of Birth:_____

Racial Group:_____

Religion:_____

Age:_____ Height:_____ Weight:_____

Eye Color:_____ Natural Hair Color:_____ Complexion:_____

Body Type:_____ Bone Structure:_____

Other Distinguishing Features: _____

Occupation:_____

Education:_____

Special skills, characteristics, achievements:_____

Describe his/her personality:_____

Has any member of your family, including yourself, had a problem or defect AT BIRTH in any of the following body systems?

| | Yes | No | Type of Defect | Affected Family Member | Relevant Circumstances |
|---|---|---|---|---|---|
| Organ (heart, lung, kidney, etc.) | ☐ | ☐ | | | |
| Blood circulation | ☐ | ☐ | | | |
| Respiratory system | ☐ | ☐ | | | |
| Gastrointestinal system | ☐ | ☐ | | | |
| Genital/Urinary | ☐ | ☐ | | | |
| Metabolic (hormones, enzymes, etc.) | ☐ | ☐ | | | |
| Nervous system, brain, spinal cord | ☐ | ☐ | | | |
| Bones, muscles, joints, limbs | ☐ | ☐ | | | |
| Cleft Lip / Cleft Palate | ☐ | ☐ | | | |
| Other | ☐ | ☐ | | | |

Are there any diseases, abnormalities or conditions that appear to run in your family?

☐Yes ☐No

If yes, please indicate the disease(s) and the family members affected:

Has anyone in your family, including yourself, experienced recurring and/or chronic physical symptoms that have not been evaluated by a physician? (Please include those symptoms that you may not consider serious).

☐Yes ☐No

If yes, please explain:

In the following charts, please indicate the number of relatives who have been diagnosed with each condition in the corresponding boxes. **If you have the condition, mark an X under "You." If none of your family members have the condition, you must mark an X under "No One."**

## Heart Conditions

| Family Member: | You | Mom | Dad | Siblings | | Grandparents | | | | Aunts | | Uncles | | Maternal Cousins | | Paternal Cousins | | No One |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | - | - | - | F | M | MGM | MGF | PGM | PGF | Mat | Pat | Mat | Pat | F | M | F | M | - |
| Heart Disease/ Defect From Birth | | | | | | | | | | | | | | | | | | |
| Other Heart Disease/Defect | | | | | | | | | | | | | | | | | | |
| Heart Attack | | | | | | | | | | | | | | | | | | |
| Hardening of Arteries | | | | | | | | | | | | | | | | | | |
| High Blood Pressure | | | | | | | | | | | | | | | | | | |
| Hypertrophic Idiopathic Subaortic Stenosis (HISS) | | | | | | | | | | | | | | | | | | |
| Other Heart Conditions | | | | | | | | | | | | | | | | | | |

## Blood Conditions

| Family Member | You | Mom | Dad | Siblings | | Grandparents | | | | Aunts | | Uncles | | Maternal Cousins | | Paternal Cousins | | No One |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | - | - | - | F | M | MGM | MGF | PGM | PGF | Mat | Pat | Mat | Pat | F | M | F | M | - |
| Anemia | | | | | | | | | | | | | | | | | | |
| Leukemia | | | | | | | | | | | | | | | | | | |
| Other Blood Disorders | | | | | | | | | | | | | | | | | | |

## Respiratory Conditions (Lungs)

| Family Member: | You | Mom | Dad | Siblings | | Grandparents | | | | Aunts | | Uncles | | Maternal Cousins | | Paternal Cousins | | No One |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | - | - | - | F | M | MGM | MGF | PGM | PGF | Mat | Pat | Mat | Pat | F | M | F | M | - |
| Hay Fever | | | | | | | | | | | | | | | | | | |
| Asthma | | | | | | | | | | | | | | | | | | |
| Emphysema | | | | | | | | | | | | | | | | | | |
| Tuberculosis | | | | | | | | | | | | | | | | | | |
| Lung Cancer | | | | | | | | | | | | | | | | | | |
| Pneumonia | | | | | | | | | | | | | | | | | | |
| Other Lung Disease | | | | | | | | | | | | | | | | | | |

## Urinary Tract Conditions

| Family Member | You | Mom | Dad | Siblings | | Grandparents | | | | Aunts | | Uncles | | Maternal Cousins | | Paternal Cousins | | No One |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | - | - | - | F | M | MGM | MGF | PGM | PGF | Mat | Pat | Mat | Pat | F | M | F | M | - |
| Kidney Disease | | | | | | | | | | | | | | | | | | |
| Alport's Syndrome | | | | | | | | | | | | | | | | | | |
| Adult Onset Polycystic Kidney | | | | | | | | | | | | | | | | | | |
| Other Disorders/ Diseases | | | | | | | | | | | | | | | | | | |

## Gastro-Intestinal Conditions

| Family Member: | You | Mom | Dad | Siblings | | Grandparents | | | | Aunts | | Uncles | | Maternal Cousins | | Paternal Cousins | | No One |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | F | M | MGM | MGF | PGM | PGF | Mat | Pat | Mat | Pat | F | M | F | M | |
| Ulcer of Stomach/ Duodenum | | | | | | | | | | | | | | | | | | |
| Gall Stones | | | | | | | | | | | | | | | | | | |
| Hepatitis A (Infectious) | | | | | | | | | | | | | | | | | | |
| Hepatitis B (Serum) | | | | | | | | | | | | | | | | | | |
| Other Liver Disease | | | | | | | | | | | | | | | | | | |
| Colon Cancer | | | | | | | | | | | | | | | | | | |
| Ulcerative Colitis | | | | | | | | | | | | | | | | | | |
| Crohn's Disease | | | | | | | | | | | | | | | | | | |
| Cystic Fibrosis | | | | | | | | | | | | | | | | | | |
| Intestinal Cancer | | | | | | | | | | | | | | | | | | |
| Hereditary Hypercholesterolemia | | | | | | | | | | | | | | | | | | |
| Familial Colon Polyps | | | | | | | | | | | | | | | | | | |
| Other Disorders/ Diseases | | | | | | | | | | | | | | | | | | |

## Skin Conditions

| Family Member: | You | Mom | Dad | Siblings | | Grandparents | | | | Aunts | | Uncles | | Maternal Cousins | | Paternal Cousins | | No One |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | F | M | MGM | MGF | PGM | PGF | Mat | Pat | Mat | Pat | F | M | F | M | |
| Acne | | | | | | | | | | | | | | | | | | |
| Eczema | | | | | | | | | | | | | | | | | | |
| Skin Cancer | | | | | | | | | | | | | | | | | | |
| Pigmentation Disorders | | | | | | | | | | | | | | | | | | |
| Melanoma | | | | | | | | | | | | | | | | | | |
| Albinism | | | | | | | | | | | | | | | | | | |
| Neurofibromatosis | | | | | | | | | | | | | | | | | | |
| Other Skin Disorders | | | | | | | | | | | | | | | | | | |

## Genetic Conditions

| Family Member: | You | Mom | Dad | Siblings | | Grandparents | | | | Aunts | | Uncles | | Maternal Cousins | | Paternal Cousins | | No One |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | F | M | MGM | MGF | PGM | PGF | Mat | Pat | Mat | Pat | F | M | F | M | |
| Hereditary Spherocytosis | | | | | | | | | | | | | | | | | | |
| Sickle-Cell Anemia | | | | | | | | | | | | | | | | | | |
| Hemophilia/Other | | | | | | | | | | | | | | | | | | |
| Fragile X Syndrome | | | | | | | | | | | | | | | | | | |
| Thalassemia | | | | | | | | | | | | | | | | | | |
| Tay Sachs Disease | | | | | | | | | | | | | | | | | | |
| G6DP Deficiency | | | | | | | | | | | | | | | | | | |
| Spinal Muscular Atrophy | | | | | | | | | | | | | | | | | | |
| Other Disorders/ Diseases | | | | | | | | | | | | | | | | | | |

## Genital/Reproductive System Conditions

| Family Member: | You | Mom | Dad | Siblings | | Grandparents | | | | Aunts | | Uncles | | Maternal Cousins | | Paternal Cousins | | No One |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | F | M | MGM | MGF | PGM | PGF | Mat | Pat | Mat | Pat | F | M | F | M | |
| Prostate Cancer | | | | | | | | | | | | | | | | | | |
| Uterine Fibroids | | | | | | | | | | | | | | | | | | |
| Ovarian Cysts | | | | | | | | | | | | | | | | | | |
| Cancer of Cervix/ Ovaries/Uterus | | | | | | | | | | | | | | | | | | |
| DES Exposure | | | | | | | | | | | | | | | | | | |
| Breast Cancer | | | | | | | | | | | | | | | | | | |
| Infertility Workup | | | | | | | | | | | | | | | | | | |
| Balanced Translocation | | | | | | | | | | | | | | | | | | |
| Other Disorders/ Diseases | | | | | | | | | | | | | | | | | | |

## Metabolic/Endocrine Conditions

| Family Member: | You | Mom | Dad | Siblings | | Grandparents | | | | Aunts | | Uncles | | Maternal Cousins | | Paternal Cousins | | No One |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | F | M | MGM | MGF | PGM | PGF | Mat | Pat | Mat | Pat | F | M | F | M | |
| Diabetes (Type 2) | | | | | | | | | | | | | | | | | | |
| Hypoglycemia | | | | | | | | | | | | | | | | | | |
| Thyroid Cancer | | | | | | | | | | | | | | | | | | |
| Hyper/Hypo Thyroid | | | | | | | | | | | | | | | | | | |
| Goiter | | | | | | | | | | | | | | | | | | |
| Adrenal Dysfunction/ Disorder | | | | | | | | | | | | | | | | | | |
| Other Disorders/ Diseases | | | | | | | | | | | | | | | | | | |

## Mental Health Conditions

| Family Member: | You | Mom | Dad | Siblings | | Grandparents | | | | Aunts | | Uncles | | Maternal Cousins | | Paternal Cousins | | No One |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | F | M | MGM | MGF | PGM | PGF | Mat | Pat | Mat | Pat | F | M | F | M | |
| Schizophrenia | | | | | | | | | | | | | | | | | | |
| Bi-Polar/Manic Depression | | | | | | | | | | | | | | | | | | |
| Other Mental Disorders Requiring Hospitalization/ Medications | | | | | | | | | | | | | | | | | | |
| Severe Depression/ Anxiety/Phobias/ Inability to Function | | | | | | | | | | | | | | | | | | |
| Alcoholism | | | | | | | | | | | | | | | | | | |
| Drug Abuse/Misuse/ Addiction | | | | | | | | | | | | | | | | | | |

## Neurological Conditions

| Family Member: | You | Mom | Dad | Siblings | | Grandparents | | | | Aunts | | Uncles | | Maternal Cousins | | Paternal Cousins | | No One |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | F | M | MGM | MGF | PGM | PGF | Mat | Pat | Mat | Pat | F | M | F | M | |
| Migraines | | | | | | | | | | | | | | | | | | |
| Mental Retardation | | | | | | | | | | | | | | | | | | |
| Senility Before Age 50 | | | | | | | | | | | | | | | | | | |
| Alzheimer's Disease | | | | | | | | | | | | | | | | | | |
| Multiple Sclerosis | | | | | | | | | | | | | | | | | | |
| Tuberculosis Sclerosis | | | | | | | | | | | | | | | | | | |
| Cerebral Palsy | | | | | | | | | | | | | | | | | | |
| Amyotrophic Lateral Sclerosis | | | | | | | | | | | | | | | | | | |
| Epilepsy or Seizures | | | | | | | | | | | | | | | | | | |
| Hydrocephalus (Water on Brain) | | | | | | | | | | | | | | | | | | |
| Congenital Hydrocephalus (Aqueduct Obstruction) | | | | | | | | | | | | | | | | | | |
| Huntington's Disease | | | | | | | | | | | | | | | | | | |
| Gaucher's Disease | | | | | | | | | | | | | | | | | | |
| Wilson's Disease | | | | | | | | | | | | | | | | | | |
| Creutzfeldt-Jakob disorder or other neurological disorder | | | | | | | | | | | | | | | | | | |

## Muscle, Bone, and Joint Conditions

| Family Member: | You | Mom | Dad | Siblings | | Grandparents | | | | Aunts | | Uncles | | Maternal Cousins | | Paternal Cousins | | No One |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | F | M | MGM | MGF | PGM | PGF | Mat | Pat | Mat | Pat | F | M | F | M | |
| Muscular Dystrophy | | | | | | | | | | | | | | | | | | |
| Duchenne-Becker's Muscular Dystrophy | | | | | | | | | | | | | | | | | | |
| Myotonic Dystrophy | | | | | | | | | | | | | | | | | | |
| Autoimmune Disease | | | | | | | | | | | | | | | | | | |
| Lupus | | | | | | | | | | | | | | | | | | |
| Deformity of Spine | | | | | | | | | | | | | | | | | | |
| Osteoperosis | | | | | | | | | | | | | | | | | | |
| Dwarfism | | | | | | | | | | | | | | | | | | |
| Low Back Disease | | | | | | | | | | | | | | | | | | |
| Arthritis: Rheumatoid, Osteo, Other | | | | | | | | | | | | | | | | | | |
| Gout | | | | | | | | | | | | | | | | | | |
| Cleft Palate | | | | | | | | | | | | | | | | | | |
| Cleft Lip | | | | | | | | | | | | | | | | | | |
| Congenital Hip Dislocation | | | | | | | | | | | | | | | | | | |
| Other Disorders/ Diseases | | | | | | | | | | | | | | | | | | |

## Sight, Sound, Smell Conditions

| Family Member: | You | Mom | Dad | Siblings | | Grandparents | | | | Aunts | | Uncles | | Maternal Cousins | | Paternal Cousins | | No One |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | F | M | MGM | MGF | PGM | PGF | Mat | Pat | Mat | Pat | F | M | F | M | |
| Deafness Before Age 60 | | | | | | | | | | | | | | | | | | |
| Significant Hearing Loss | | | | | | | | | | | | | | | | | | |
| Deformity of the Ear | | | | | | | | | | | | | | | | | | |
| Cataracts Before Age 50 | | | | | | | | | | | | | | | | | | |
| Blindness | | | | | | | | | | | | | | | | | | |
| Color Blindness | | | | | | | | | | | | | | | | | | |
| Glaucoma | | | | | | | | | | | | | | | | | | |
| Deviated Septum | | | | | | | | | | | | | | | | | | |
| Severe Myopia (Poor Vision) | | | | | | | | | | | | | | | | | | |
| Retinitis (Inflamed Retina) | | | | | | | | | | | | | | | | | | |
| Retinoblastoma (Retina Cancer) | | | | | | | | | | | | | | | | | | |
| Retinitis Pigmentosa (Night Blindness, Tunnel Vision) | | | | | | | | | | | | | | | | | | |
| Other Disorders/ Diseases | | | | | | | | | | | | | | | | | | |

## Miscellaneous

| Family Member | You | Mom | Dad | Siblings | | Grandparents | | | | Aunts | | Uncles | | Maternal Cousins | | Paternal Cousins | | No One |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | - | - | - | F | M | MGM | MGF | PGM | PGF | Mat | Pat | Mat | Pat | F | M | F | M | - |
| Other Cancer Not Mentioned | | | | | | | | | | | | | | | | | | |
| Other Condition Not Mentioned | | | | | | | | | | | | | | | | | | |

## Risk Factor Questionnaire

| | Yes | No | Don't Know | Donor Comments | Nurse's Comments |
|---|---|---|---|---|---|
| Have you injected drugs for a non-medical reason in the last 5 years, including intravenous, intramuscular, or subcutaneous injection? | ☐ | ☐ | ☐ | | |
| Do you have a clotting disorder for which you have received human-derived clotting factor concentration? Or had sex with anyone who has? | ☐ | ☐ | ☐ | | |
| Have you had sex for drugs or money in the past 5 years? | ☐ | ☐ | ☐ | | |
| In the past 12 months, have you given money or drugs to anyone to have sex with you? | ☐ | ☐ | ☐ | | |
| Have you had sex in the past 12 months with anyone who would answer yes to the above 4 questions? | ☐ | ☐ | ☐ | | |
| In the past 12 months, have you had sex with a man who has had sex with another man in the past 5 years? | ☐ | ☐ | ☐ | | |
| In the past 12 months, have you had sex with a person known or suspected to have HIV, or active hepatitis B or C? | ☐ | ☐ | ☐ | | |
| In the past 12 months, have you been exposed to known or suspected HIV, hepatitis B and/or hepatitis C infected blood through percutaneous inoculation, contact with an open wound, non-intact skin or mucous membrane? | ☐ | ☐ | ☐ | | |
| In the past 12 months, have you been in close contact or had sex with or shared a kitchen or bathroom with a person having active viral hepatitis? | ☐ | ☐ | ☐ | | |
| In the past 12 months, have you had tattooing, ear or body piercing? If so, please give dates. | ☐ | ☐ | ☐ | | |
| After the age of 11, have you ever had viral hepatitis? | ☐ | ☐ | ☐ | | |
| Have you yourself received or had intimate contact (i.e. exchanged bodily fluids, including sharing toothbrushes and razors) with someone who has received organs or cells from non-human sources?(Xenotransplation) | ☐ | ☐ | ☐ | | |
| Have you had or been in contact with anyone who has had a recent small pox vaccination? | ☐ | ☐ | ☐ | | |
| Have you been diagnosed with West Nile Virus? | ☐ | ☐ | ☐ | | |
| Have you had a headache and a fever within the last 7 days? | ☐ | ☐ | ☐ | | |
| In the past 12 months, have you had acupuncture, electrolysis, an accidental needle stick, or a sharp instrument injury? If so, please give dates. | ☐ | ☐ | ☐ | | |
| Have you ever received growth hormone made from human pituitary glands or any blood products? | ☐ | ☐ | ☐ | | |
| Have you ever received a dura mater (brain covering) bone or skin graft? Give dates. | ☐ | ☐ | ☐ | | |

| | Yes | No | Don't Know | Donor Comments | Nurse's Comments |
|---|---|---|---|---|---|
| Have you or your blood relatives ever had Creutzfeldt-Jakob disease or any neurological disease? | ☐ | ☐ | ☐ | | |
| In the past 12 months, have you had a positive syphilis test? | ☐ | ☐ | ☐ | | |
| In the past 12 months, have you had or been treated for syphilis, gonorrhea, or Chlamydia? | ☐ | ☐ | ☐ | | |
| Have you ever been in jail? For how long? | ☐ | ☐ | ☐ | | |
| From 1980 through 1996, were you a member of the US military, a civilian military employee, or a dependent of a member of the US military? | ☐ | ☐ | ☐ | | |
| In the past 3 years, have you ever been outside of the United States? Where and when? | ☐ | ☐ | ☐ | | |
| Since 1980, have you ever lived in or traveled to Europe? (Includes: England, Ireland, Scotland, Wales, the Isle of Man, the Channel Islands, Gibraltar or the Falkland Islands) Give dates. | ☐ | ☐ | ☐ | | |
| Have you ever been in a place affected by SARS (i.e., China) or been treated or been with an affected person in the past 14 days? | ☐ | ☐ | ☐ | | |
| Were you born in, have you lived in, or have you traveled to any African country since 1977? | ☐ | ☐ | ☐ | | |
| Have you had sexual contact with anyone who was born in or lived in any African country since 1977? | ☐ | ☐ | ☐ | | |
| Have you had a blood transfusion, or were you deferred as a blood donor? | ☐ | ☐ | ☐ | | |
| Have you ever been diagnosed with T.cruzi or Chagas? | ☐ | ☐ | ☐ | | |
| Have you had immunoglobin or Rhogam vaccine? If so, which, and when? | ☐ | ☐ | ☐ | | |
| Have you ever been exposed to toxic substances? | ☐ | ☐ | ☐ | | |
| Does your occupation put you at risk for exposure of radiation? | ☐ | ☐ | ☐ | | |
| In the last six months have you or a sexual partner lived in or travelled to any area affected by Zika? Have you or a sexual partner been diagnosed with Zika Infection in the past 6 months? | ☐ | ☐ | ☐ | | |
| Within the preceding six months, have you been the recipient of a bite from an animal suspected of rabies? | ☐ | ☐ | ☐ | | |

I have reviewed all risk factor questions and verify my answers to be true:

Donor Signature: _____Date:_____

DE Coordinator Review Signature:_____ Date:_____

Dates: Created 9/9/08 VL
Revised 06/25/19 VL

I, _____, have carefully read and answered all of the questions in this donor egg application. My responses are true and correct to the best of my knowledge. In addition, with the exception of all personally identifying information, I have agreed to allow RMA Long Island IVF, P.C. ("RMA Long Island IVF") to share a portion of this application that contains potentially-identifying information about me (pages 1-13 of this packet, referred to as the "Abstract"), with intended parents. Although the Abstract does not contain my name, date of bith, or address, etc. it may be possible for someone to identify me based on the combination of other information disclosed in the Abstract. I, therefore, waive my rights to privacy under HIPAA and any other pertinent federal and state laws concerning privacy and/or confidentiality. I also hereby release and forever discharge RMA Long Island IVF, its directors, officers and employees from and against any claims stemming from the provision of the Abstract to any intended parents. I further understand that while RMA Long Island IVF will avoid disclosure to every extent possible, intended parents and donors assume the risk of identification via participation in this program.

Potential Donor's Signature _____
Date_____

I hereby authorize RMA Long Island IVF to release to my insurance carrier records pertaining to my medical history, services rendered, or treatment given to me.

Potential Donor's Signature _____
Date_____

If you have any comments or concerns, please feel free to share them with us:

Please save your work and email this completed application as an attachment to **dmathys@longislandivf.com and trothwell@liivf.com**, OR you may print and mail it to:

**RMA Long Island IVF Donor Egg Program**
**8 Corporate Center Drive, Suite 101**
**Melville, NY 11747**

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