

EGG DONOR PROFILE

Name _____

Maiden Name _____

Address _____

Phone (home) _____ (Work) _____

Email address _____

Date of Birth _____ Place of birth _____

Religion _____ Ancestry/Nationality _____

Race _____

Marital Status: Single () Married () Separated () Divorced ()

Husband's name _____

Physical description

Height: _____ Weight: _____

Hair Color: _____ Eye Color : _____

Complexion: Fair () Olive () Medium () Tan ()

Identification

Social Security No.: _____

Drivers License: _____

Educational History

Number of years attended: Grade School ____ High School ____ College ____

Educational Achievements: _____

Educational Goals: _____

Vocational and /or other training: _____

Occupational History

Date: _____

Present occupation: _____

Address of present employer: _____

Telephone number: _____ Hours: _____

Can you be called at work? Yes () No ()

Length of employment: _____

Do you plan to stop working? Yes () No ()

If so, when? _____

Hobbies, Talents, Interest

Medical Information on Egg Donor

OUTLINE OF THE EGG DONOR'S HEALTH HISTORY INCLUDING ALL FAMILY MEMBERS

Place an "X" if the listed medical condition exists in your medical history or if any relatives or other family members have/had any of the conditions. If one of your relative's deaths was the result of a particular medical condition, note it on the line to the right of the condition and write the age at which they died.

PLACE AN 'X'	<u>CONGENITAL IMPAIRMENTS</u>	List the member(s) from your maternal or paternal side of your family who have or had each impairment
	Club foot or any orthopedic problem	
	Harelip (Cleft lip) or Cleft palate	
	Cerebral Palsy	
	Down's Syndrome	
	Hydrocephalus (Water on the brain)	
	Muscular dystrophy	
	Dwarfism	
	Spina Bifida	
	Congenital heart defect	
	Other	

PLACE AN 'X'	<u>ALLERGIES</u>	List the member(s) from your maternal or paternal side of your family who have or had each impairment
	Eczema or other skin conditions	
	Hay fever	
	Milk allergy	
	Drug allergy(s)	
	Other	
PLACE AN 'X'	EYE, EAR, NOSE AND THROAT DISORDERS	List the member(s) from your maternal or paternal side of your family who have or had each impairment
	Farsighted	
	Nearsighted	
	Different color eyes	
	Night blindness	
	Glaucoma	
	Blindness	
	Other visual problems	
	Sinus or nasal problems	
	Ear infections	
	Deafness	
	Other ear problems	
	Teeth problems	
	Gum disease	
	Other	

PLACE AN 'X'	CIRCULATORY DISORDERS	List the member(s) from your maternal or paternal side of your family who have or had each impairment
	Hypertension (high blood pressure)	
	Heart murmurs	
	Heart attack (coronary)	
	Hemophilia (free bleeder)	
	Leukemia	
	Stroke	
	Anemia	
	Sickle cell anemia or trait	
	Heart Surgery	
	Any other heart or circulatory problems	

PLACE AN 'X'	RESPIRATORY AND DIGESTIVE DISORDERS	List the member(s) from your maternal or paternal side of your family who have or had each impairment
	Asthma	
	Bronchitis	
	Cystic fibrosis	
	Sudden infant death syndrome	
	Frequent pneumonia	
	Other respiratory disorders	
	Ulcers	
	Colitis	
	Gall bladder problem	
	High Cholesterol	
	Obesity	
	Anorexia/Bulimia	
	Colon Cancer	
	Other Digestive Disorders	

PLACE AN 'X'	<u>URINARY TRACT CONDITIONS</u>	List the member(s) from your maternal or paternal side of your family who have or had each impairment
	Bladder Problems	
	Kidney problems	

PLACE AN 'X'	DEVELOPMENTAL DISORDERS, MENTAL, BEHAVIORAL, AND NERVOUS DISORDERS.	List the member(s) from your maternal or paternal side of your family who have or had each impairment
	Speech problems	
	Learning disability	
	Retardation: mental or physical	
	Other developmental disorders	
	Diagnosed schizophrenia	
	Diagnosed manic depressive	
	Alcoholism or heavy drinking	
	Drug abuse	
	Other mental or behavioral disorders	
	Multiple sclerosis	
	Lou Gehrig's disease	
	Seizures or convulsions	
	Huntington's disease	
	Epilepsy	
	Migraine headaches	
	Other nervous system disorders	

PLACE AN 'X'	<u>MISCELLANEOUS DISORDERS</u>	List the member(s) from your maternal or paternal side of your family who have or had each impairment
	Diabetes	
	Arthritis	
	Gouty arthritis	
	Rheumatoid arthritis	
	Hodgkin's disease	
	Cysts, lumps, or growths	
	Tumors	
	HIV/AIDS	
	Others	

PLACE AN 'X'	FEMININE DISORDERS	List the member(s) from your maternal or paternal side of your family who have or had each impairment
	Endometriosis	
	Menstrual problems	
	Problem pregnancies	
	Other problems	
	What age did your period begin?	

CONFIDENTIAL DRUG USAGE

This is **STRICTLY CONFIDENTIAL**. Place an "X" in the "no" box, if you have never used that drug/alcohol.

DRUG & ALCOHOL USAGE	Use occasion-ally (1-5 times)	Use Daily	Use Weekly	Use monthly	NO
CIGARETTES					
BEER					
WINE					
LIQUOR					
MARIJUANA					
COCAINE					
AMPHETAMINES					
HEROINE					
METHADONE					
QUAALUDES					
PCP					
LSD					
STIMULANTS					
DEPRESSANT					
DIET PILLS					
TRANQUILIZERS					
ANTI-CONVULSANTS					
PRESCRIPTION DRUGS					

Please list any other medical issues that were not covered in the information above:

Please list any additional comments, concerns or questions you may have: _____

EGG DONOR ACKNOWLEDGEMENT

I represent that the information contained in this Egg Donor Profile (including but not limited to the medical information) is true and accurate.

I acknowledge that the intended parents and other parties will rely on this information in making a determination to proceed. I hereby agree that the information contained in this form may be given to the intended parents, their physicians and specialists, and their attorney.

I further understand that any false statement herein may be viewed as perjury and in violation of the penal laws of my state and may subject me to criminal and/or civil penalties under the law.

STATE OF _____
COUNTY OF _____

The foregoing instrument was sworn to and subscribed before me this ___ day of _____, 2002, by _____, who is personally known to me or who has produced _____ as identification.

Notary Public

(Print, Type or Stamp Name)

Please return with a photograph.