

Reproductive Medicine & Infertility Associates
 2101 Woodwinds Drive, Suite 100, Woodbury, MN 55125 651-222-6050 1-800-440-7359

DONOR APPLICATION & MEDICAL/GENETIC HISTORY

To: Prospective Gamete (egg or sperm) Donor or Gestational Carrier (G.C.)

All prospective gamete donors (including anonymous egg donors, known egg donors, egg share participants, and both members of a couple using a gestational carrier) and gestational carriers must complete this application and medical/genetic history questionnaire. It is important that you answer each and every question to the best of your ability. Leave no question unanswered. We thank you for your honesty in supporting our efforts to maintain a safe donor population for our community.

The undersigned agrees that, to the best of her/his knowledge and belief, the information provided in this application is complete and correct. The undersigned furthermore agrees to report to our clinic any significant changes in the status of her/his health, especially in regards to sexually transmitted disease and to notify the clinic of any new acupuncture treatments, electrolysis treatments, ear or body piercing or tattooing that occur(s) after completion of this form.

Donor/G.C. Applicant Name (Printed)	Donor/G.C. Applicant Signature	Date
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If you are married or have a significant other/regular sexual partner, please provide the following information for that person:

Printed Full Name (First, M.I., Last)	Date of Birth
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Check the category that applies to you: Anonymous egg donor Known egg donor Egg share participant
 Intended parent (female) Intended parent (male) Gestational carrier

If you are a known egg donor, please provide the name of your recipient; if you are an intended parent, please provide the name of your gestational carrier; and if you are a gestational carrier, please provide the name(s) of your intended parents. _____

.....

Donor Application Number (Clinic will complete): _____

OK to proceed/ fwd to Gen.
 Not acceptable

 Signature of RMIA Physician Doing Initial Review (if required) Date

OK to proceed
 Not acceptable

 Signature of RMIA Physician Doing Final Review Date

 Signature of RMIA Staff Member who Reviewed Form for Completeness Date

INSTRUCTIONS: Please print all of the requested information. Write "NA" in blanks that are not applicable. Please be specific. Avoid expressions such as "natural" or "old age" for causes of death. List any health problems as specifically as possible. Give ages to your best approximation. List exact relationships, such as "first cousin through my mother's sister." Please provide information on all relatives requested. You do not need to list names. If you have questions, please contact the clinic at 651-222-6050 or 1-800-440-7359.

PERSONAL INFORMATION

Date: _____

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone(s): (____) _____ (____) _____ (____) _____
Home Cell Work

Email: _____

Messages should be left at: _____ Date of Birth: _____ Age: _____

Place of Birth: _____ Social Security Number: _____

-----GESTATIONAL CARRIERS AND INTENDED PARENTS MAY SKIP TO QUESTIONS AFTER NEXT DOTTED LINE-----

Are you adopted? Yes No

Race: Native American Black, Non-Hispanic White, Non-Hispanic Latina /Hispanic
 Asian/Pacific Islander East Indian Multi Race

Country/Countries of Ancestors' Origins: _____

Religion: Protestant Catholic Jewish Islam Other (Specify): _____

Natural Hair color: Black Dark Brown Brown Light Brown Blonde Auburn Red

Hair texture: Straight Wavy Curly Kinky ~ Baldness: Yes No Baldness in Family: Yes No

Eye color: Blue Brown Hazel Green Blue-Green Blue-Grey Black

Bone size: Small Small-Medium Medium Medium-Large Large

Complexion: Very Fair Fair Medium Olive Dark

Current Occupation: _____

Highest Degree earned: High School Vo-Tech AA Bachelors Masters Doctorate

Specify Degrees: _____

Current hobbies and interests: _____

Height: _____ inches Weight: _____ pounds

Blood type (if known): A B AB O Rh: Positive Negative

Marital Status: Married Single Divorced Separated

How many children do you have? _____

Have you ever been convicted of a crime: Yes No

If yes, for what crime: _____

If yes, did you spend any time in jail/prison: Yes No Length of time: _____



DONOR RISK FACTOR HISTORY

Please circle either Yes or No; and if Yes, please explain if requested.

1. Are you presently taking any prescribed medications? Yes No
If yes, please specify what and why: _____
2. Have you taken any prescribed medications (other than noted in #1) within the last six weeks? Yes No
If yes, please specify what and why: _____
3. Have you ever used marijuana or other illegal drugs (e.g., LSD, cocaine, heroin, ecstasy, etc.)? Yes No
If yes, what, when and how often? _____
4. Do you smoke cigarettes? Yes No If yes, for how long? _____ How many cigarettes daily? _____
5. Have you ever had or been treated for any form of sexually transmitted disease, including syphilis, gonorrhea or chlamydia?
Yes No If yes, specify: _____
6. Did you exhibit any of the following conditions within the preceding 12 months?
Dysuria (painful urination) Yes No
Urethral Discharge Yes No
Genital Ulcer Yes No
7. In the preceding six months, did you have a sexual partner who had a Trichomonas infection? Yes No
8. Have you ever experienced any of the following conditions?
Genital Herpes Yes No If yes, list date _____
Genital Warts Yes No If yes, list date _____
Hepatitis Yes No If yes, list date _____
9. In the preceding 12 months, did you have sex or close contact (e.g., living in the same household, where sharing of kitchen and bathroom facilities occurred regularly) with anyone who has had?
Genital Herpes Yes No
Genital Warts Yes No
Chronic Hepatitis (carrier) Yes No
10. In the preceding 12 months, have you undergone tattooing? Yes No If yes, list date _____
11. In the preceding 12 months, have you had acupuncture/ear piercing/body piercing/electrolysis? Yes No
If yes, identify type and list date(s): _____
12. Have you ever been previously excluded from blood donation? Yes No
If yes, identify the reason and date(s): _____
13. Have you ever been treated with human pituitary-derived growth hormone (pit-hGH)? Yes No
If yes, explain _____
14. Have you had a blood transfusion in the preceding 12 months? Yes No
If yes, explain _____
15. Were you bitten by an animal suspected of rabies in the preceding 12 months? Yes No
If yes, when: _____ explain _____
16. Have you been diagnosed with Creutzfeldt-Jakob disease or do you have any blood relatives with non-iatrogenic Creutzfeldt-Jakob disease? Yes No
If yes, explain _____
17. Do you have any history of dementia or degenerative neurologic disorders of viral or unknown etiology? Yes No
If yes, explain _____

18. Have you received a transplant of human dura mater? Yes No
 If yes, explain _____
19. Have you been diagnosed with West Nile Virus, encephalitis or meningitis of viral or unknown cause? Yes No
 If yes, explain _____
20. Did you have a vaccination or immunization in the preceding 12 months? Yes No
 If yes, explain _____
21. In the preceding 12 months, did you have sex or close contact with someone who received the smallpox vaccine? Yes No
 If yes, explain _____

PERSONAL MEDICAL HISTORY

Allergies (medicines, food, pollen, etc)? Yes No
 If yes, please list substance and reaction caused: _____

List any childhood allergies that you have outgrown: _____

Do you have normal hearing? Yes No
 If no, please explain: _____

Have you or any of your sisters, brothers or parents required braces or any other significant orthodontic work? Yes No
 If yes, please explain: _____

Have any of your relatives had cosmetic dentistry? Yes No
 If yes, please explain: _____

Were you born with any birth defects (i.e., heart defect, cleft lip or palate, club feet, etc.)? Yes No
 If yes, please explain: _____

Have you had any (major or minor) operations/surgical procedures: Yes No
 If yes, please complete:

Year	Type of Operation/Surgical Procedure
_____	_____
_____	_____
_____	_____

Have you ever been hospitalized other than for surgery? Yes No
 If yes, please complete:

Year	Type of Illness
_____	_____
_____	_____
_____	_____

Have you ever had any broken bones? Yes No
 If yes, please explain: _____

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

How many days in the preceding 12 months could you not work because of illness, etc. (colds, flu, accidents, surgery, etc)? _____

Are you currently under a physician's care for any reason? Yes No

If yes, please explain: _____

Do you have any health problems that were not covered in the previous questions? Yes No

If yes, please explain: _____

List all current medications (include prescription, nonprescription, vitamins, aspirin, antacids, laxatives, herbal & sports supplements, etc.)

Medication	How Often	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all drugs you have taken in the preceding 12 months that were not listed above (including recreational drugs)

Medication	How Often	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever been treated for any form of cancer? Yes No

If yes, please explain (include cancer diagnosis and type of treatment): _____

Have you ever had or been treated for syphilis? Yes No

If yes, when: _____ How many times? _____ When was the last time? _____

Have you ever had or been treated for gonorrhea? Yes No

If yes, when: _____ How many times? _____ When was the last time? _____

Have you been tested for HIV (AIDS)? Yes No

If yes, when: _____ Reason for testing: _____

Have you ever known or associated with anyone who has told you that they had a positive HIV (AIDS virus) test? Yes No

If yes, please explain: _____

Are you now or have you ever had homosexual experiences or intercourse with a homosexual/bisexual male? Yes No

Have you ever had any intravenous (IV) infusions of blood or have you ever given yourself or had anyone give you IV injections for any purpose? Yes No

If yes, please explain: _____

Do you take or have you ever taken any concentrated products derived from blood or blood substances? Yes No

Have you or any of your sexual partners ever had:

NSU (non specific urethritis)	Myself:	Yes	No	If yes, when _____
	Partner:	Yes	No	If yes, when _____
Chlamydia	Myself:	Yes	No	If yes, when _____
	Partner:	Yes	No	If yes, when _____

Venereal warts	Myself:	Yes	No	If yes, when _____
	Partner:	Yes	No	If yes, when _____
Herpes	Myself:	Yes	No	If yes, when _____
	Partner:	Yes	No	If yes, when _____
Other sexually Transmissible diseases	Myself:	Yes	No	If yes, when _____
	Partner:	Yes	No	If yes, when _____

How many sexual partners have you had sexual activity with in the last: Week _____ Month _____ Year _____

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: _____

Did you travel outside the United States (except Canada) in the preceding three years? Yes No
 If yes, when and where? _____

If yes, did you contract any disease(s) from your foreign travel? Yes No
 If yes, please list disease(s): _____

Have you ever been exposed to "agent orange" or any other herbicides or chemicals in military action or elsewhere? (forest service, highway maintenance, etc.) Yes No
 Which substance(s)? _____
 If yes, when: _____ Where? _____

Have you ever used or do you currently use any of the following drugs?

Marijuana	Yes	No	If yes, Frequency/Year(s) _____	How Used _____
Cocaine	Yes	No	If yes, Frequency/Year(s) _____	How Used _____
Barbiturates	Yes	No	If yes, Frequency/Year(s) _____	How Used _____
Narcotics/Opiates (Heroin, Methadone, Opium, Morphine, Codeine)	Yes	No	If yes, Frequency/Year(s) _____	How Used _____
Amphetamines	Yes	No	If yes, Frequency/Year(s) _____	How Used _____
Hallucinogens	Yes	No	If yes, Frequency/Year(s) _____	How Used _____
Tranquilizers	Yes	No	If yes, Frequency/Year(s) _____	How Used _____
PCP	Yes	No	If yes, Frequency/Year(s) _____	How Used _____
Inhalants	Yes	No	If yes, Frequency/Year(s) _____	How Used _____
Steroids	Yes	No	If yes, Frequency/Year(s) _____	How Used _____

Do you drink alcoholic beverages: Yes No
 If yes, which kinds? _____ Beer _____ Wine _____ Liquor
 Approximately how many drinks per day or week do you consume? _____
 If you drink less than 3 drinks per day, was there ever a time when you drank more? Yes No
 If yes, how much _____ When (give years) _____

Have you ever been in an alcohol or substance abuse program? Yes No

Do you have any relatives with alcoholism? Yes No
 If yes, who? _____

Do you use tobacco products? Yes No
 If cigarettes, how many packs a day? _____ How long have you been smoking regularly? _____
 Other tobacco products? _____
 If you did smoke but quit, when did you last smoke? _____

Have you been or are you exposed to any EXCESSIVE amounts of the following in your work environment, living environment or while involved in hobbies? Please consider carefully.

Exposed to	Yes/No	When	How Often
Toxic chemicals, solvents or their fumes	Yes No		
Radiation (x-rays or radioisotopes)	Yes No		
Chemotherapeutics	Yes No		

-----FEMALES ONLY, MALES MAY SKIP TO GENERAL MEDICAL HISTORY/REVIEW OF SYSTEMS-----

Gynecologic History:

Age at onset of menses _____

of days from beginning of one cycle to the beginning of the next (naturally, not on birth control): Average: _____ Range: _____

Length (# of days) of menstrual flow: _____ Amount of flow (please circle): Light Moderate Heavy

First day (date) of last menstrual period: _____ First day (date) of previous menstrual period: _____

Describe any menstrual problems: _____

Describe any vaginal discharge or irritation: _____

Most Recent Pap Smear: _____ Have you ever had an abnormal Pap smear? Yes No
 If yes, have your subsequent Pap smears been normal? Yes No

Describe any difficulty with intercourse: _____

Do you have problems with pelvic pain, infections, endometriosis, etc? _____

Have you ever been treated for infertility? Yes No

Contraceptive History:

Currently use: _____ IUD _____ Diaphragm _____ Condom _____ Birth Control Pills _____ Birth Control Patch
 _____ Rhythm _____ Spermicide _____ Depo-Provera _____ Permanent Sterilization (e.g. tubal ligation)

If Birth Control Pills/Patch, how long have you been taking/using them? _____

Why did you start taking/using them? _____

If Depo-Provera when was your last injection? _____



Are you of Jewish ancestry? Yes No Unknown

If yes, please check: _____ Ashkenazi _____ Sephardic _____ Other

Have you been tested as a carrier for any of the following diseases:			If yes, result(s)		
Tay-Sachs disease:	Yes	No	_____ carrier	_____ not a carrier	_____ unknown
Gaucher's disease:	Yes	No	_____ carrier	_____ not a carrier	_____ unknown
Canavan disease:	Yes	No	_____ carrier	_____ not a carrier	_____ unknown
Fanconi anemia, group C:	Yes	No	_____ carrier	_____ not a carrier	_____ unknown
Niemann-Pick disease, type A:	Yes	No	_____ carrier	_____ not a carrier	_____ unknown
Mucopolidosis, type IV:	Yes	No	_____ carrier	_____ not a carrier	_____ unknown
Familial dysautonomia:	Yes	No	_____ carrier	_____ not a carrier	_____ unknown
Bloom syndrome:	Yes	No	_____ carrier	_____ not a carrier	_____ unknown
Cystic fibrosis	Yes	No	_____ carrier	_____ not a carrier	_____ unknown
Glycogen storage disease 1A	Yes	No	_____ carrier	_____ not a carrier	_____ unknown
Maple syrup urine disease	Yes	No	_____ carrier	_____ not a carrier	_____ unknown

Are you of black or Mexican/Latin American ancestry? Yes No Unknown
 If yes, have you been tested as a carrier of sickle cell disease? Yes No Unknown
 If yes, result: _____ carrier _____ not carrier _____ unknown

Are you of Mediterranean, Latin American, Chinese or Southeast Asian ancestry? Yes No Unknown
 If yes, have you been tested as a carrier of thalassemia? Yes No Unknown
 If yes, result: _____ carrier _____ not carrier _____ unknown

Are you of white ancestry? Yes No Unknown
 If yes, have you been tested as a carrier of cystic fibrosis? Yes No Unknown
 If yes, result: _____ carrier _____ not carrier _____ unknown

Are you a twin, triplet, etc? Yes No

Is there a history of multiple births in your family? Yes No

Genetic History Questionnaire (intended parents and gestational carriers do not need to complete)

The following questions apply to yourself and your family members, whether living or dead, including your children; your parents, your sisters and brothers (also half-sisters and half-brothers), your nieces and nephews, your mother's sisters, brothers and parents, your father's sisters, brothers and parents and your cousins.

Do you have any of the following? Please check either YES or NO for each question. For each question to which you answer YES, please give a more detailed explanation in the area (on page 11 of 13) following the questions.

- YES NO
1. ----- Any relatives with any of the common disorders, listed below, that were diagnosed earlier in life than typical?
 These common disorders and early ages of onset for each of them are:
 - a. Heart disease before age 50?
 - b. Vision loss before age 55?
 - c. Hearing loss before age 60?
 - d. Dementia (such as Alzheimer's disease) before age 60?
 - e. Breast cancer before age 50?
 - f. Colon cancer before age 50?
 - g. Prostate cancer before age 60?
 2. Any relatives that died as infants or in childhood?
 3. Any relatives that died at an early age (before 50)?

4. Any closely related individuals in your family that have the same condition, especially if the condition is rare?
5. Any relatives that have experienced 3 or more pregnancy losses (e.g., miscarriages, stillbirths)? Any babies with birth defects detected before birth (by ultrasound) or that were miscarried? Any relatives that have had a stillborn baby with or without birth defects?
6. Any relatives with bilateral (both sides) disease in paired organs, such as kidneys, breasts, ovaries, lungs, etc?
7. Any relative(s) who had a sudden cardiac death even though they seemed previously healthy?
8. Any relative(s) with diagnosed mental illnesses such as bipolar disease (manic-depressive disorder), schizophrenia or depression?
9. Any relative(s) in consanguineous (first cousins or more closely related) relationships who have children with medical problems or birth defects?
10. ----- Any relatives with:
- a. Two or more medical conditions (e.g., diabetes and muscle disease or hearing loss and kidney disease)?
- b. A medical condition and dysmorphic (malformed or different looking) features?
- c. Developmental delay with dysmorphic features and/or physical birth anomalies?
- d. Developmental delay with or without other medical conditions?
- e. Severe learning disabilities?
- f. Mental retardation?
- g. Autism?
- h. Progressive mental retardation or loss of achieved developmental milestones?
- i. Unexplained hypotonia (low/poor muscle tone)?
- j. A movement disorder (like Parkinson's disease)?
- k. Unexplained seizures?
- l. Unexplained ataxia (unbalanced gait or walk)?
- m. Two or more major birth defects (e.g. neural tube defect, congenital heart defect, etc.)?
- n. Three or more minor birth anomalies (extra or missing fingers and/or toes, etc.)?
- o. Cleft palate or cleft lip with or without cleft palate?
- p. One major birth defect with two minor birth anomalies?
- q. Unusual birthmarks, particularly if associated with learning disabilities, seizures or dysmorphic features?
- r. Hair anomalies, such as sparse, brittle, coarse or absent hair?
- s. Congenital (from birth) or juvenile deafness?
- t. Congenital or juvenile blindness?
- u. Cataracts at a young age?
- v. Ambiguous genitalia (genitals that are difficult to classify as male or female)?
- w. Proportionate short stature with dysmorphic features and/or delayed or arrested puberty?
- x. Disproportionate short stature?
- y. A history of infertility?
11. ----- Any female relatives with:
- a. Primary amenorrhea (no menstrual period before age 16)?
- b. Premature ovarian failure (menopause before age of 35), with or without a family history of individuals, in particular males, with mental retardation?
- c. Proportionate short stature and primary amenorrhea?
- d. Ovarian cancer, particularly if premenopausal at diagnosis and with bilateral involvement?
12. ----- Any male relatives with:
- a. Hypogonadism (small genitalia) and/or significant gynecomastia (breast development)?
- b. Breast cancer?
- c. Congenital absence of the vas deferens?
- d. Oligozoospermia (low sperm count) or azoospermia (no sperm)?

Num.	CONDITION	YES	NO	Num.	CONDITION	YES	NO
13	Adrenal dysfunction			43	Hunter's syndrome		
14	Albinism			44	Huntington's chorea		
15	Alcoholism			45	Hypospadias		
16	Allergies			46	Kidney disease/disorders/cancer		
17	Alzheimer's disease			47	Lesch-Nyhan syndrome		
18	Asthma			48	Leukemia		
19	Blindness or significant vision loss			49	Liver cancer		
20	Breast cancer			50	Marfan syndrome		
21	Canavan's disease			51	Muscular dystrophy		
22	Cataracts before age 50			52	Neurofibromatosis		
23	Club feet			53	Phenylketonuria		
24	Colon disease			54	Pigmentation disorder		
25	Color blindness			55	Premature menopause		
26	Congenital heart defect			56	Prostate cancer		
27	Congenital hip problems			57	Pyloric stenosis		
28	Crohn's disease			58	Retinitis pigmentosa		
29	Cystic fibrosis			59	Seizures		
30	Deformity of the ear			60	Sickle-cell anemia		
31	Diabetes mellitus			61	Skin cancer		
32	Drug abuse or addiction			62	Spina bifida		
33	Endometriosis			63	Stroke		
34	Epilepsy			64	Tay Sachs		
35	Fragile X			65	Thalassemia		
36	Gaucher's disease			66	Thyroid disease/cancer		
37	Goiter			67	Turner syndrome		
38	Hemophilia			68	Ulcerative colitis		
39	Hermaphroditism			69	Uterine cancer		
40	High blood pressure (hypertension)			70	Uterine fibroids		
41	High cholesterol/lipids			71	Wilson's disease		
42	Hirschsprung's disease			72	Any cancer not already noted		

If you answered YES to any of the questions in this Genetic History Questionnaire section, in the area below please indicate the question number (and letter, e.g. 12a, if applicable), the relative(s) to whom the question applies and provide explanatory comments. If more room is needed, please continue on the reverse side of page 13.

Question Number	Relative(s) to Whom Question Applies	Explanatory Comments

Please check this box if more room was needed and information is continued on reverse side of page 13.

MOTHER'S FAMILY HISTORY

Relative	Living	Dead	Age	If Dead, Cause of Death	Health Problems	Age Diagnosed
Grandfather						
Grandmother						
Aunt						
Aunt						
Aunt						
Aunt						
Uncle						
Uncle						
Uncle						
Uncle						
Mother						

Include stillborns, infant deaths, and childhood deaths. Also indicate on a separate page if any of your cousins has any major medical problems, birth defects, developmental delay or other listed problems. Also indicate which aunt or uncle is their parent.

FATHER'S FAMILY HISTORY

Relative	Living	Dead	Age	If Dead, Cause of Death	Health Problems	Age Diagnosed
Grandfather						
Grandmother						
Aunt						
Aunt						
Aunt						
Aunt						
Uncle						
Uncle						
Uncle						
Uncle						
Father						

Include stillborns, infant deaths, and childhood deaths. Also indicate on a separate page if any of your cousins has any major medical problems, birth defects, developmental delay or other listed problems. Also indicate which aunt or uncle is their parent.

SIBLING HISTORY

Sex	Living	Dead	Age	If Dead, Cause of Death	Health Problems	Age Diagnosed

CHILDREN'S HISTORY

Sex	Living	Dead	Age	If Dead, Cause of Death	Health Problems	Age Diagnosed

Why do you want to be an egg donor (to be answered by anonymous egg donors only)?
