Please return this application to:
Third Party Reproduction Coordinator
Strong Fertility and Reproductive Science Center
500 Red Creek Dr, STE # 220
Rochester, New York 14623

Strong Fertility Center Egg Donor Application

Date _____/______/_______

Name ____

Address ____ City/State ______________ Zip __________

Birth date ______/______/______ Age __________ Birthplace ____

Home phone ____________________ Best time to reach ____________ OK to leave message? ☐ Yes ☐ No

Occupation ____ Work hours __________________

Email address ____ Are your work hours flexible? ☐ Yes ☐ No

Number of years at present job ____

Health insurance carrier ______________________________ (You must have health insurance coverage to participate)

Business phone _______________ OK to call at work? ☐ Yes ☐ No OK to leave message? ☐ Yes ☐ No

Partner's name _______________________________________ Length of relationship ___________ years

How many pregnancies have you had? (Include live born plus miscarriages, ectopic pregnancies, stillborn, etc.) _________

How many living children? _____________

Do you wish to donate anonymously? ☐ Yes ☐ No (OR) Do you have a recipient? ☐ Yes ☐ No

If donating for a known recipient, please list:

Recipient's name ____

Recipient's address ____

Relationship to you ____

Are you adopted? ☐ Yes ☐ No Do you have any allergies? ☐ Yes ☐ No

If yes, please check all that apply ☐ Food ☐ Drugs ☐ Environmental ☐ Other: ____________________

Please list any medication allergies and the reaction if known ____

How did you hear about the Egg Donor Program? ____

Education:

_____ Completed High School
_____ Associates Degree/Field _________________________________
_____ Trade School /Trade studied ____________________________
_____ Some College
_____ College Degree/Major __________________________________
_____ Master's Degree/Field ___________________________________
_____ Doctorate Degree/Field _________________________________

Please list any talents or skills ____

Hobbies/special interests ____

How would you describe yourself physically? ____

What is your biggest stress in life? ____

Why did you decide to become an egg donor? ____

Body build (describe, for example, small or large boned, slight, strong, etc.) _____________________________________

....

Donor History

Please fill out as accurately and truthfully as possible. Please complete all questions.

Marital and Family History

Marital status ____

If ever married, date or dates of previous marriages ____

Physical Characteristics

Ethnic origin (e.g., French, Irish, etc.)

Mother ______________________________________ Father ____

African American	☐ **Mother**	☐ **Father**	☐ **MGM**	☐ **MGF**	☐ **PGM**	☐ **PGF**
Eastern European (Ashkenazi) Jewish	☐ **Mother**	☐ **Father**	☐ **MGM**	☐ **MGF**	☐ **PGM**	☐ **PGF**
Mediterranean (Greek, Italian)	☐ **Mother**	☐ **Father**	☐ **MGM**	☐ **MGF**	☐ **PGM**	☐ **PGF**

Hispanic	☐ **Mother** ☐ **Father** ☐ **MGM** ☐ **MGF** ☐ **PGM** ☐ **PGF**
Indian (from India)	☐ **Mother** ☐ **Father** ☐ **MGM** ☐ **MGF** ☐ **PGM** ☐ **PGF**
American Indian	☐ **Mother** ☐ **Father** ☐ **MGM** ☐ **MGF** ☐ **PGM** ☐ **PGF**
Southeast Asian	☐ **Mother** ☐ **Father** ☐ **MGM** ☐ **MGF** ☐ **PGM** ☐ **PGF**
French Canadian	☐ **Mother** ☐ **Father** ☐ **MGM** ☐ **MGF** ☐ **PGM** ☐ **PGF**
Cajun	☐ **Mother** ☐ **Father** ☐ **MGM** ☐ **MGF** ☐ **PGM** ☐ **PGF**

(**MGM**=Maternal Grandmother, **MGF**=Maternal Grandfather, **PGM**=Paternal Grandmother, **PGF**=Paternal Grandfather)

Blood type, if known ________ Height __________ Weight __________ Weight at age 21 ________

Natural Eye Color ___________________________ Natural Hair Color ______________________

Hair (check all that apply): ☐ Thin ☐ Thick ☐ Curly ☐ Straight ☐ Average ☐ Wavy

Complexion (check one): ☐ Light ☐ Medium ☐ Olive ☐ Rosy ☐ Freckled ☐ Asian

For African Americans: ☐ Light ☐ Medium ☐ Dark

Any birthmarks? ____

Reproductive History

Menstrual history:

Age of first menses ____ How many days is it from the first day of a period to the start of the next period? ____

Do you have irregular cycles (shorter than 25 days or longer than 42 days)? ______________________________

If yes, please explain ____

Describe any medical or surgical treatment for menstrual problems _____________________________________

Date of last Pap smear ____________________ Result ___________________________________

Have you ever had an abnormal pap _________ If yes, when & why ___________________________________

Have you ever had a pelvic infection requiring treatment with antibiotics ______ If yes, when ______________

Pregnancy:

Please list **all** pregnancies, the outcome and date.

Pregnancy Date	Pregnancy Outcome (i.e. Miscarriage, Vaginal Delivery, termination)

Have you ever been diagnosed with a sexually transmitted disease? ☐ Yes ☐ No

If yes, please list dates and diagnosis ____

____

How many sexual partners have you had in the past year? ________ In the past six months? __________

Contraceptive History

Currently use: IUD (type) _______ Diaphragm _____ Condoms _____ Birth Control Pills ______
Rhythm _____ Spermicide _______ Depo-Provera ______ Tubal Ligation _____ None ______

If Birth Control Pills ________________________(name) How long on Birth Control Pills? _______________

Currently Breastfeeding? ☐ Yes ☐ No

Breasts:

Have you ever had lumps or cysts in your breasts? ☐ Yes ☐ No

If yes, please explain ____

Have you ever had breast surgery? ☐ Yes ☐ No

If yes, please explain ____

Health Questionnaire

Have you ever been rejected as a blood donor? _______ If so, when? _________________________________

Have you ever been treated for substance abuse, depression, or any other psychiatric disorder? _______

If yes, please list dates and diagnosis ____

Were you ever hospitalized as part of the treatment for your condition? _________________________________

Have you experienced any personal traumatic event?

☐ Serious accident ☐ Sexual assault ☐ Physical abuse ☐ Rape ☐ Incest ☐ Sexual Abuse

Other (please explain) ____

Have you ever been in counseling or psychotherapy? ☐ Yes ☐ No

If yes, please give reason, start date, and stop date if applicable ______________________

____

Have you ever been tested for: Tay-Sachs, Sickle Cell Anemia, or Thalassemia? ☐ Yes ☐ No

If yes, which one and what was the result? ______________________

Have you ever been arrested or convicted of a felony? (Other than minor traffic offenses) ☐ Yes ☐ No

If yes, please describe circumstances ______________________

Please list the frequency you use or have you used any of the following? (Check NLU if you "**N**o **L**onger **U**se")

Caffeine	______________	☐ NLU
Tobacco	______________	☐ NLU
Alcohol	______________	☐ NLU
Marijuana	______________	☐ NLU
Cocaine	______________	☐ NLU
Other recreational drugs	______________	☐ NLU

Have you ever *applied* or been screened to be an egg donor before? ☐ Yes ☐ No

If yes, list name and location of donor program(s) ______________________

Have you ever been a tissue donor before? ☐ Yes ☐ No

What type (egg, bone marrow, blood, etc.)? ______________________

Are you currently enrolled as an egg donor in another program? ☐ Yes ☐ No

How many times do you anticipate you will donate your eggs? __________ (maximum of 6)

Have you or **any** of your partners [either past or present] had any of the following? (Check yourself and/or partner if yes)

Herpes, Genital	☐ You	☐ Partner
Gonorrhea	☐ You	☐ Partner
Venereal Warts	☐ You	☐ Partner
Syphilis	☐ You	☐ Partner
Chlamydia	☐ You	☐ Partner
Non-specific Urethritis	☐ You	☐ Partner
Viral Hepatitis B or C	☐ You	☐ Partner
HIV (AIDS)	☐ You	☐ Partner
Genital Sores	☐ You	☐ Partner
Trichomonas	☐ You	☐ Partner
Other sexually transmitted diseases	☐ You	☐ Partner

Please list and describe **all** of your tattoos and body piercings:

Date Received	Description	Location on Body	Sterile Needles Used?

****Note: If additional tattoos/piercings-please continue to list on back of this sheet-----------------------------→

Have you been exposed to chemicals, drugs, or gases in any jobs, activities, or hobbies over the past five years?
☐ Yes ☐ No If yes, please list ____

Job/Activity	Drug/Chemical Gases	Date of Employment

Do you have any health problems/Serious Illnesses/Broken Bones? ☐ Yes ☐ No

If yes, please describe ____

____

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

If yes, please explain ____

Have you ever had surgery? ☐ Yes ☐ No

Please explain and provide dates ____

Have you ever been hospitalized? ☐ Yes ☐ No

Please explain and provide dates:

____

Have you ever had a major illness? (Pneumonia, Mononucleosis, Hepatitis, Amoebic dysentery etc.) ☐ Yes ☐ No

Please explain ____

List any medications you are currently taking or have taken within last 12 months __________________________

____

If you had any childhood allergies you have outgrown, please list _____________________________________

Diet: (Check one)

☐ Non-vegetarian ☐ Vegetarian ☐ Poor diet ☐ Average diet ☐ Excellent diet

Do you exercise: ☐ No ☐ Occasionally ☐ Regularly

Vision: Do you wear glasses/contacts? ☐ Yes ☐ No Age you first wore glasses ________

☐ Nearsighted ☐ Farsighted ☐ Glaucoma

Hearing: ☐ Normal ☐ Describe any problems ____

Teeth (check one): ☐ Poor ☐ Fair ☐ Good Orthodontic work (braces) in the past? ____________________

Please check the appropriate answer (please answer all questions)		
Have you ever been bitten by a rabid animal or an animal suspected of having rabies	☐ Yes	☐ No
Have you injected drugs (includes intravenous, intramuscular or subcutaneous injections) for a non-medical reason in the past 5 years?	☐ Yes	☐ No
Do you have hemophilia or a related clotting disorder?	☐ Yes	☐ No
If yes, have you received human-derived clotting factor concentrates?	☐ Yes	☐ No
Have you engaged in sex in exchange for drugs or money in the past five years?	☐ Yes	☐ No
In the past year, have you:		
Had sex with a person known or suspected to have HIV, hepatitis B, or hepatitis C?	☐ Yes	☐ No
Been exposed to blood (via needle stick, or contact with an open wound, non-intact skin, or mucous membranes) that is known or suspected to be infected with HIV, Hepatitis B, or C ?	☐ Yes	☐ No
Have you ever been diagnosed with viral hepatitis or had a reactive test for hepatitis?	☐ Yes	☐ No
If yes, was it Hepatitis A, B, or C? ________________		
If yes, how old were you? ________________		
In the past year, have you been in close contact with another person who has clinically active hepatitis?	☐ Yes	☐ No
Have you ever had liver enlargement or unexplained jaundice?	☐ Yes	☐ No
Have you ever had bacteremia, septicemia, sepsis syndrome, or septic shock?	☐ Yes	☐ No
Have you had smallpox vaccination within the past 2 months?	☐ Yes	☐ No
Have you developed skin lesions as a result of close contact with another individual who received the small pox vaccine?	☐ Yes	☐ No
If yes, did this happen in the last two months?	☐ Yes	☐ No
In the past year, have you had sex with:		
A needle drug user?	☐ Yes	☐ No
A person with hemophilia or related clotting disorder?	☐ Yes	☐ No
A man who has had sex with another man in the past five years?	☐ Yes	☐ No
A person who has engaged in sex in exchange for drugs or money in the past five years?	☐ Yes	☐ No
Have you or any of your sexual partners been treated for syphilis, gonorrhea or chlamydia in the past 12 months?	☐ Yes	☐ No

Question	Yes	No
Have you or any of your sexual partners been incarcerated for more than 72 hours during the past 12 months?	☐ Yes	☐ No
Have you received a tattoo, ear or body piercing within the past 6 months?	☐ Yes	☐ No
Have you received a tattoo, ear or body piercing within the past 12 months?	☐ Yes	☐ No
Have you ever been evaluated, diagnosed or treated for the West Nile Virus?	☐ Yes	☐ No
If yes, was this within the 120 days?	☐ Yes	☐ No
Have you had a simultaneous fever and headache within the past 7 days?	☐ Yes	☐ No
Have you been in close contact with someone known or suspected to have SARS in the past 14 days?	☐ Yes	☐ No
Have you traveled to areas affected by SARS in the past 14 days?	☐ Yes	☐ No
Have you been evaluated, diagnosed or treated for SARS in the past month?	☐ Yes	☐ No
Have you had a medical diagnosis of ZIKA infection in past 6 months?	☐ Yes	☐ No
Have you traveled in the past 6 months	☐ Yes	☐ No
If yes, Where ___________ When (list dates) ____________		
Has anyone you have had sex with traveled in past 6 months	☐ Yes	☐ No
If yes, Where __________ When (list dates) ____________		
Have you or your sexual partner or any member of your household ever had a transplant or other medical procedure that involved being exposed to live cells, tissues, or organs from an animal?	☐ Yes	☐ No
The following questions are about transmissible spongiform encephalopathy (TSE), such as Creutzfeld-Jakob disease (CJD). These are neurologic diseases that can cause a change in cognition, gait, or speech:		
Do you or a blood relative have a history of CJD or any other form or variant of CJD?	☐ Yes	☐ No
Have you been diagnosed with dementia or any degenerative/demyelinating disease of the central nervous system?	☐ Yes	☐ No
Have you traveled or resided in the U.K. for a total of 3 or more months between 1980-1996? *(includes England, Ireland, Scotland, Wales, the Isle of Man, the Channel Islands, Gibraltar,and the Faulkland Islands).*	☐ Yes	☐ No
Have you received any transfusion of blood or blood products in the U.K. from 1980 until the present?	☐ Yes	☐ No
Have you resided in Europe outside of the U.K. for 5 or more years between 1980 and the present? *(includes Albania, Austria, Belgium, Bosnia-Herzegovina, Bulgaria, Croatia, Czech Republic, Denmark, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Liechtenstein, Luxemborg, Macedonia, Netherlands, Norway, Poland, Portugal, Romania, Slovak Republic, Slovenia, Spain, Sweden, Switzerland and Yugoslavia*).	☐ Yes	☐ No
Have you resided at a U.S. Military base in Germany, Turkey, Spain, Belgium, U.K., Portugal, Italy, Netherlands, or Greece for 6 months or more since 1980?	☐ Yes	☐ No

Have you received injections of human-derived pituitary growth hormone?	☐ Yes	☐ No
Have you ever injected bovine insulin since 1980?	☐ Yes	☐ No
Have you received a non-synthetic dura mater (brain covering) graft or transplant?	☐ Yes	☐ No

Family History

Including yourself and half-siblings, how many blood siblings are in your immediate family? ___________

Number of brothers _____ Number of sisters ______ Number of maternal aunts ______

Number of maternal uncles_______ Number of paternal aunts ______ Number of paternal uncles ______

Do you have any brothers or sisters that died in infancy or childhood? ☐ Yes ☐ No

If yes, please explain ____

Are there any genetic diseases or conditions that run in your family? ☐ Yes ☐ No

If yes, please explain:

____

____

Please describe the following characteristics of your family members:

Relation	Natural Hair Color	Eye Color	Height	Ethnic Origin	Age if Living	Age at Death	Cause of Death
Father							
Mother							
Paternal Grandmother							
Paternal Grandfather							
Maternal Grandmother							
Maternal Grandfather							

Genetic/Family History

Were you born with any birth defects? ☐ Yes ☐ No Please list if yes ________________________________

Has anyone in your family had any of the following conditions?

Please Check the appropriate answer (please answer all questions)		
1. Downs Syndrome	☐ Yes	☐ No
2. Mental Retardation	☐ Yes	☐ No
3. Seizure Disorder	☐ Yes	☐ No
4. Loss of Muscle Coordination	☐ Yes	☐ No
5. Premature Senility (before 50)	☐ Yes	☐ No
6. Alzheimer's disease	☐ Yes	☐ No
7. Deafness (before 60)	☐ Yes	☐ No
8. Blindness	☐ Yes	☐ No
9. Cataracts (before 40)	☐ Yes	☐ No
10. Any mental health problems--mild depression, anxiety	☐ Yes	☐ No
11. Schizophrenia or manic-depressive Disorder	☐ Yes	☐ No
12. Serious Birth Defects	☐ Yes	☐ No
13. Cleft Lip and/or Cleft Palate	☐ Yes	☐ No
14. Club Feet	☐ Yes	☐ No
15. "Open Spine" or "Water on the Brain"	☐ Yes	☐ No
16. Congenital Heart Defects	☐ Yes	☐ No
17. Congenital Hip Problems	☐ Yes	☐ No
18. Two or More Miscarriages or Stillborn	☐ Yes	☐ No
19. Crib death (neonatal death)	☐ Yes	☐ No
20. Diabetes Mellitus	☐ Yes	☐ No
21. Thyroid Disease	☐ Yes	☐ No
22. Progressive Kidney Disease	☐ Yes	☐ No
23. Skin Disease	☐ Yes	☐ No
24. Coffee-Colored Spots on the Skin (the size of a quarter or larger) or Lumps Under the Skin	☐ Yes	☐ No
25. Early Death (less than 50)	☐ Yes	☐ No
26. Cystic Fibrosis	☐ Yes	☐ No
27. Emphysema	☐ Yes	☐ No
28. Tuberculosis	☐ Yes	☐ No
29. Lung disease	☐ Yes	☐ No

30. Rheumatoid Arthritis	☐ Yes	☐ No
31. Blood Diseases		
Hemophilia	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Sickle Cell Anemia	☐ Yes	☐ No
Leukemia/Lymphoma	☐ Yes	☐ No
Thalassemia	☐ Yes	☐ No
32. Reproductive Problems		
Ovarian Malignancy (Cancer)	☐ Yes	☐ No
Endometriosis	☐ Yes	☐ No
Undescended Testicles	☐ Yes	☐ No
Hypospadias	☐ Yes	☐ No
33. Alcoholism	☐ Yes	☐ No
34. Drug Abuse	☐ Yes	☐ No
35. Cancer (type and location)	☐ Yes	☐ No
36. Heart Disease	☐ Yes	☐ No

If yes to any of above genetic/family history conditions, please give details below:

Condition # Affected	Specific Relation	Specific Condition	Age Affected

Genetic/Family History

Mother's Family

Is your mother: ☐ Living ☐ Deceased Current Age (or age at death) __________
If deceased, cause of death ____

Health Problems (If Any)	Age Diagnosed

Maternal aunts and uncles (on your mother's side), **who are deceased** (include stillborns, infant deaths, and childhood deaths)

Sex	Age at Death	Cause of Death	Age Diagnosed

Maternal aunts and uncles (your mother's brothers and sisters), **who are living**:

Sex	Age	Health Problem	Age Diagnosed

Maternal grandfather (your mother's father) : ☐ Living ☐ Deceased Current Age (or age at death) ________
If deceased, cause of death ____

Health Problems (If Any)	Age Diagnosed

Maternal grandmother (your mother's mother) : ☐ Living ☐ Deceased Current Age (or age at death) _______
If deceased, cause of death ____

Health Problems (If Any)	Age Diagnosed

Father's Family

Is your father: ☐ Living ☐ Deceased Current Age (or age at death) ________

If deceased, cause of death ____

Health Problems (If Any)	Age Diagnosed

Paternal aunts and uncles (on your father's side), **who are deceased** (include stillborns, infant deaths, and childhood deaths)

Sex	Age at Death	Cause of Death	Age Diagnosed

Paternal aunts and uncles (your father's brothers and sisters), **who are living**:

Sex	Age	Health Problem	Age Diagnosed

Paternal grandfather (your father's father): ☐ Living ☐ Deceased Current Age (or age at death) ________
If deceased, cause of death ____

Health Problems (If Any)	Age Diagnosed

Paternal grandmother (your father's mother): ☐ Living ☐ Deceased Current Age (or age at death) ______
If deceased, cause of death ____

Health Problems (If Any)	Age Diagnosed

Siblings

Your brothers and sisters, living

Sex	Age	Health Problem	Age Diagnosed

Your brothers and sisters, deceased

Sex	Age at Death	Cause of Death	Age Diagnosed

Children

Your living children

Sex	Age	Health Problem	Age Diagnosed

Your children, Deceased

Sex	Age at Death	Cause of Death	Age Diagnosed

Did you consult your family when completing your family medical history? ☐ Yes ☐ No

I hereby attest that all information disclosed in this application is accurate, true, and up-to-date to the best of my knowledge. ____

(Signature of Applicant)

……………………………………..Office Use Only……………………………………………

Reviewed by ____ Date _______/_______/_______

- Further information needed? ☐ Yes ☐ No

____

____

- Approved to proceed with screening and testing by ___________________________ Date ____/____/____