

**IN-VITRO FERTILIZATION WITH DONATED OOCYTES
COMPREHENSIVE HISTORY OF RECIPIENT COUPLE (WIFE)**

Personal History

Name _____ Date of Birth _____

Home Address _____

Home Phone _____ Work Phone _____

Type of Employment _____

Social Security # _____ Medical Insurance _____

Marital Status _____ Religion _____

Highest education degree (high school, college, graduate school, etc.) _____

Ethnic background (check all that applies)

Northern European Caucasian (specify) _____

Greek _____

Middle Eastern _____

Italian _____

Jewish _____

African American _____

Hispanic _____

Southeast Asian _____

Asian Indian _____

American Indian _____

Other ethnic group (specify) _____

Height _____ Weight _____

Natural hair color _____ Eye color _____

Complexion (Fair, Medium, Dark) _____ Blood type (if known) _____

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Medical History

Gynecologic history

Age at first period _____ Interval between periods _____

Duration of period _____ Bleeding between periods (yes/no) _____

Methods of birth control used now and in the past _____

Current frequency of intercourse (weekly) _____

Obstetrical history

Number of previous pregnancy _____

How many of your pregnancies have resulted in:

Miscarriage _____

Abortion _____

Stillbirths _____

Tubal pregnancy _____

Live births _____

Past medical history

Medical illness _____

Medications taken within the last 30 days _____

Drug allergies _____

Surgeries in the past (list all surgeries and why done) _____

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Hobbies _____

Coffee (cups/day) _____ # Cigarettes per day _____

Alcohol consumption (type, quantity, and frequency) _____

Recreational drug use (type, quantity, and frequency) _____

Intravenous drug use (type, quantity, and frequency) _____

Recreational drug use in current and/or past sexual partner(s) (type, quantity, and frequency) _____

Intravenous drug use in current and/or past sexual partner(s)(type, quantity, and frequency) _____

Reasons for requesting anonymous oocyte (egg) donation _____

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Family History

CHILDREN

Living

	Name	Sex	Age	Health status
1.	_____			
2.	_____			
3.	_____			
4.	_____			
5.	_____			
6.	_____			

NOTES: _____

Deceased (including neonatal & childhood deaths)

	Name	Sex	Age at Death	Cause of Death
1.	_____			
2.	_____			

NOTES: _____

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Family History

(If you are adopted, do not complete this section and proceed to page 8)

Father (if living) age: _____ Health status: _____

if deceased, age at death: _____ Cause of death: _____

Mother (if living) age: _____ Health status: _____

if deceased, age at death: _____ Cause of death: _____

Paternal grandfather
(if living) age: _____ Health status: _____

if deceased, age at death: _____ Cause of death: _____

Paternal grandmother
(if living) age: _____ Health status: _____

if deceased, age at death: _____ Cause of death: _____

Maternal grandfather
(if living) age: _____ Health status: _____

if deceased, age at death: _____ Cause of death: _____

Maternal grandmother
(if living) age: _____ Health status: _____

if deceased, age at death: _____ Cause of death: _____

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Family History

BROTHERS AND SISTERS

Living

	Name	Sex	Age	Health status
1.	_____			
2.	_____			
3.	_____			
4.	_____			
5.	_____			
6.	_____			
7.	_____			
8.	_____			

NOTES: _____

Deceased (including neonatal & childhood deaths)

	Name	Age at Death	Cause of Death
1.	_____		
2.	_____		
3.	_____		
4.	_____		

NOTES: _____

**IN-VITRO FERTILIZATION WITH DONATED OOCYTES
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Family History

PATERNAL UNCLES AND AUNTS

Living

Name	Sex	Age	Health status
1. _____			
2. _____			
3. _____			
4. _____			
5. _____			
6. _____			

NOTES: _____

Deceased (including neonatal & childhood deaths)

Name	Age at Death	Cause of Death
1. _____		
2. _____		

NOTES: _____

PATERNAL FIRST COUSINS

Neonatal death? _____ Cause(if known) _____
Birth Defects? _____ Specific Defect _____

NOTES: _____

**IN-VITRO FERTILIZATION WITH DONATED OOCYTES
COMPREHENSIVE HISTORY OF RECIPIENT COUPLE (WIFE)**

Family History

MATERNAL UNCLES AND AUNTS

Living

Name	Sex	Age	Health status
1. _____			
2. _____			
3. _____			
4. _____			
5. _____			
6. _____			

NOTES: _____

Deceased (including neonatal & childhood deaths)

Name	Age at Death	Cause of Death
1. _____		
2. _____		

NOTES: _____

MATERNAL FIRST COUSINS

Neonatal death? _____ Cause(if known) _____
Birth Defects? _____ Specific Defect _____

NOTES: _____

**IN-VITRO FERTILIZATION WITH DONATED OOCYTES
COMPREHENSIVE HISTORY OF RECIPIENT COUPLE (WIFE)**

Do you have a personal or family history of the following conditions: (if yes to any of the questions, please explain at the end of this section)

Condition	Yourself		Family		Comments (Indicate which family member and age of onset)
	yes	no	yes	no	
1. Congenital malformation					
Cleft lip	yes	no	yes	no	
Cleft palate	yes	no	yes	no	
Club foot	yes	no	yes	no	
Congenital heart disease	yes	no	yes	no	
Spina bifida	yes	no	yes	no	
Others	yes	no	yes	no	
2. Children with					
Down's syndrome	yes	no	yes	no	
Other chromosomal abnormalities	yes	no	yes	no	
Mental retardation	yes	no	yes	no	
Learning Delay	yes	no	yes	no	
Congenital birth defect	yes	no	yes	no	
3. Hemophilia or Bleeding disorder	yes	no	yes	no	
4. Albinism	yes	no	yes	no	
5. Retinitis Pigmentosa	yes	no	yes	no	
6. Cystic fibrosis	yes	no	yes	no	
7. Muscular Dystrophy	yes	no	yes	no	
8. Huntington's chorea	yes	no	yes	no	

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Condition	Yourself		Family		Comments (Indicate which family member and age of onset)
	yes	no	yes	no	
9. Thalassemia	yes	no	yes	no	
10. Sickle cell disease	yes	no	yes	no	
11. Tay Sach's disease	yes	no	yes	no	
12. Neurofibromatosis	yes	no	yes	no	
13. Marfan syndrome	yes	no	yes	no	
14. Colon cancer	yes	no	yes	no	
15. Leukemia or Lymphoma	yes	no	yes	no	
16. Childhood cancer	yes	no	yes	no	
17. High blood pressure	yes	no	yes	no	
18. Diabetes	yes	no	yes	no	
19. High cholesterol	yes	no	yes	no	
20. Heart attack	yes	no	yes	no	
21. Obesity	yes	no	yes	no	
22. Stroke	yes	no	yes	no	
23. Embolism or Thromboplebitis	yes	no	yes	no	
24. Seizure disorders	yes	no	yes	no	
25. Blindness	yes	no	yes	no	
26. Deafness	yes	no	yes	no	
27. Ulcerative colitis	yes	no	yes	no	
28. Crohn's disease	yes	no	yes	no	
29. Thyroid disease	yes	no	yes	no	
30. Rheumatoid Arthritis	yes	no	yes	no	

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Do you have a personal or family history of the following conditions: (if yes to any of the questions, please explain at the end of this section)

Condition	Yourself		Family		Comments (Indicate which family member and age of onset)
	yes	no	yes	no	
31. Lupus	yes	no	yes	no	
32. Jaundice	yes	no	yes	no	
33. Hepatitis	yes	no	yes	no	
34. Blood transfusion	yes	no	yes	no	
35. Anemia	yes	no	yes	no	
36. Asthma	yes	no	yes	no	
37. Kidney disease	yes	no	yes	no	
38. Depression	yes	no	yes	no	
39. Schizophrenia	yes	no	yes	no	
40. Drug addiction	yes	no	yes	no	
41. Alcoholism	yes	no	yes	no	
42. Sexually transmitted diseases					
Gonorrhea	yes	no	yes	no	
Chlamydia	yes	no	yes	no	
Syphilis	yes	no	yes	no	
Condyloma	yes	no	yes	no	
Genital herpes	yes	no	yes	no	
Human Immunodeficiency Virus (HIV)	yes	no	yes	no	
43. Infertility	yes	no	yes	no	
44. Radiation or Chemotherapy	yes	no	yes	no	
45. Hospitalization	yes	no	yes	no	

