

Information for Oocyte Donor

Introduction

Thank you for expressing an interest in becoming an oocyte (egg) donor at the Family Fertility Center. Our program is directed by H. Christina Lee, M.D., J.D. She is board certified in both the specialties of Reproductive Endocrinology, and Obstetrics & Gynecology.

Eligibility

If you are between 18 to 31 years of age and are in good health you are encouraged to participate. Women of all ethnicities and races are welcome.

Overview

Oocyte donation requires that the donor be given hormones to increase the number of mature eggs normally released each month. These hormones are medications that need to be injected daily, and the use of these medications must be taught. The ovaries where the eggs reside are internal organs, and therefore a needle must be used to extract the mature eggs for purposes of harvesting. Donors are given medications to allow them to be sedated throughout this short procedure. Surgery is usually not involved, and bleeding is minimal. Menstrual cycles usually return to their normal pattern approximately 4 to 6 weeks after the procedure. There is believed to be no untoward effects on your future fertility or menstrual cycles.

The Screening Process

If you are interested to become an oocyte donor, you are required to complete an anonymous oocyte (egg) donor questionnaire. If a potential matched recipient is identified, further medical and/or psychological screening examinations are required. Most donors require 2 or 3 visits with our staff and 1 or 2 visits with a designated licensed psychological counselor or psychiatrist to complete this initial process. Applicants find the screening process a rewarding experience. Time is taken to help you explore your personal and family health history. You are informed of the results of all laboratory tests including genetic screening, blood count, infectious diseases screening, Pap smear and urine analysis. These tests are provided free of charge.

First visit: this visit usually takes place on the third day of a spontaneous menstrual cycle. You will be given four forms: Information for Oocyte Donor, Oocyte (Egg) Donor Risk Sheet, Consent to Participate in the Anonymous Oocyte Donation, and Anonymous Oocyte (Egg) Donor Questionnaire. You should take these forms home and review them thoroughly. A clinical staff speaks with you about our program. Time is taken to answer any and all questions that you may have about becoming an egg donor, explain the various medications and medical procedures required of donors going through an egg donation procedure, risks associated with oocyte donation will be discussed.

Blood sample will be drawn for ovarian reserve screening. This includes measurement of reproductive hormones: FSH, LH and estradiol. A pelvic ultrasound will be performed to assess the total number of small follicles you have on both ovaries.

Initials _____

Information for Oocyte Donor

You must complete, sign and return all four forms: Information for Oocyte Donor, Oocyte (Egg) Donor Risk Sheet, Consent to Participate in the Anonymous Oocyte Donation, and Anonymous Oocyte (Egg) Donor Questionnaire, along with a recent photo of you. Until these forms are completed and return, the process will not go forward. Once these forms are received, you file will be saved to the pool of available donors. Visits subsequent to this initial screening process will be required only if a well matched recipient couple is identified. If we do not contact you within a month or two, you are encouraged to contact us periodically to let us know you are still interested to donate.

Egg Donation Cycle

Once a matched recipient couple is identified, you will be contacted. Most likely you will be seen between day 2-3 of your menstrual cycle. At this visit the physician and/or nurse will further explain the process, obtain a focused history and perform a physical examination, including a pelvic examination and a Pap smear, if none was done within last 12 months. Blood, urine and cervical samples will be taken to screen for general health condition, sexually transmitted diseases including HIV testing, genetic diseases screening, chromosomal analysis and drug use screening. This visit lasts 30 to 60 minutes. Instructions in the use of medications and the procedural aspects of egg donation are discussed.

Separate visit(s) to a licensed psychological counselor or psychiatrist designated by our Center for a thorough psychological evaluation may be necessary.

All subsequent visits involve a vaginal ultrasound of the pelvis and blood test to evaluate the status of the eggs you will be donating. These visits usually take 30 minutes to complete. During this time you will also be asked to sign a consent form allowing us to receive your eggs and to perform the necessary procedure to extract the eggs.

Egg Aspiration

The day the eggs are ready to harvest you will need to spend a half a day at the Family Fertility Center. The eggs are removed from you using a needle placed under ultrasound guidance into each ovary. You will be sedated using medications to put you to sleep to accomplish the 20-30 minute procedure. Following the aspiration you will be recovered in the recovery room for 1 to 2 hours prior to being discharged. Since sedatives are administered, you will be required to have a friend or relative drive you home. You may have lower abdominal tenderness and bloating after the procedure. This may last for several weeks, but will usually disappear shortly following the menstrual period that occurs 1-2 weeks after the procedure.

Compensation

If you are accepted into our donor program you are entitled to be compensated. Compensation is provided for the time required in performing the duties of a donor. You are not selling us your eggs. Compensation payment is paid on the day of oocyte retrieval. You are functioning as an independent contract free agent, and are not employed by the physician, or staff at the Family Fertility Center. Therefore, you are not entitled to employment benefits, and **all risks of the procedure are assumed and accepted by you.** Furthermore, Family Fertility Center is required by law to report the compensation as your income on a 1099 Form. No income tax is withheld from this compensation for you because you are an independent contract free agent. You must set aside a portion of this compensation for your income tax.

Initials _____

Information for Oocyte Donor

Identity Release and Disclosure Policy

Egg donation will be performed anonymously. You may wish to be contacted in the future for medical emergencies whereupon you may serve as an organ donor to the offspring born as a result of your egg donation. The choice is yours.

Legal Concerns

Presently no state statutes or case law exists regarding egg donors. Screening procedures and the conduct of the therapy is governed by guidelines established and approved by the American Society for Reproductive Medicine, formerly the American Fertility Society. Since 2005, specific screening tests for sexually transmitted diseases are mandated by the Food and Drug Administration (F.D.A.) for all oocyte donors authorized by federal law, 21CFR Part 1271 for Human Cells, Tissues, and Cellular Based Products (HCT/P).

How to Begin

If you meet our criteria for eligibility and would like to be an anonymous egg donor, please complete and notarized the enclosed anonymous oocyte donor questionnaire. Return the questionnaire along with a recent photo to our office at 95 Highland Avenue, Suite #100, Bethlehem, PA 18017. If a potential matched recipient is identified, you will be contacted by our office for further medical and psychological screenings.

I, _____, hereby verify that I have read the above information pertaining to anonymous donation of oocytes. I further verify that all my questions have been answered satisfactorily.

Name Signature Date

Initials_____

OOCYTE (EGG) DONOR RISK SHEET

Thank you for your interest in becoming an egg donor. There are many couples whose infertility is caused by either the absence of or the poor quality of the woman's oocytes (eggs). Your willingness to donate eggs will make it possible for them to achieve their goal of having a child, becoming parents and having a family. The donation of eggs from one woman to another is a simple concept which is nevertheless somewhat complex in execution. If you become an egg donor, you will be given one or more injectable or orally administered medications which will prepare your ovaries for the egg collection or harvest. The harvest procedure (follicle aspiration) requires the use of narcotics and sedatives in order to minimize the associated discomfort. By giving your eggs to an infertile couple, you establish a relationship with this couple which may lead to possible personal or legal interaction in the future.

It is the purpose of this document to make you aware of as many of the potential risks (real or imagined) which may be associated with the act of being an egg donor.

I. Physical Risks

A. Short term risks

The short term risks and side effects of this procedure are related to the physical requirements associated with the egg donation. You will be required to transport yourself to and from the Family Fertility Center office for approximately ten visits required for ovarian stimulation. In addition, you will need transportation to and from the Family Fertility Center (provided by someone else) on the day of oocyte (egg) retrieval. Since you are acting as an independent contractor, the responsibility and liability for the risks associated with this travel are yours. The risk associated with the injection of the medication and with the blood drawing is for the most part limited to pain at the injection (or phlebotomy) site and possible formation of hematoma (bruise). Prior to the egg retrieval procedure, you will have an IV started, which may be uncomfortable. You will be given an injection of narcotics and sedatives in order to make you feel sleepy and make you comfortable for the aspiration. The egg retrieval itself involves the placement of a needle directly into each ovary and the aspiration (withdrawal) of the fluid from all the ovarian follicles. In this manner, the eggs are obtained from the ovary. There is a theoretical risk of infection and bleeding associated with any surgical procedure no matter how small. In addition, both antibiotic preparations as well as antiseptic solutions are used in conjunction with the procedure to help minimize the risk of infection. However, the theoretical risk remains and is estimated at somewhere less than 1%. In extreme cases of pelvic infection and/or bleeding, admissions to the hospital, intravenous antibiotics, blood transfusion and/or surgical operation may be required. Permanent sterility may result from such serious pelvic infection and/or bleeding.

B. Risks of the medications

The medications which you will be injecting yourself with are all of a hormonal nature and are used to prepare your ovaries for the follicle aspiration procedure. Since they are hormonal, there may be an associated emotional response associated with the use of these medications. This response varies from individual to individual but may include depression, euphoria, restlessness, irritability, and sleeplessness. Other side effects which may or may not happen to you include hot flashes, temporary visual changes (blurring and accommodation changes), headache and ovarian cyst. Some ovarian cyst may cause pain in the lower abdomen or may require drainage with a needle. For a full description of the side effects of all of the medications, you are encouraged to ask for the product package insert.

Initials _____

OOCYTE (EGG) DONOR RISK SHEET

One of the side effects that you will be monitored for is ovarian hyperstimulation syndrome. When young fertile women are given fertility drugs the ovary may over-respond and produce very many follicles and very high levels of estrogen. When this happens, by a mechanism that is not well understood, some women will develop ovarian hyperstimulation syndrome, which is associated with ovarian swelling above and beyond that seen with normal response as well as with fluid collection in the abdomen (“ascites”). Patients may become nauseous and feel bloated. In extreme cases admission to the hospital may be required in order to given intravenous liquids. The approximate incidence of severe ovarian hyperstimulation syndrome is approximately 1% and a moderate form is expected in about 5% of cases.

As most oocyte donors are young and fertile, unintended pregnancy may result in the cycle when fertility drugs are used. It is your responsibility to care for or to terminate the unintended pregnancy, as well as the birth of the child as a result of this unintended pregnancy. We strongly advise you abstain from sexual intercourse during the months you undergo egg donation.

Several recent publications link the use of “fertility drugs” in women with infertility with an increased likelihood of ovarian cancer. The findings of these studies were preliminary and it is unclear what ultimate impact, if any, it may have on oocyte donors like you.

C. Long term risks

The ultimate long term risk of undergoing ovarian hyperstimulation and egg retrieval are not known. While many thousands of cycles of ovarian stimulation and egg retrieval have been performed worldwide, most of these have occurred in infertile women themselves. Less total cycles have been performed on donors. Since most donors have had children in the past, and infertile women were infertile to begin with, it is not known whether this type of procedure can have an adverse impact upon your future fertility.

There is nothing about the stimulation of the procedure that would make one think that fertility would be compromised, unless an infection were to occur. The ovarian stimulation and egg retrieval does not remove from your body any eggs that would otherwise remain there. All of these eggs would naturally be lost each month either by ovulation or by a process of degeneration and resorption called atresia, which is the fate of the majority of the eggs in your ovaries. As a result, the process of egg donation is not thought to speed up ovarian aging or the depletion of eggs in your ovaries. However, since the procedure is relatively new, we do not have the reassurance that 30 or 40 years down the line; some side effects will be found. In addition, 15% of all couples in the United States are infertile. Many of these are cases of secondary infertility, meaning that they had fertility before and now are unable to conceive again. You may find that in the future you will have a fertility problem. This may happen regardless of whether you become an egg donor or not. However, you must understand that we do not know with complete certainty that your donating eggs will not in some way compromise your future fertility. Because of this uncertainty, the American Society of Reproductive Medicine recommends a maximum of six cycles of oocytes donation per life time.

II. Emotional Side Effects

In addition to the physical effects described above, you may find that the process of donating eggs to another woman may cause you some amount of emotional distress in the future. As mentioned above, the use of hormonal medication may be associated with a variety of emotional swings. You should also

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OOCYTE (EGG) DONOR RISK SHEET

understand that certain religious groups (notably Catholics and Orthodox Jews) do not approve of any form of infertility treatment, including oocyte donation. You may meet with disapproval from individuals who belong to these groups. You should also ask yourself what emotional impact you will feel if a child is born as a result of your egg donation. Will you feel a need to seek this child out years down the line? If you

later find that you are unable to have children, will you regret your decision to donate eggs now or will you rather feel satisfied that at least you had the opportunity to help someone else have a child? These are personal questions that you should answer yourself. You should understand that donating eggs is not exactly like donating blood in that this is not an emotionally neutral issue. Many people have feelings about it, and you may find that you have some long-term emotional feelings about the process.

III. Legal Implications

The process of egg donation is analogous to sperm donation. However egg donation is a relatively new treatment modality. No clear legal standard has been established by case law or statute regarding its use. This means as of now, there is no assurance that any contract or agreement that is entered into with respect to egg donation will necessarily be honored in the future.

With respect to sperm donation, courts have basically upheld the anonymity of an anonymous donor and the legal parenthood of the recipient couple (if the couple is married and wife conceives as a result of artificial insemination by donor sperm the husband becomes the legal father of that child at the moment of conception). Nevertheless, when you donate eggs to another couple, you inadvertently or unknowingly establish a relationship which may make you liable for legal action. No suits have occurred to date on this legal issue, but it is conceivable that at some time in the future a suit will be brought forth regarding custody, visitation, maternity, child support and inheritance.

The decision to become an egg donor is an important one and should not be made lightly. All of us at the Family Fertility Center have chosen to do the kind of work that we do because we know it is needed and because we believe that it is important. Your decision to participate in this type of program should be yours and yours alone.

Initials _____

OOCYTE (EGG) DONOR RISK SHEET

IV. Specific Disclaimer Regarding Future Fertility

Future fertility is always uncertain and we do not know if egg donation affects it adversely. You agree that if you experience any difficulty with achieving pregnancy in the future, you will hold the Family Fertility Center, its staff, and Dr. H Christina Lee harmless from liability.

Your signature below indicates that you have read the preceding list of risks and understand that there may be other risks of which we have not yet thought. You further acknowledge that you accept these risks associated with oocyte donation. You enter into this process of your own free will and that you are not being coerced. You have had an opportunity to ask questions and that all of your questions have been answered to your satisfaction.

Print Name of Donor

Signature of Donor

Date

The foregoing was read, discussed, and signed in my presence, and in my opinion the person signing did so freely, and with full knowledge and understanding.

Print Name of Witness

Signature of Witness

Date

Initials _____

CONSENT TO PARTICIPATE IN ANONYMOUS OOCYTE (EGG) DONATION

I, _____, am over the age of eighteen (18) years, voluntarily offer my service as a donor of oocyte (eggs).

I understand that, if chosen as a donor, the eggs may be utilized in a number of ways including but not limited to the following:

- (1) the eggs may be received by one infertile couple or individual or they may be shared by more than one infertile couple or individual;
- (2) the individual (s) or infertile couple(s) receiving the eggs may be of any age, gender, ethnicity, sexual orientation, marital status, nationality, religion and socioeconomic background;
- (3) all or some of the eggs may be fertilized immediately with sperm;
- (4) all or some of the eggs may be frozen and fertilized at a latter time;
- (5) the sperm used to fertilize the eggs may be produced by or retrieved from the male partner of an infertile couple, a male individual or from a sperm donor chosen by an infertile couple or individual;
- (6) all or some of the embryos resulting from the in-vitro fertilization treatment may be transferred immediately in the fresh cycle;
- (7) all or some of the embryos resulting from the in-vitro fertilization treatment may be frozen and transferred at a later time;
- (8) the embryos will be transferred to the uterus of a (or more than one) female who is (are) the intended parent(s) or they may be transferred to a (or more than one) gestational surrogate(s); and
- (9) the disposition of any excess eggs that are not fertilized and any excess embryos that are not transferred will be determined solely by the couple(s) or individual(s) who is/are the recipient(s) of the eggs. These excess eggs or embryos may be frozen for later use by the same couple(s) or individuals; destroyed and discarded; donated to other couple(s) or individual(s) for reproductive purpose; or donated for research purpose.

The infertile couple(s) or individual(s) receiving the unfertilized eggs from me will be the parent(s) of any child(ren) born as a result of the use of these donated eggs. I accept and agree that I will have neither the rights nor the duties of a parent to any offspring born as a result of my egg donation. Also, I waive any rights to any decision making regarding the use of the donated eggs. This includes but not limited to decision making with respect to:

- (a) how the eggs are used: including the number of couple(s) or individual(s) sharing the entire lot of eggs from a single retrieval; the characteristics of the couple(s) or individual(s) receiving the eggs; the number of eggs to be inseminated; and whether any unused eggs will be discarded, frozen, donated to other couple(s) for reproductive purpose or donated for research purpose
- (b) whom the fertilized eggs (embryos) are transferred to: whether it is the female intended parent or a gestational surrogate;
- (c) when the fertilized eggs (embryos) are transferred: fresh transfer or freeze and transfer at a latter date;
- (d) what will be done with any fertilized eggs (embryos) which are not transferred: whether they will be frozen, discarded, donated to other couple(s) for reproductive purpose, or donated for research purpose; and
- (e) pregnancy termination in the event a pregnancy results from the fertilized eggs.

Initials _____

CONSENT TO PARTICIPATE IN ANONYMOUS OOCYTE (EGG) DONATION

Furthermore, I waive any right to make legal claims against the recipient couple(s) or individual(s), doctor(s) involved in this procedure, and the Family Fertility Center with regard to parental rights including issues of disclosure of information, visiting rights, shared custody, inheritance and maternity.

To the best of my knowledge:

a) I am in good health; I have no communicable disease; and I do not now, nor have I ever suffered from any physical or mental impairment or disability or ailment, except as follows: _____

b) I am not now, nor have I ever been afflicted with human immunodeficiency viruses (HIV), syphilis, gonorrhea, chlamydia, genital herpes, condyloma or any other venereal disease, except as follows:

c) I am not now, nor have I ever engaged in behavior recognized to be risk factors for human immunodeficiency virus (HIV) infection. These include but not limited to blood transfusion prior to 1985, prostitution, intravenous drug use, sexual relationship with a partner or partner(s) known to be HIV infected or engaged in behavior generally recognized to be risk factors for HIV infection.

d) I am not now, nor have I ever had alcoholism, drug addiction, or intravenous drug abuse, except as follows: _____

e) None of my grandparents, parents, brothers, sisters, or children, if any, nor their lineal descendants, have ever been afflicted with emotional illness or any inherited mental or physical disabilities or disease, except as follows: _____

For the purpose of determining whether I am acceptable as a donor of eggs, I consent to a physical examination, including the taking of blood and other body fluids, by the physician(s) and staff at the Family Fertility Center or any other clinical laboratory facilities whom you designate. I understand that **my blood will be tested for the presence of HIV antibodies and illegal drug use**; and that chromosomal and genetic tests will be performed. I understand that detailed health and genetic information about me and my family will be obtained. As part of a screening process, I understand that I may be required to undergo a psychological evaluation by a licensed psychological counselor or a psychiatrist chosen by the Family Fertility Center. I understand that the results of these assessments and tests will be kept on file and will be provided, on request, on an anonymous basis to the recipient of my eggs and/or any resulting offspring.

I understand that at any time during the process relating to the donation of eggs, that with the discretion of the medical team, I may be disqualified as a donor of eggs. I understand that up to the time that the eggs are removed from my ovaries, I may, at any time, withdraw my consent to donation of eggs. However, if I decide to withdraw from the donation before egg retrieval, I will not receive any compensation. Once the eggs are removed from my ovaries, I understand that **I will have no control over the use or disposition of the eggs.**

Initials _____

CONSENT TO PARTICIPATE IN ANONYMOUS OOCYTE (EGG) DONATION

I understand that the procedure for donation of my eggs will include the following:

a) Ovarian stimulation and ovulation triggering

I will administer to myself orally clomiphene citrate, subcutaneously Leuprolide Acetate (Lupron®) or gonadotropin releasing hormone (GnRH) antagonist (Ganirelix® or Cetrotide®), and intramuscularly/subcutaneously human menopausal gonadotropins (Menopur®), subcutaneous recombinant human gonadotropin (Brevelle®, Follistim® or Gonal-F®), and human chorionic gonadotropin (hCG) (Pregnyl®, Novarel® or Ovidrel®) which are fertility drugs to stimulate my ovaries to produce multiple eggs. Side effects of these drugs have been explained to me verbally as well as in writing in the Oocyte (Egg) Donor Risk Sheet.

b) Monitoring

I will undergo serial ultrasound examination and blood tests to determine the proper dosing of fertility drugs and timing of the egg retrieval.

c) Egg retrieval

I will undergo transvaginal ultrasound guided needle aspiration to recover the egg or eggs approximately thirty-six (36) hours after the hCG injection. A needle will be inserted into the ovary to recover the egg or eggs. It will be within the discretion of the physician to determine the number of eggs that will be removed. The procedure and risks have been explained to me verbally as well as in writing in the Oocyte (Egg) Donor Risk Sheet. The procedure is usually performed after sedatives and narcotics are given to me. I understand that I cannot drive myself home after this procedure. It is my responsibility to arrange a ride home.

The medical cost for the treatment of any complication as a result of the oocyte donation process and treatment will be covered, to the extent that is covered, by an insurance policy purchased by the recipient(s) on my behalf. However, financial compensation for any injury and any other consequential damages directly or indirectly arising from the donation of my eggs is not available. I agree that compensation will not be demanded of the physician or staff at the Family Fertility Center. Furthermore, I agree to refrain from bringing legal action of any kind, and refrain from aiding or abetting anyone else in bringing legal action for or on account of any matter or thing which might arise out of my service as a donor of eggs.

Initials _____

FAMILY FERTILITY CENTER

www.familyfertility.com

H. Christina Lee, M.D., J.D., H.C.L.D., F.A.C.O.G.

95 Highland Avenue, #100

Bethlehem, PA 18017

Telephone (610) 868-8600

Fax (610) 868-8700

CONSENT TO PARTICIPATE IN ANONYMOUS OOCYTE (EGG) DONATION

My signature below indicates that all information regarding my present and past health history is truthful. I have read and signed the Oocyte (Egg) Donor Risk Sheet. I fully understand the risks associated with oocyte donation. Furthermore, I have fully reviewed and understand the contents of this consent. I hereby consent to participate in anonymous oocyte (egg) donation and accept the risks associated with it. This consent is freely and voluntarily given by me. I have not relied on any inducements, promises or representations made by the Family Fertility Center or any of its physicians or staff. I have an opportunity to ask questions and my questions have been answered to my satisfaction.

Print Name of Donor

Signature of Donor

Date

The foregoing was read, discussed, and signed in my presence, and in my opinion the person signing did so freely, and with full knowledge and understanding.

Print Name of Witness

Signature of Witness

Date

Initials_____

Anonymous Oocyte (Egg) Donor Questionnaire

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) _____

Initials _____

Medical History

Gynecologic history

Age at first period_____ Interval between periods_____

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

Method of birth control used now and in the past_____

Age at first intercourse_____ Sexual orientation_____

Number of current sexual partner(s)_____

Number of sexual partners since first intercourse_____

Number of current or past sexual partner(s) that are known bisexual_____

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_____

Initials_____

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Medications taken within the last 30 days _____

Drug allergies _____

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

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 participation in 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: _____

Initials _____

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Family History

(If you are adopted, do not complete this section and proceed to page 9)

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: _____

Initials _____

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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: _____

Initials _____

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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: _____

Initials _____

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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: _____

Initials _____

FAMILY FERTILITY CENTER**www.familyfertility.com****H. Christina Lee, M.D., J.D., H.C.L.D., F.A.C.O.G.**

95 Highland Avenue, #100

Bethlehem, PA 18017

Telephone (610) 868-8600

Fax (610) 868-8700

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	

Initials _____

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	
8. Huntington's chorea	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. Breast cancer	yes	no	yes	no	
15. Colon cancer	yes	no	yes	no	
16. Ovarian cancer	yes	no	yes	no	
17. Leukemia or Lymphoma	yes	no	yes	no	
18. Childhood cancer	yes	no	yes	no	
19. High blood pressure	yes	no	yes	no	
20. Diabetes	yes	no	yes	no	
21. High cholesterol	yes	no	yes	no	
22. Heart attack	yes	no	yes	no	
23. Obesity	yes	no	yes	no	
24. Stroke	yes	no	yes	no	
25. Embolism or Thrombophlebitis	yes	no	yes	no	
26. Seizure disorders	yes	no	yes	no	
27. Migraine headache	yes	no	yes	no	

Initials _____

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	
28. Blindness	yes	no	yes	no	
29. Deafness	yes	no	yes	no	
30. Ulcerative colitis	yes	no	yes	no	
31. Crohn's disease	yes	no	yes	no	
32. Thyroid disease	yes	no	yes	no	
33. Rheumatoid Arthritis	yes	no	yes	no	
34. Lupus	yes	no	yes	no	
35. Jaundice	yes	no	yes	no	
36. Hepatitis	yes	no	yes	no	
37. Blood transfusion	yes	no	yes	no	
38. Anemia	yes	no	yes	no	
39. Asthma	yes	no	yes	no	
40. Kidney disease	yes	no	yes	no	
41. Depression	yes	no	yes	no	
42. Schizophrenia	yes	no	yes	no	
43. Drug addiction	yes	no	yes	no	
44. Alcoholism	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	
45. 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	
46. Infertility	yes	no	yes	no	
47. Endometriosis	yes	no	yes	no	
48. Pelvic inflammatory disease	yes	no	yes	no	
49. Ovarian cysts	yes	no	yes	no	
50. Radiation or Chemotherapy	yes	no	yes	no	
51. Hospitalization	yes	no	yes	no	
52. Other medical conditions not listed	_____				

Explanation for any of the conditions above: _____

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I HAVE CAREFULLY READ THE FOREGOING QUESTIONS AND HAVE ANSWERED THEM COMPLETELY AND TRUTHFULLY.

Signature of Oocyte Donor

State of _____

County of _____

Sworn and Subscribed to before me,

Date _____ **20** _____

Signature & Seal of Notary Public

State of _____

My commission expires _____

Initials _____