**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 Telephone (610) 868-8600
Bethlehem, PA 18017 Fax (610) 868-8700



# 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)_____

## 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_____

_____

_____

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_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

## 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:_____

_____

_____

_____

_____

_____

_____

_____

## 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:_____

## 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:_____

_____

_____

_____

## 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:_____

_____

_____

## 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:_____

_____

_____

**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) |
|---|---|---|---|---|---|
| 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 | |

**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) |
|---|---|---|---|---|---|
| 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 Thromboplebitis | yes | no | yes | no | |
| 26. Seizure disorders | yes | no | yes | no | |
| 27. Migraine headache | yes | no | yes | no | |
| 28. Blindness | yes | no | yes | no | |
| 29. Deafness | yes | no | yes | no | |
| 30. Ulcerative colitis | yes | no | yes | no | |

**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) |
|---|---|---|---|---|---|
| 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 | |
| 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 | |

**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) |
|---|---|---|---|---|---|
| 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:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

**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_____**