

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

**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**

Medical illness \_\_\_\_\_

\_\_\_\_\_

Medications taken within the last 30 days \_\_\_\_\_

\_\_\_\_\_

Drug allergies \_\_\_\_\_

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

\_\_\_\_\_

Number of pregnancy sired by you \_\_\_\_\_ Number of living children \_\_\_\_\_

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) \_\_\_\_\_

Hobbies \_\_\_\_\_

\_\_\_\_\_

Reasons for requesting anonymous oocyte (egg) donation \_\_\_\_\_

\_\_\_\_\_

Any specific feature(s) egg donor must have or must not have?

\_\_\_\_\_

\_\_\_\_\_

**IN-VITRO FERTILIZATION WITH DONATED OOCYTES  
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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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

**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: \_\_\_\_\_

**IN-VITRO FERTILIZATION WITH DONATED OOCYTES  
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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 (HUSBAND)**

**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 (HUSBAND)**

**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 Thrombophlebitis	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	

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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	
30. Rheumatoid Arthritis	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	

