FAMILY FERTILITY CENTER **www.familyfertility.com**
95 Highland Avenue, Suite #100
Bethlehem, Pennsylvania 18017
Telephone (610) 868-8600 Fax (610) 868-8700
Ha-Lin Christina Lee, M.D., J.D., F.A.C.O.G., H.C.L.D.
Medical and Laboratory Director

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)_____

FAMILY FERTILITY CENTER **www.familyfertility.com**
95 Highland Avenue, Suite #100
Bethlehem, Pennsylvania 18017
Telephone (610) 868-8600 Fax (610) 868-8700
Ha-Lin Christina Lee, M.D., J.D., F.A.C.O.G., H.C.L.D.
Medical and Laboratory Director

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

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)_____

_____

_____

FAMILY FERTILITY CENTER **www.familyfertility.com**
95 Highland Avenue, Suite #100
Bethlehem, Pennsylvania 18017
Telephone (610) 868-8600 Fax (610) 868-8700
Ha-Lin Christina Lee, M.D., J.D., F.A.C.O.G., H.C.L.D.
Medical and Laboratory Director

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

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_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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

_____

_____

_____

_____

_____

FAMILY FERTILITY CENTER **www.familyfertility.com**
95 Highland Avenue, Suite #100 Ha-Lin Christina Lee, M.D., J.D., F.A.C.O.G., H.C.L.D.
Bethlehem, Pennsylvania 18017 Medical and Laboratory Director
Telephone (610) 868-8600 Fax (610) 868-8700

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

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:_____

_____

_____

_____

_____

_____

_____

95 Highland Avenue, Suite #100
Bethlehem, Pennsylvania 18017
Telephone (610) 868-8600 Fax (610) 868-8700

Ha-Lin Christina Lee, M.D., J.D., F.A.C.O.G., H.C.L.D.
Medical and Laboratory Director

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

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:_____

FAMILY FERTILITY CENTER **www.familyfertility.com**
95 Highland Avenue, Suite #100
Bethlehem, Pennsylvania 18017
Telephone (610) 868-8600 Fax (610) 868-8700
Ha-Lin Christina Lee, M.D., J.D., F.A.C.O.G., H.C.L.D.
Medical and Laboratory Director

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

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 FERTILITY CENTER **www.familyfertility.com**
95 Highland Avenue, Suite #100
Bethlehem, Pennsylvania 18017
Telephone (610) 868-8600 Fax (610) 868-8700
Ha-Lin Christina Lee, M.D., J.D., F.A.C.O.G., H.C.L.D.
Medical and Laboratory Director

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

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 FERTILITY CENTER **www.familyfertility.com**
95 Highland Avenue, Suite #100 Ha-Lin Christina Lee, M.D., J.D., F.A.C.O.G., H.C.L.D.
Bethlehem, Pennsylvania 18017 Medical and Laboratory Director
Telephone (610) 868-8600 Fax (610) 868-8700

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:_____

_____

FAMILY FERTILITY CENTER **www.familyfertility.com**
95 Highland Avenue, Suite #100 Ha-Lin Christina Lee, M.D., J.D., F.A.C.O.G., H.C.L.D.
Bethlehem, Pennsylvania 18017 Medical and Laboratory Director
Telephone (610) 868-8600 Fax (610) 868-8700

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)
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	

FAMILY FERTILITY CENTER **www.familyfertility.com**
95 Highland Avenue, Suite #100 Ha-Lin Christina Lee, M.D., J.D., F.A.C.O.G., H.C.L.D.
Bethlehem, Pennsylvania 18017 Medical and Laboratory Director
Telephone (610) 868-8600 Fax (610) 868-8700

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)
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	

FAMILY FERTILITY CENTER **www.familyfertility.com**
95 Highland Avenue, Suite #100
Bethlehem, Pennsylvania 18017
Telephone (610) 868-8600 Fax (610) 868-8700
Ha-Lin Christina Lee, M.D., J.D., F.A.C.O.G., H.C.L.D.
Medical and Laboratory Director

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)
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	

FAMILY FERTILITY CENTER **www.familyfertility.com**
95 Highland Avenue, Suite #100
Bethlehem, Pennsylvania 18017
Telephone (610) 868-8600 Fax (610) 868-8700
Ha-Lin Christina Lee, M.D., J.D., F.A.C.O.G., H.C.L.D.
Medical and Laboratory Director

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)
44. Radiation or Chemotherapy	yes	no	yes	no	
45. Hospitalization	yes	no	yes	no	

46. Other medical conditions not listed_____

Explanation for any of the conditions above:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____
Signature of Wife or Female Partner Date