



# The Institute for Reproductive Medicine and Science of Saint Barnabas

*An affiliate of the Saint Barnabas Health Care System*

## OVUM DONOR PERSONAL HISTORY

### *Instructions:*

This document will be completed entirely by you and will provide a personal history of yourself that will be given to the ovum recipients. The recipients may some day give this document to any children that may result from your donated egg(s). While not every couple will choose to disclose this information to the child(ren) all parents want to be able to provide accurate medical information. If children are told that they are born through your donation, the information contained within this document may be very important to them for medical and psychological reasons. It is for these reasons that we ask you to answer each question as carefully and thoroughly as you are able.

All information requested is voluntary and will remain anonymous. Any identifying information such as name, social security number, and address will be omitted from the packet given to the recipients. A copy of this history form will be given to the recipients but will exclude identifying information and the supplementary questionnaire.

Donating your eggs is a caring and generous act, given in spite of some risk and discomfort. Those couples who receive eggs feel deep gratitude and respect for the gift you give so willingly. Naturally, most recipients and their children want to know as much as possible about the medical history of the woman who made their family possible. Thank you for letting them know you a little better.

*The Institute for Reproductive Medicine Science of Saint Barnabas Medical Center*

I certify that the following answers are truthful and accurate to the best of my knowledge and that I have included all pertinent information.

Signed: \_\_\_\_\_

### **INTERNAL USE**

DATE: \_\_\_\_\_

CALLED: \_\_\_\_\_

CONSULTATION: \_\_\_\_\_

LETTER: \_\_\_\_\_

# Donor History Form

Date: \_\_\_\_\_ How did you hear about this program?: \_\_\_\_\_  
Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Address: \_\_\_\_\_ Insurance Co.: \_\_\_\_\_  
\_\_\_\_\_ Insurance #: \_\_\_\_\_  
Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_  
Best Time to call: \_\_\_\_\_

## PHYSICAL CHARACTERISTICS

Date of Birth: \_\_\_\_\_  
Height: \_\_\_\_\_ Weight: at 21? \_\_\_\_\_ Current Wt.: \_\_\_\_\_  
Eye Color: \_\_\_\_\_ Blood Type: \_\_\_\_\_  
Body Frame: \_\_\_\_\_ small \_\_\_\_\_ medium \_\_\_\_\_ large  
Natural Hair Color: \_\_\_\_\_  
Hair (check all that apply)  
\_\_\_\_\_ curly/wavy (naturally) \_\_\_\_\_ curly/wavy (processed)  
\_\_\_\_\_ straight (naturally) \_\_\_\_\_ straight (processed)  
\_\_\_\_\_ average texture \_\_\_\_\_ thin texture  
\_\_\_\_\_ premature graying (at what age \_\_\_\_\_)  
Skin Color \_\_\_\_\_ fair \_\_\_\_\_ medium \_\_\_\_\_ olive \_\_\_\_\_ lt. brown \_\_\_\_\_ dk. brown  
\_\_\_\_\_ ebony \_\_\_\_\_ freckled \_\_\_\_\_ rosy \_\_\_\_\_ birthmarks \_\_\_\_\_

## PERSONAL CHARACTERISTICS

Race/Ethnic Origin: \_\_\_\_\_  
Mother \_\_\_\_\_ Father \_\_\_\_\_  
Right Handed \_\_\_\_\_ Left Handed \_\_\_\_\_ Ambidextrous \_\_\_\_\_  
Marital Status: \_\_\_\_\_ single \_\_\_\_\_ married \_\_\_\_\_ separated \_\_\_\_\_ divorced \_\_\_\_\_ widowed  
Duration of relationship with partner: \_\_\_\_\_  
Education:  
\_\_\_\_\_ completed grade school  
\_\_\_\_\_ completed high school (GPA \_\_\_\_\_)  
\_\_\_\_\_ currently in college, pursuing degree in \_\_\_\_\_ (GPA \_\_\_\_\_)  
\_\_\_\_\_ completed college, degree in \_\_\_\_\_ (GPA \_\_\_\_\_)  
\_\_\_\_\_ currently pursuing advanced degree in \_\_\_\_\_  
\_\_\_\_\_ advanced degree in \_\_\_\_\_

Testing Scores: SAT: \_\_\_\_\_ GRE: \_\_\_\_\_ MAT: \_\_\_\_\_ LSAT: \_\_\_\_\_ MCAT: \_\_\_\_\_

## PERSONAL HEALTH HISTORY

VISION (without corrective lenses):  
\_\_\_\_\_ Poor \_\_\_\_\_ Fair \_\_\_\_\_ Good \_\_\_\_\_ Excellent  
Do you wear corrective lenses? \_\_\_\_\_ Yes \_\_\_\_\_ No  
For what problem(s)? \_\_\_\_\_ Nearsighted \_\_\_\_\_ Farsighted  
\_\_\_\_\_ Other (explain) \_\_\_\_\_  
Age first wore glasses \_\_\_\_\_

**PERSONAL HEALTH HISTORY, CONTINUED**

HEARING (without corrective aids):

\_\_\_\_\_ Poor \_\_\_\_\_ Fair \_\_\_\_\_ Good \_\_\_\_\_ Excellent

Do you wear corrective aids? \_\_\_\_\_ Yes \_\_\_\_\_ No

For what problem(s)? \_\_\_\_\_

TEETH: \_\_\_\_\_ Poor \_\_\_\_\_ Fair \_\_\_\_\_ Good \_\_\_\_\_ Excellent

Any abnormalities? \_\_\_\_\_ Orthodontic work \_\_\_\_\_ At what age \_\_\_\_\_

Do you smoke cigarettes? \_\_\_\_\_ Yes \_\_\_\_\_ No

If Yes, how many packs per day? \_\_\_\_\_ # years \_\_\_\_\_

DIET: \_\_\_\_\_ Vegetarian \_\_\_\_\_ Non-Vegetarian

Diet (nutrition): \_\_\_\_\_ Poor \_\_\_\_\_ Average \_\_\_\_\_ Good

Describe your likes & dislikes \_\_\_\_\_

ALLERGIES: \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, are they to: \_\_\_\_\_ Food(s) \_\_\_\_\_ Medication(s)

\_\_\_\_\_ Environmental \_\_\_\_\_ Other

For each allergy, describe specific substance and reaction(s) and age first noticed & treatment (if any):

Substance	Age	Reaction(s)	Treatment
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List any allergies you have outgrown: \_\_\_\_\_

\_\_\_\_\_

Have you had any surgery(ies):

List any surgery(ies) you have had & dates of surgery

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

Have you had any hospitalization(s) not mentioned above: \_\_\_\_\_

\_\_\_\_\_

Have you had a blood transfusion? \_\_\_\_\_

How long ago? \_\_\_\_\_

Have you had major radiation or X-Ray exposure? \_\_\_\_\_ Yes \_\_\_\_\_ No

If Yes, explain: \_\_\_\_\_

\_\_\_\_\_

## PERSONAL HEALTH HISTORY, *CONTINUED*

Number of sex partners within the last 6 months: \_\_\_\_\_

If applicable, my sex partner has had other sex partners in the last 6 months: \_\_\_\_\_ Yes \_\_\_\_\_ No

\_\_\_\_\_  
Signature

Method of contraception used: \_\_\_\_\_ How Long \_\_\_\_\_

Have you or any of your sexual partners had:

	Self	Partner	When	How Often
NSU (non-specific urethritis)				
Syphilis				
Gonorrhea				
Chlamydia				
Venereal Warts				
Herpes				
Hepatitis				
Use of IV (intravenous) drugs				
Other sexually transmitted diseases				

## REPRODUCTIVE HISTORY

Age at first period: \_\_\_\_\_ Days each cycle \_\_\_\_\_ Are periods regular/irregular \_\_\_\_\_

Any treatment needed for menstrual problems? \_\_\_\_\_ Birth Control Pills \_\_\_\_\_ Provera \_\_\_\_\_

Did you ever have trouble conceiving? Yes \_\_\_\_\_ No \_\_\_\_\_

List # of pregnancies & outcome:

Year	C-Section/Vaginal Delivery Healthy Baby	Miscarriage	Ectopic	Termination
1.				
2.				
3.				
4.				

Any complications: \_\_\_\_\_

## PERSONAL HEALTH: WORK HISTORY / EXPOSURE

List jobs held in the past five years and exposure as noted.

Job Title	Dates of Employment		Exposure to chemicals, drugs, fumes, pesticides, asbestos, lead, gases (describe)
	Year Began	Year Ended	

## PERSONAL FAMILY HISTORY

How many blood siblings are in your immediate family (including yourself)? \_\_\_\_\_

\_\_\_\_\_ # of males          \_\_\_\_\_ # of females

**Please describe your family members by the following characteristics:**

*\*The following abbreviations in the table are:*

MGM = Maternal Grandmother

MGF = Maternal Grandfather

PGM = Paternal Grandmother

PGF = Paternal Grandfather

RELATION	EYE COLOR	HAIR COLOR	HEIGHT/WEIGHT	COMPLEXION	AGE IF LIVING	AGE AT DEATH	CAUSE OF DEATH
Mother							
Father							
MGM*							
MGF*							
PGM*							
PGF*							
Brothers	1.	1.	1.	1.	1.	1.	1.
	2.	2.	2.	2.	2.	2.	2.
	3.	3.	3.	3.	3.	3.	3.
	4.	4.	4.	4.	4.	4.	4.
Sisters	1.	1.	1.	1.	1.	1.	1.
	2.	2.	2.	2.	2.	2.	2.
	3.	3.	3.	3.	3.	3.	3.
	4.	4.	4.	4.	4.	4.	4.

Are you adopted?    \_\_\_\_\_ Yes    \_\_\_\_\_ No

Have twins or multiple births occurred in your family?    \_\_\_\_\_ Yes    \_\_\_\_\_ No

Are there any known genetic diseases or conditions that run in your family? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please identify: \_\_\_\_\_

Have you ever been tested as a carrier of:

Tay-Sach's disease (if Jewish ancestry) \_\_\_\_\_ carrier \_\_\_\_\_ non carrier \_\_\_\_\_ unknown  
 Sickle cell disease (if Afro American) \_\_\_\_\_ carrier \_\_\_\_\_ non carrier \_\_\_\_\_ unknown  
 Cystic fibrosis (if Caucasian): \_\_\_\_\_ carrier \_\_\_\_\_ non carrier \_\_\_\_\_ unknown  
 Thalassemia (if Italian-Greek) \_\_\_\_\_ carrier \_\_\_\_\_ non carrier \_\_\_\_\_ unknown

Carefully review the following list of medical problems and identify any which are present in the listed family members.

	You	Mother	Father	Sibling	MGM/MGF PGM/PGF	Aunt / Uncle	Cousin
<b>HEART</b>							
stroke							
heart attack							
heart disease							
1. from birth							
2. other							
hardening of the arteries							
high blood pressure							
high cholesterol level							
<b>BLOOD</b>							
anemia							
sickle-cell anemia							
hemophilia or other bleeding disorder							
leukemia							
HIV virus							
lymphoma							
other blood disorder							
<b>RESPIRATORY</b>							
hayfever/ environmental allergy							
asthma							
emphysema							
tuberculosis							
lung cancer							
pneumonia							
other lung disease							
<b>GASTRO-INTESTINAL</b>							
ulcer of stomach or duodenum							
gall stones							
hepatitis A (infectious)							
hepatitis B (serum)							
cirrhosis							
other liver disease							
colon cancer							
ulcerative colitis							
Crohn's disease							
cystic fibrosis							
intestinal cancer							

	You	Mother	Father	Sibling	MGM/MGF PGM/PGF	Aunt / Uncle	Cousin
<b>GASTRO-INTESTINAL</b>							
developmental disorders of the stomach and intestine							
pyloric stenosis							
rectal disorder							
any other cancer/problem of digestive system							
<b>METABOLIC/ENDOCRINE</b>							
diabetes mellitus							
hypoglycemia							
thyroid cancer							
thyroid disease							
goiter							
adrenal dysfunction or disorder							
hyperactivity							
<b>URINARY</b>							
kidney disease							
other disease of urinary tract (urethra, bladder, ureter)							
<b>GENITAL/REPRODUCTIVE</b>							
undescended testicle							
hermaphroditism/ ambiguous genitals							
hypospadias							
prostate cancer							
testicular cancer							
uterine fibroids							
ovarian cysts							
cancer of cervix, ovaries or uterus							
<b>REPRODUCTIVE OUTCOMES</b>							
2 or more miscarriages							
stillborn							
death of a newborn infant							
neonatal jaundice							
<b>NEUROLOGICAL</b>							
migraines							
mental retardation							
Down's Syndrome							
senility before age 50							
Multiple Sclerosis							
Cerebral Palsy							
epilepsy / seizures							
hydrocephalus							
spina bifida / neural tube effect							

	You	Mother	Father	Sibling	MGM/MGF PGM/PGF	Aunt / Uncle	Cousin
<b>NEUROLOGICAL</b>							
Huntington's disease							
Gaucher's disease							
Wilson's disease							
Parkinson's disease							
paraplegia							
Tourette's Syndrome							
scoliosis							
other diseases of nervous system							
<b>MENTAL HEALTH</b>							
schizophrenia							
manic depressive or bipolar disorder							
other mental health disorder requiring hospitalization							
<b>MUSCLE / BONE / JOINTS</b>							
muscular dystrophy							
other chronic muscle disease							
loss of muscle coordination							
lupus							
osteoporosis							
dwarfism							
arthritis							
gout							
Myasthenia Gravis							
<b>SIGHT/SOUND/SMELL</b>							
Deafness before age 60							
deformity of the ear							
cataracts before age 50							
blindness							
color blindness							
glaucoma							
deviated septum							
any other sight/sound/smell disorder							
<b>SKIN</b>							
acne							
eczema							
skin cancer							
pigmentation disorders							
Neurofibromatosis							
other disorders of the skin							
<b>CONGENITAL ANOMALIES</b>							
cleft lip/palate							
congenital hip problems							
club feet							
Other							
<b>THERMOSOMAL/ABNORMALITIES</b>							
Turner Syndrome							

	You	Mother	Father	Sibling	MGM/MGF PGM/PGF	Aunt / Uncle	Cousin
<b>THERMOSOMAL/ABNORMALITIES</b>							
Kleinfelter Syndrome							
<b>CONGENITAL ANOMALIES</b>							
Cri du chat Syndrome							
Trisomy 18							
Trisomy 13							
Fragile X Syndrome							
Other							
<b>OTHER</b>							
alcoholism							
drug abuse, misuse or addiction							
breast cancer/lumps/cysts							
any other cancer not mentioned							
any other condition not mentioned							

Explain: \_\_\_\_\_

What are the three most important characteristics to you that the recipient parents possess (e.g., religion, personality, appearance):

What do you hope to achieve by volunteering in the egg donor program (e.g., emotionally, financially) \_\_\_\_\_

What message would you like passed on to the recipient of your eggs/their offspring? \_\_\_\_\_

What helped you decide to become an egg donor? \_\_\_\_\_

PLEASE ATTACH A RECENT CLEAR, COLOR PHOTOGRAPH OF YOURSELF  
(For internal use only)



**YOUR CHILDHOOD:**

Describe yourself as a child (e.g., personality, health, happiness, etc.).

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What was it like growing up in your family?

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What religion did you belong to as a child?

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What is your earliest memory as a child?

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What problems did you have as a child (e.g., health, allergies, learning, social, etc.)?

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**WHEN I WAS A CHILD:**

My favorite thing to do was: \_\_\_\_\_

At home I was expected to: \_\_\_\_\_

My parents were strict about: \_\_\_\_\_

My parents taught me to value: \_\_\_\_\_

What I loved most about my father was: \_\_\_\_\_

What I loved most about my mother was: \_\_\_\_\_

My favorite relatives were: \_\_\_\_\_

I loved to visit: \_\_\_\_\_

In comparison to others I was: \_\_\_\_\_

**YOUR TEENAGE YEARS:**

Describe yourself as a teenager:

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Describe your achievements:

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Did you do poorly in anything?

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Did you have any problems as teenager (e.g., health, acne, social, educational, etc.)?

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**WHEN I WAS A TEENAGER:**

My favorite subject(s) was: \_\_\_\_\_

My worst subject(s) was: \_\_\_\_\_

The activities I was involved in were: \_\_\_\_\_

The most important influence on me was: \_\_\_\_\_

In comparison to others I was: \_\_\_\_\_

I liked to go: \_\_\_\_\_

I traveled to: \_\_\_\_\_

I was talented as: \_\_\_\_\_

My ambition was to: \_\_\_\_\_

**ADULTHOOD EDUCATION:**

Years completed: \_\_\_\_\_

Colleges attended: \_\_\_\_\_

Major subject(s) studied: \_\_\_\_\_

Degrees earned or pursuing now: \_\_\_\_\_

**RELIGION:**

Are you an Atheist \_\_\_\_\_ Agnostic \_\_\_\_\_

How religious are you now? Very \_\_\_\_\_ Moderately \_\_\_\_\_

Occasionally attend \_\_\_\_\_ Not at all \_\_\_\_\_

Religion born into: \_\_\_\_\_ Religion practiced: \_\_\_\_\_

**ACTIVITIES:**

How athletic are you?

Very Athletic \_\_\_\_\_ Average \_\_\_\_\_ Not Athletic \_\_\_\_\_

Do you exercise: Regularly \_\_\_\_\_ Occasionally \_\_\_\_\_ Rarely \_\_\_\_\_

What types of exercise or physical activities do you enjoy?

\_\_\_\_\_

\_\_\_\_\_

Do you have musical ability?

\_\_\_\_\_

What other skills or talents do you have (e.g., painting, writing, reading, ability at games, crossword puzzles, handicraft, etc.)? Please describe in detail.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Describe any special interests you have (e.g., Girl Scout leader, fund raiser, pet owner, etc.).

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What physical, artistic, intellectual or social abilities do you feel best about?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What have been your achievements as an adult?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# DONOR SCREENING QUESTIONNAIRE

This questionnaire assesses potential health risks in donors and will assist the ovum donor team in processing your application. Please answer as completely as possible. Your answers are confidential and will not be disclosed with identifying information without your permission, unless required by law.

1. In the last five years, have you engaged in sexual activity with a man who has engaged in homosexual or bisexual behavior?  
\_\_\_\_\_
  
2. In the last five years, have you injected drugs in yourself for non-medical reasons?  
\_\_\_\_\_
  
3. Have you had sex in exchange for money or drugs in the preceding five years?  
\_\_\_\_\_
  
4. Have you had sex in the preceding 12 months with any person described in the 4 items above or any person suspected of having HIV, hepatitis B virus, or hepatitis C virus infection? \_\_\_\_\_
  
5. Have you been exposed within the last 12 months to known or suspected HIV, hepatitis B, and/or hepatitis C infected blood through percutaneous inoculation (e.g., needlestick) or through contact with an open wound, non-intact skin, or mucous membrane? \_\_\_\_\_
  
6. Have you been incarcerated for more than 72 consecutive hours during the previous 12 months? \_\_\_\_\_
  
7. Do you have a current or past diagnosis of viral hepatitis (except for a past diagnosis of cytomegalovirus or Epstein-Barr virus hepatitis, documented hepatitis A, or viral hepatitis occurring before the age of 11 years)?  
\_\_\_\_\_
  
8. Have you had close contact\* with another person having viral hepatitis within 12 months preceding donation? \_\_\_\_\_
  
9. In the last 12 months have you undergone tattooing, acupuncture, ear or body piercing? If so, when? \_\_\_\_\_

10. Do you have a diagnosis of Creutzfeldt-Jakob disease (Mad Cow disease) or known family history (blood relative) of a person with Creutzfeldt-Jakob disease?

\_\_\_\_\_

11. Do you have a history of dementia or degenerative neurologic disorders of viral or unknown etiology? \_\_\_\_\_

12. Have you ever received injections of human pituitary-derived growth hormone (pit-hGH)? \_\_\_\_\_

13. Have you ever received transplants of human tissue (i.e. - bone marrow, kidney, etc.)? \_\_\_\_\_

If yes, please explain \_\_\_\_\_

14. How many sexual partners have you had in your lifetime? \_\_\_\_\_

In the last year? \_\_\_\_\_ In the last 6 months? \_\_\_\_\_

\*Close contact" is defined as sexual contact or contact resulting in exchange of body fluids and includes living in the same household, where sharing kitchen and toilet facilities occurs regularly.

I have answered the above questions to the best of my ability as accurately as possible.

\_\_\_\_\_  
Donor candidate                      Date

\_\_\_\_\_  
Witness                                      Date

**SUPPLEMENTARY QUESTIONNAIRE (Not to be given to recipients)**

**I certify that the following answers are truthful and accurate to the best of my knowledge and that I have included all pertinent information.**

Signed: \_\_\_\_\_

**PSYCHIATRIC AND COUNSELING HISTORY**

1. Have you ever been hospitalized for substance abuse, depression, or any other psychological problem?

No  Yes (If yes, please list dates and diagnosis):

Dates	Diagnosis/Reason

2. Have you ever been in counseling or psychotherapy?

No  Yes (If yes, please list dates and diagnosis or reason):

Dates	Diagnosis/Reason

3. Have you ever had psychotropic medications (e.g. antidepressants, anxiolytics/anti-anxiety, antipsychotic, etc) by any physician?

No  Yes (Please give dates):

4. Please list year and location of any body tattoos or piercings:

\_\_\_\_\_

## PERSONAL HISTORY AND OPINIONS

5. Have you ever been arrested or convicted of any crime (other than minor traffic offenses):

No                       Yes

6. Have you ever had children removed from your custody:

No                       Yes (Explain: \_\_\_\_\_)

7. Are you currently involved in any lawsuits?  No  Yes

(If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

8. Do you or have you used any of the following:?

No                       Yes (If yes, please list dates and diagnosis or reason):

Substance	Years or Dates	Frequency
Alcohol		
Marijuana		
Cocaine		
Tobacco		
Caffeine		
Prescription Drugs		
Other		

9. Do you presently have any health problems? (If yes, please describe:)


10. What do you think is the biggest stress in your life at present?


11. Describe the couple for whom you would like to donate.


12. What do you anticipate your feelings and reactions will be to becoming an egg donor?

What difficulties do you anticipate?


13. Have you had any personal experience with a traumatic event?

Event	Yes or No
Serious Accident	
Rape or sexual assault	
Incest, sexual or physical abuse	
Victim of any crime	
Other	

14. Have you been a donor before? If yes, indicate what type (e.g. ovum, blood, bone marrow, etc.)

\_\_\_\_\_

At this time the policy of this program is total anonymity. Should the disclosure policy change, would you like to know if pregnancy occurred?

No                       Yes                       Uncertain \_\_\_\_\_

At present participants in this program are strictly anonymous. We would like your opinion on the following questions.

Would you be willing to: (check all that apply)

- Participate in annual follow-up for medical update and to explore reactions to ovum donation.
- Speak by telephone with the recipients but not meet in person
- Share non-identifying letters
- Share a current picture of yourself
- Meet in person with the recipients
- Exchange identifying information

Would you like to meet any children who may result from your egg donation once they reach 18 years of age?

Please check all that apply:

- Would definitely not like to meet
- Would like to meet the child(ren)
- Would like to share picture with child(ren)
- Would not object if child(ren) wished to meet but would not seek a meeting

Would you consider donating your eggs on more than one occasion?

- No                       Yes (If yes, how many times do you anticipate donating your eggs: \_\_\_\_\_)

Would you consider updating your records with any pertinent medical information that might impact the off spring from your donation?

- No                       Yes