OVERLAKE REPRODUCTIVE HEALTH

DONOR INTAKE / REGISTRATION FORM

PLEASE PRINT

CONTACT INFROMATION:

NAME: _____ DOB: _____ AGE: _____
DRIVER'S LICENSE # _____ MARITAL STATUS: _____
ADDRESS: _____
CITY/STATE: _____ ZIP:_____
HOME PHONE: (_____)_____ CELL PHONE: (____)_____
EMAIL: _____
CURRENT EMPLOYER: _____ JOB TITLE: _____
OCCUPATION: _____ WORK PHONE: (_____)_____

PERSONAL HEATH INFORMATION:

PRIMARY CARE PHYSICIAN: _____ OBGYN PHYSICIAN: _____
DATE OF LAST PHYISICAL: _____ RESULTS: _____
DATE OF LAST PAP SMEAR: _____ RESULTS: _____
ARE YOU ON BIRTH CONTROL?_____ IF YES, CHECK WHICH APPLIES

☐ CONTRACEPTIVE INJECTION (DEPO-PROVERA) (IF YES, DATE OF LAST INJECTION_____)

☐ ORAL PILL ☐ NUVA RING ☐ CONTRACEPTIVE IMPLANT (NORPLANT) ☐ IUD

(PLEASE NOTE THAT IF YOU ARE CHOSEN TO BECOME A DONOR IT WILL BE YOUR RESPONIBILITY TO HAVE IUD REPLACED)

DO YOU HAVE REGULAR PERIODS? _____
IF NO, INDICATE HOW MANY DAYS BETWEEN PERIODS: _____
HAVE YOU EVER BEEN PREGNANT? _____
IF YES, # LIVE BIRTHS: _____
HAVE YOU EVER BEEN A DONOR BEFORE? _____ # OF CYCLES:
IF YES, PLEASE INDICATE CLINIC INFORMATION: _____
_____

(PLEASE SIGN RECORDS RELEASE FORM SO WE MAY OBTAIN YOUR LAST CYCLE/ / CLINICAL INFORMATION)

DRUG ALLERIGES?_____ LATEX / FOOD ALLERGIES? _____

EMERGENCY INFORMATION: Person to contact in case of emergency, not living at the above address.
NAME: _____
RELATIONSHIP TO YOU:_____
ADDRESS: _____
CITY/STATE: _____ ZIP:_____
PHONE: (_____)_____

BY SIGNING BELOW I AM STATING THAT THE ABOVE INFORMATION IS CORRECT TO MY KNOWLEDGE AND IT IS MY RESPONISABILITY TO KEEP OVERLAKE REPRODUCTIVE HEALTH WITH MY CURRENT CONTACT INFORMATION. I ACKNOWLEDGE THAT WITHOUT CURRENT INFORMATION I MAY NOT BE CONTACTED AND THEREFORE MAY NOT BE CHOSEN BY A POTENTIAL RECIEPENT.

DONOR SIGNATURE _____ DATE _____

Dates Reviewed & Updated: _____ _____ _____ _____ _____

Donor # (clinic use only) ☐

Rev 5/13

Overlake Reproductive Health

ETHNICITY: Your ethnic origin/where your ancestors are originally from. Be specific (such as French, Chinese, Ashkenzi Jewish, Scottish, Asian Indian, Persian **NOTE: "White" or "Caucasian" is NOT specific enough**

What is your ethnicity:

What is the ethnicity of your mother? Your father?

Are you of Caucasian ancestry?

If yes, have you been tested as a carrier of Cystic Fibrosis? if tested, the results:

Are you of French Canadian ancestry?

If yes, have you been tested for Tay Sachs disease? If tested, the results:

Are you of Jewish Ancestry?

If yes (info at www.jewishgeneticscenter.org/what/), have you been tested as a carrier of the following:

Bloom Syndrome? Dysautonomia ? Canavan's disease?

Fanconi Anemia? Gaucher's disease? Tay Sachs disease?

Nieman-Pick?

Are you of Black Ancestry? If yes, have you been tested for Sickle Cell disease?

Results:

Are you of Mediterranean (Greek or Italian) ancestry?

Are you of Caribbean, Mexican, or Central American ancestry?

Are you of Middle Eastern ancestry? Are you of Asian ancestry?

If yes to any of the above 4 questions, have you been tested as a carrier of Thalassemia?

Results:

PERSONAL CHARACTERISTICS

Height Weight (lbs) Eye color Hair color

Hair type Skin color

Body type/bone structure Religion born into:

Education (check one) ☐ Completed grade school ☐ Completed high school or equivalent

☐ Currently pursuing a degree, please list

☐ Completed college degrees, please list

Have you ever been convicted of a felony?

If yes, list all convictions, sentences:

Were you born with any type of birth defect or condition requiring surgery in the first five years of life?

Do you wear glasses? How is your vision without glasses?

Estimate your vision without glasses 20/ What type of vision problems do you have

How many fillings do you have?

Do you have any crowns, bridges, other extensive dental work?

If yes, please describe

Do you have any hearing loss? If yes, please describe

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In the past six months, have you been exposed to any of the following in your living environment or while involved in hobbies or extra-curricular activities?

Exposure	When	How Often
☐ Toxic chemicals		
☐ Lawn/Garden Sprays		
☐ Fumes/exhaust		
☐ Flea powders/sprays		
☐ Asbestos		

I. FERTILITY HISTORY:

A-1 FEMALE: (Menstrual and Pregnancy History)

Have you ever been told you are infertile? Do you use birth control?

Total # of pregnacies:

Please list all pregnancies (include all miscarriages, abortions, tubals, etc)

Date Pregnancy Ended or Delivered	Length of Pregnancy	How long to conceive	Result	Infertility Therapy?
1.	Wks			
2.	Wks			
3.	Wks			
4.	Wks			

Were there any complications or problems during, including high blood pressure, preeclampsia, intrauterine growth retardation, or gestational diabetes?

Explain: 1.
2.
3.

Did you require any of the following procedures? if yes please indicate in the box which pregnancies:

C-section Surgery

Blood transfusion Antibiotics

D & C Other

Explain: 1.
2.
3.

Age when you first noticed: Breast development years old Pubic hair years old Underarm hair: years old

Age at first period: years old. Date of the first day of your last period

If your menstrual cycles are regular, what is the usual number of days from the first day of one period to the first day of the next

How many days does your menstrual flow last? Do you consider your menstrual flow abnormal?

If yes, how?

Do you have severe cramping or pelvic pain with your periods?

Do you have pelvic pain between periods? (If it is a significant problem, please complete pelvic pain questionnaire)

Do you need medication to bring on a period? Do you spot or bleed between periods?

Do you have premenstrual symptoms other than cramps? Do you have pain with intercourse?

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Are your periods now, or have they ever been irregular or unpredictable?

If yes: 1. When

2. Average # of periods in a year

3. Shortest time in between periods

4. Longest time spent without menstruating

Do you have acne or oily skin? Do you have a breast discharge?

Are you currently breast feeding?

Do you have extra body hair? If yes, where?

What has been your maximum weight? When?

What has been your minimum adult weight? When?

Have you ever had a sudden weight change? If yes, when?

Do you feel that you are underweight? Do you feel that you are overweight?

How many meals do you usually eat per day?

Do you follow a particular food diet or have any special dietary habits?

Have you ever been diagnosed with an eating disorder, such as anorexia or bulemia?

Have you ever used self-induced vomiting to control overeating?

Do you regularly participate in any vigorous exercise?

What: Number of hours a week Number of miles a week

Contraceptive History

What kind of contraceptives have you used, if any?

☐ IUD (ParaGard®, Mirena) ☐ Pills ☐ Condoms ☐ Nuvaring® ☐ Patch (Ortho Evra®)

☐ Contraceptive Implants (Norplant) ☐ Injectable contraception (Depo-Provera(, Lunelle(, etc)

☐ Other ☐ None

Please list contraceptives that you have used in the past, starting with what you currently use

Current contraceptive: Name From

Prior contraceptives: Name From To

Name From To

Name From To

Have you or your doctor ever noted any problems with your contraceptive use?

Explain

Have you ever stopped using a contraceptive because of a problem?

Explain

Were there any problems with your cycles after stopping the contraceptive use?

Explain

If you have ever used an IUD, did you note any problems? If yes, what were they?

Was it removed because of a problem? Explain:

Have you had tubal sterilization procedure (tubes tied)? If yes, when?

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If yes, have you had a tubal reversal (tubes untied)? when?

If you have ever used an IUD, did you note any problems? If yes, what were they?

Was it removed because of a problem? Explain:

Have you had tubal sterilization procedure (tubes tied)? If yes, when?

If yes, have you had a tubal reversal (tubes untied)? when?

A-3 FEMALE: (Uterine, Tubal, Pelvic)

Please mark if, and when, you have/had any of the following sexually transmitted diseases or pelvic infections?

☐ Chlamydia Date ☐ Gonorrhea Date ☐ HIV/AIDS Date

☐ Syphilis Date ☐ Hepatitis Date

Have you had your appendix removed? Why?

Did your mother take any hormones when she was pregnant with you?

Have you ever had a D&C for an abortion, to end a miscarriage, following childbirth, or for abnormal bleeding?

Explain:

Have you ever had any of the following? If no, skip to the next question.

Procedure	Dates	Results
Laparoscopy:		
Tubal Surgery:		
Other Pelvic Surgery:		
Abdominal Surgery:		

Have you ever been noted to have or been treated for endometriosis?

Current Treatment:

Prior Treatment:

Have you ever taken any of the following medications to induce ovulation or normalize your cycle? (mark)

☐ Clomid ☐ Seropohene ☐ Parlodel ☐ Follistim ☐ HCG

☐ Letrozole ☐ Progesterone ☐ Bravelle ☐ Gonal-F ☐ GNRH

☐ Prednisone ☐ Lupron ☐ Other

Dates	Medication	Dose	Results	Comments

III. FEMALE MEDICAL HISTORY:

Do you have or have you ever had (circle all that apply):

☐ Rheumatic fever ☐ Gallbladder problems ☐ Seizures ☐ Neurological problems

☐ Scarlet fever ☐ High blood pressure ☐ Epilepsy ☐ Appendicitis

☐ Tuberculosis ☐ Liver problems ☐ Dizziness ☐ Loss of balance

☐ Hepatitis ☐ Chronic headaches ☐ Ulcers ☐ Vaginitis

☐ Pelvic infection ☐ Colitis ☐ Breast problems ☐ Pneumonia

Donor # (clinic use only)

☐ Heart murmur ☐ Kidney infection ☐ Parasites ☐ Breast discharge
☐ Chicken pox ☐ Anemia ☐ Ovarian cysts ☐ Heart disease
☐ Thyroid problems ☐ Arthritis ☐ Cancer ☐ Breast lump
☐ Other

Comments

Pap Smear History

When was your last pap smear? (month/year) / Result

When was your last abnormal pap smear? / ☐ Not applicable

Have you undergone any procedures as a result of an abnormal pap smear?

If yes, what procedure?

Breast Screening History

Have you ever had a mammogram? If yes, when /

Result: ☐ Normal ☐ Abnormal - Explain

Have you ever undergone surgery?

Date	Type	Hospital

Were there complications? Were there anesthesia problems?

Were there bleeding problems?

Comments:

Are you allergic to any medication, drugs, foods, metals, other?

Have you ever had therapy with a mental health professional?

If yes, when and why?

Have you ever been hospitalized for psychiatric reasons?

If yes, when and what were the circumstances?

Have you ever been hospitalized for reasons other than those already described?

If yes, when and for what reason?

Do you regularly take medications?

1. Over the counter (list)
2. Prescriptions (list)
3. Currently taking (list)

Donor # (clinic use only)

Do you use or have you ever used:

1. Alcohol ☐ # of glasses per week Beer ☐ Cocktails ☐ Wine ☐
2. Cigarettes, presently ☐ Prior use ☐ # packs per day ☐ # of years ☐
3. Illicit or recreational drugs (specify) ☐

IV. REVIEW OF SYSTEMS:

General:

- ☐ Recent weight gain or loss
- ☐ Anorexia/Bulimia
- ☐ Lack of energy
- ☐ Fever/chills
- ☐ Other
- ☐ None

Head, Eyes, Ears, Nose and Throat:

- ☐ Dizziness ☐ Chronic nasal congestion
- ☐ Headaches ☐ Loss of sense of smell
- ☐ Blurred Vision
- ☐ Ringing ears
- ☐ Hearing loss/deafness
- ☐ Other
- ☐ None

Respiratory:

- ☐ Shortness of breath
- ☐ Asthma ☐ Bronchitis
- ☐ Pneumonia
- ☐ Bloody cough
- ☐ Tuberculosis
- ☐ Other
- ☐ None

Endocrine/Hormonal:

- ☐ Thyroid gland problems
- ☐ Rapid weight gain or loss
- ☐ Excessive hunger/thirst
- ☐ Temperature intolerance- hot flashes or feeling cold
- ☐ Diabetes ☐ Hair loss
- ☐ Other
- ☐ None

Breasts:

- ☐ Discharge clear? ☐ bloody? ☐ milky? ☐
- ☐ Lumps ☐ Reduction
- ☐ Abnormal mammogram
- ☐ Augmentation/Breast implants
  - ☐ Saline? ☐ Silicon?
- ☐ Pain ☐ Cancer
- ☐ Other
- ☐ None

Neurological Problems:

- ☐ /eakness/Loss of balance
- ☐ Numbness ☐ Memory loss
- ☐ Headaches
- ☐ Migraine headaches
- ☐ Seizures/Epilepsy
- ☐ Other
- ☐ None

Gastrointestinal:

- ☐ Nausea/Vomiting ☐ Ulcers
- ☐ Hepatitis ☐ Diarrhea
- ☐ Blood in your stools
- ☐ Change in bowel habits
- ☐ Colitis (ulcerative or Crohn's)
- ☐ Constipation
- ☐ Irritable Bowel Syndrome
- ☐ Other
- ☐ None

Genito-Urinary:

- ☐ Bladder infections
- ☐ Kidney infections
- ☐ Vaginal infections
- ☐ Frequent urination
- ☐ Blood in the urine
- ☐ Leaking urine
- ☐ Herpes
- ☐ Other
- ☐ None

Skin/Extremities

- ☐ Unexplained rash/inflammation
- ☐ Acne
- ☐ Skin Cancer
- ☐ Burn injury
- ☐ Moles changing in appearance
- ☐ Excess hair growth
- ☐ None
- ☐ Other

Mental Health Problems:

- ☐ Depression
- ☐ Schizophrenia
- ☐ Anxiety disorder
- ☐ Other
- ☐ None

Donor # (clinic use only) ☐

Cardiovascular

- ☐ Palpitations/Skipped beats
- ☐ Chest pain ☐ Stroke
- ☐ Heart attack
- ☐ Murmers
- ☐ High blood pressure
- ☐ Rheumatic fever
- ☐ Mitral valve prolapse

Need antibiotics before dental procedures? ▼

Hematologic

- ☐ Blood clotting disorder/Blood clot
- ☐ Sickle cell anemia
- ☐ Easy bruising
- ☐ Swollen glands/lymph nodes
- ☐ Blood transfusions (dates and reasons)
- ☐ Thrombophlebitis
- ☐ Other
- ☐ None

Musculoskeletal:

- ☐ Unusual muscle weakness
- ☐ Decreased energy/stamina
- ☐ Rheumatoid arthritis
- ☐ Lupus Erythematosus
- ☐ Myasthenia gravis
- ☐ Other
- ☐ None

B-1 FEMALE FAMILY HISTORY:

Relative	**Alive/Dead**	**Age**
Mother		
Father		
Sisters/Brothers:		
1. S / B		
2. S / B		
3. S / B		
4. S / B		

Please describe the appearance of your family members:

Family Member	Eye Color	Hair Color (before turning gray)	Complexion (light, medium, dark)	Height	Body type (small, medium, large)	Vision (poor, fair, good, excellent)
Mother						
Father						
Sibling 1						
Sibling 2						
Sibling 3						
Sibling 4						
MGM						
MGF						
PGM						
PGF						

M = maternal GM = grandmother P = paternal GF = grandfather

Comments

Donor # (clinic use only)

FAMILY MEDICAL HISTORY:

Carefully review the following list of medical problems and identify any which are present in the listed family members. (please mark only if the family member has/had the condition)

	You	Mother	Father	Sibling	MGM/MGF PGM/PGF	Aunt/ Uncle	Cousin
HEART							
Stroke							
heart attack							
heart disease							
1. from birth							
2. other							
hardening of the arteries							
high blood pressure							
high cholesterol level							
BLOOD							
anemia							
sickle-cell anemia							
hemophilia or other bleeding disorder							
leukemia							
HIV virus							
lymphoma							
other blood disorder							
RESPIRATORY							
hay fever/ environmental allergy							
asthma							
emphysema							
tuberculosis							
Lung cancer							
pneumonia							
other lung disease							
GASTRO-INTESTINAL							
Ulcer of stomach or duodenum							
gall stones							
hepatitis A (infectious)							
hepatitis B (serum)							
cirrhosis							
other liver disease							

Donor # (clinic use only)

	You	Mother	Father	Sibling	MGM/MGF PGM/PGF	Aunt/ Uncle	Cousin
colon cancer							
ulcerative colitis							
Crohn's disease							
cystic fibrosis							
intestinal cancer							
Rectal disorder							
pyloric stenosis							
developmental disorders of the stomach and intestine							
any other cancer/problem of the digestive system							
METABOLIC/ENDOCRINE							
diabetes mellitus							
hypoglycemia							
thyroid cancer							
thyroid disease							
goiter							
hyperactivity							
adrenal dysfunction or disorder							
URINARY							
kidney disease							
other disease of the urinary tract (urethra, bladder, ureter)							
GENITAL/REPRODUCTIVE							
undescended testicle							
ovarian cysts							
hypospadias							
prostate cancer							
testicular cancer							
uterine fibroids							
hermaphroditism/ambiguous genitals							
cancer of cervix, ovaries, or uterus							
REPRODUCTIVE OUTCOMES							
2 or more miscarriages							
stillborn							

Donor # (clinic use only)

	You	Mother	Father	Sibling	MGM/MGF PGM/PGF	Aunt/ Uncle	Cousin
death of a newborn infant							
neonatal jaundice							
NEUROLOGICAL							
migraines							
mental retardation							
Down's syndrome							
senility before age 50							
Multiple Sclerosis							
Cerebral Palsy							
epilepsy/seizures							
hydrocephalus							
spina bifida/neural tube defect							
Huntington's disease							
Gaucher's disease							
Wilson's disease							
Parkinson's disease							
paraplegia							
Tourrette's Syndrome							
scoliosis							
other diseases of the nervous system							
MENTAL HEALTH							
schizophrenia							
manic depressive or bipolar disorder							
other mental health disorder requiring hospitalization							
MUSCLE/BONE/JOINTS							
muscular dystrophy							
other chronic muscle disease							
loss of muscle coordination							
lupus							
osteoporosis							
dwarfism							
arthritis							
gout							

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Explain:

Do any hereditary diseases or abnormal conditions run in your family (including breast, bowel, or ovarian cancer)?

V. MOTIVATIONAL

This information is used to help the prospective donor egg recipients know a little about who they are choosing so please fill out this section as completely as possible. if more space is required you may also answer the following questions in a separate word document and send it jesse@fertileweb.com

Describe your personality and character:

What are your hobbies, interests, talents?

What are your dislikes and/or things that frustrate you?

What are your favorite foods?

What kind of music do you like?

Did you play any instruments in school or currently?

Did you play any sports in school?

What is your favorite color?

What is your favorite magazine?

Did you have any pets growing up, or currently?

What is your favorite book?

Do you consider yourself outgoing?

What is your favorite movie?

What is your favorite tv show?

What was your favorite subject in school?

What was your high school GPA?

What was your SAT scores?

What is your dream job?

Donor # (clinic use only)

Did your Father go to college?

Current career?

Did your Mother go to college?

Current career?

Where do you see yourself in 5 years? 10 years?

What is your favorite childhood memory?

If you were to be cast as a lead role in a film what would your character be like?

What places have you traveled, or places you would like to go, and why?

What is one thing you would change about yourself and why?

If you could pass on a message to the recipient(s) of your gametes, what would it be?

Why do you want to be a donor?

How did you hear about the donor program at Overlake Reproductive Health?

I agree to be an anonymous donor

Donor # (clinic use only)

Appendix I. Genetic Counseling

Once chosen by a recipient couple, you will be contacted by a certified genetic counselor to review your family health history as part of the donor application process. This will be done by phone or in person, and usually take 30-40 minutes. *If any issues are identified that increase the risk of birth defects or health problems in you or your children, you will be informed and invited to meet with the genetic counselor for formal genetic counseling.*

Especially with anonymous donations, this will be the only history given to the recipient(s). Therefore, prior to the consultation, we ask that you obtain as much information, in as much detail, about your family as possible. **For the purposes of this consultation, your "family" includes:** your parents, your children, your brothers and sisters (both half and whole), your nieces and nephews (on BOTH your mother and your father's side), your

grandparents, your aunts and uncles, and your cousins. *Names will NOT be included,* to preserve your confidentiality.

Here are some examples of the types of things that you need to know about your family prior to your consultation:

- Your ethnic origin/where your ancestors are originally from (such as French, Chinese, Ashkenzi Jewish, Scottish, Asian Indian, Persian). **NOTE: "White" or "Caucasian" is NOT specific enough**
- Age at time of death (ideally, date of birth and date of death)
- Cause of death (often death certificates are helpful, see www.vitalcheck.com for help with this).
- Birth defects (such as spina bifida, heart defects, cleft lip or cleft palate, Down Syndrome, undescended testicle)
- Blindness or deafness, in one eye or both, age of diagnosis, getting worse or not
- Mental retardation, specific cause if known, how diagnosed, level of function
- Difficulty conceiving, miscarriages, stillbirths, children dying before age five
- High blood pressure, high cholesterol, whether medication is needed or not
- Strokes, heart attacks, and the ages at which these occurred
- Known genetic conditions running in your family (such as sickle cell, cystic fibrosis, NF, Huntington's Disease)
- Chronic health conditions (such as asthma, hepatitis, Chron's disease, irritable bowel syndrome, multiple sclerosis [MS])
- Diabetes, whether controlled by diet, pills, or insulin shots, and age at diagnosis
- Breast cancer, age at diagnosis, whether one breast or both, how treated, any recurrence
- Ovarian cancer, age at diagnosis, how treated, any recurrence
- Colon cancer, age at diagnosis, any polyps, how treated, any recurrence
- Other cancer, age at diagnosis, how treated
- Mental illness, specific diagnosis, whether medications taken
- Alcoholism, drug abuse, whether and how treated

If you have already had any type of genetic testing done (such as being screened for sickle cell trait or Tay-Sachs disease), please obtain copies of those test results for our file. If you need help with this, please tell the ovum donor program coordinator. Additionally, please obtain and submit all relevant medical records (i.e. from your OB-Gyn office). We will need to review these with you at your first appointment.

Please complete as much of the family history portion as you can prior to your initial interview appointment. This will be needed when you are selected by a recipient couple and proceed into the genetic screening portion of the application process.