



Center of Assisted Reproduction & Endocrinology

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## ***EGG DONOR INFORMATION FORM***

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NAME: Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

TELEPHONE NUMBERS:

HOME: \_\_\_\_\_ WORK: \_\_\_\_\_ CELL: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_

SIGNIFICANT OTHER'S NAME: \_\_\_\_\_

Source of Referral: \_\_\_\_\_

Have you ever participated in an Egg Donor Program: (circle one) YES/NO

Do you have Health Insurance Coverage: (circle one) YES/NO

Name of Insurance Company: \_\_\_\_\_

FAMILY PHYSICIAN'S NAME: \_\_\_\_\_

PHYSICIAN'S ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

PHYSICIAN'S TELEPHONE NUMBER: \_\_\_\_\_



## ***EGG DONOR REPRODUCTIVE HISTORY***

How long have you been with your current partner \_\_\_\_\_

Date of your last Pap Smear \_\_\_\_\_ Have you ever had an abnormal Pap Smear? Yes/ No

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

Have you ever had an abnormal breast exam? Yes/ No

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

Have you ever had difficulty conceiving or been treated for infertility? Yes/ No

Current Method of Birth Control \_\_\_\_\_

How old were you when your period began? \_\_\_\_\_ Are your periods regular? Yes/ No

What is the average number of days between the **first** day of each period? \_\_\_\_\_

What was the longest time between your periods, within the last year \_\_\_\_\_

What was the shortest time between your periods, with the last year \_\_\_\_\_

How many days do you normally bleed during your period? \_\_\_\_\_

Do you bleed between periods? Yes/ No

Have either you or your partner experienced any of the following:

| <b>CONDITION</b>                               | <b>YOURSELF</b> | <b>PARTNER</b> |
|--|-----------------|----------------|
| Syphilis                                       |                 |                |
| Gonorrhea                                      |                 |                |
| Venereal Warts                                 |                 |                |
| Herpes   |                 |                |
| Hepatitis B and/or C                           |                 |                |
| Chlamydia                                      |                 |                |
| Intravenous (IV) Drug Use                      |                 |                |
| HIV/AIDS                                       |                 |                |
| Other Sexually Transmitted Diseases (STDs)     |                 |                |
| Homosexual Experiences                         |                 |                |
| Tattoo Within Last Year                        |                 |                |
| Number of Sexual Partners within the last year |                 |                |

### **PREGNANCY HISTORY:**

Number of Pregnancies \_\_\_\_\_

Living Children \_\_\_\_\_

Spontaneous Miscarriages \_\_\_\_\_

Abortions \_\_\_\_\_

Ectopic Pregnancies \_\_\_\_\_

# ***EGG DONOR MEDICAL HISTORY***

## **PERSONAL INFORMATION** (please circle when applicable)

|                    |                           |                       |                  |
|--------------------|---------------------------|-----------------------|------------------|
| Age                |                           |                       |                  |
| Weight             |                           |                       |                  |
| Height             |                           |                       |                  |
| Eye Color          |                           |                       |                  |
| Blood Type         |                           |                       |                  |
| Body Type          | Small                     | Medium                | Large            |
| Hair Color         |                           |                       |                  |
| Hair Type          | Straight                  | Curly                 |                  |
| Ethnic Origin      |                           |                       |                  |
| Birthplace         |                           |                       |                  |
| Religion           |                           |                       |                  |
| Marital Status     | Single                    | Married               | Divorced/Widower |
| Education          | # of years in High School | # of years in College |                  |
| Present Occupation |                           |                       |                  |

## **PERSONAL HEALTH HISTORY**

|                       |           |      |              |             |
|-----------------------|-----------|------|--------------|-------------|
| Vision                | Excellent | Good | Fair         | Poor        |
| Corrective Lenses     | Yes       | No   | Near-sighted | Far-sighted |
| Hearing               | Excellent | Good | Fair         | Poor        |
| Hearing Aides         | Yes       | No   |              |             |
| Do You Smoke          | No        | Yes  | # Packs/ Day | # Of Years  |
| Do You Drink Alcohol  | No        | Yes  | How Often    | # Of Years  |
| Diet                  | Excellent | Good | Fair         | Poor        |
| Allergies             | None      | Yes  | Please List: |             |
| Current Medications:  | None      | Yes  | Please List: |             |
| Over The Counter Med: |           |      |              |             |
| Are You Adopted       | No        | Yes  |              |             |

**PLEASE LIST ANY OPERATIONS:**

| YEAR | TYPE OF OPERATION | CITY/STATE |
|------|-------------------|------------|
|      |                   |            |

|  |  |  |
|--|--|--|
|  |  |  |
|  |  |  |
|  |  |  |

PLEASE LIST ANY **HOSPITALIZATIONS** (OTHER THAN SURGERIES OR DELIVERIES)

| <b>YEAR</b> | <b>REASON</b> | <b>CITY/STATE</b> |
|-------------|---------------|-------------------|
|             |               |                   |
|             |               |                   |
|             |               |                   |
|             |               |                   |
|             |               |                   |

HAVE YOU EVER HAD ANY SERIOUS INJURIES OR BROKEN BONES? YES/NO  
IF YES, PLEASE DESCRIBE:

| <b>YEAR</b> | <b>REASON</b> | <b>CITY/STATE</b> |
|-------------|---------------|-------------------|
|             |               |                   |
|             |               |                   |
|             |               |                   |

HAVE YOU EVER HAD ANY SERIOUS ILLNESSES? YES/NO  
IF YES, PLEASE DESCRIBE:

| <b>YEAR</b> | <b>REASON</b> | <b>CITY/STATE</b> |
|-------------|---------------|-------------------|
|             |               |                   |
|             |               |                   |
|             |               |                   |

ARE YOU PRESENTLY UNDER A PHYSICIAN'S CARE ? YES/NO  
IF YES, PLEASE DESCRIBE:

| <b>YEAR</b> | <b>ILLNESS</b> | <b>CITY/STATE</b> |
|-------------|----------------|-------------------|
|             |                |                   |
|             |                |                   |
|             |                |                   |
|             |                |                   |

***EGG DONOR GENETIC HISTORY***

Are there any known Genetic conditions or Birth Defects in you family? Yes/No  
If yes, Please explain:

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\_\_\_\_\_  
\_\_\_\_\_  
Were you born with any Birth Defects?  
If yes, please explain:

Yes/No

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Are you Caucasian?  
If yes, have you been tested as a carrier of Cystic Fibrosis?  
Results: \_\_\_\_\_Carrier \_\_\_\_\_Non Carrier \_\_\_\_\_Unknown

Yes/No

Are you of Jewish Ancestry?  
If yes, have you been tested as a carrier of Tay Sachs Disease?  
Results: \_\_\_\_\_Carrier \_\_\_\_\_Non Carrier \_\_\_\_\_Unknown

Yes/No

Are you of African Ancestry?  
If yes, have you been tested as a carrier of Sickle Cell Disease?  
Results: \_\_\_\_\_Carrier \_\_\_\_\_Non Carrier \_\_\_\_\_Unknown

Yes/No

Are you of Mediterranean (Greek or Italian) Ancestry?  
If yes, have you been tested as a carrier of Thalassemia?  
Results: \_\_\_\_\_Carrier \_\_\_\_\_Non Carrier \_\_\_\_\_Unknown

Yes/No

## ***EGG DONOR FAMILY HISTORY***

### ***FAMILY HISTORY-PATERNAL***

#### **MOTHER:**

LIVING: YES/NO IF DECEASED, AGE AT TIME OF DEATH\_\_\_\_\_

| <b>HEALTH PROBLEMS</b> | <b>AGE DIAGNOSED</b> |
|------------------------|----------------------|
|                        |                      |
|                        |                      |
|                        |                      |
|                        |                      |

**MATERNAL GRANDFATHER (YOUR MOTHER'S FATHER):**  
LIVING YES/NO IF DECEASED, AGE AT TIME OF DEATH\_\_\_\_\_

| HEALTH PROBLEMS | AGE DIAGNOSED |
|-----------------|---------------|
|                 |               |
|                 |               |
|                 |               |
|                 |               |

**MATERNAL GRANDMOTHER (YOUR MOTHER'S MOTHER)**  
LIVING YES/NO IF DECEASED, AGE AT TIME OF DEATH\_\_\_\_\_

| HEALTH PROBLEMS | AGE DIAGNOSED |
|-----------------|---------------|
|                 |               |
|                 |               |
|                 |               |
|                 |               |

**MATERNAL AUNTS AND UNCLES (YOUR MOTHER'S BROTHERS & SISTERS)**  
LIVING YES/NO IF DECEASED, AGE AT TIME OF DEATH\_\_\_\_\_

| HEALTH PROBLEMS | AGE DIAGNOSED |
|-----------------|---------------|
|                 |               |
|                 |               |
|                 |               |
|                 |               |
|                 |               |

***FAMILY HISTORY-PATERNAL***

**FATHER:**  
LIVING YES/NO IF DECEASED, AGE AT TIME OF DEATH\_\_\_\_\_

| HEALTH PROBLEMS | AGE DIAGNOSED |
|-----------------|---------------|
|                 |               |
|                 |               |
|                 |               |
|                 |               |

**PATERNAL GRANDFATHER (YOUR FATHER'S FATHER):**  
LIVING YES/NO IF DECEASED, AGE AT TIME OF DEATH\_\_\_\_\_

| HEALTH PROBLEMS | AGE DIAGNOSED |
|-----------------|---------------|
|                 |               |
|                 |               |
|                 |               |
|                 |               |

**PATERNAL GRANDMOTHER (YOUR FATHER'S MOTHER):**  
 LIVING YES/NO IF DECEASED, AGE AT TIME OF DEATH \_\_\_\_\_

| HEALTH PROBLEMS | AGE DIAGNOSED |
|-----------------|---------------|
|                 |               |
|                 |               |
|                 |               |
|                 |               |

**PATERNAL AUNTS AND UNCLES (YOUR FATHER'S BROTHERS & SISTERS):**  
 LIVING YES/NO IF DECEASED, AGE AT TIME OF DEATH \_\_\_\_\_

| HEALTH PROBLEMS | AGE DIAGNOSED |
|-----------------|---------------|
|                 |               |
|                 |               |
|                 |               |
|                 |               |
|                 |               |
|                 |               |
|                 |               |
|                 |               |
|                 |               |
|                 |               |

Please indicate with a check mark whether you and/or your relative have had any of the following:

| YOURSELF<br>YES | YOURSELF<br>NO | RELATIVE<br>YES | RELATIVE<br>NO | CONDITION                         |
|-----------------|----------------|-----------------|----------------|-----------------------------------|
|                 |                |                 |                | Down's Syndrome                   |
|                 |                |                 |                | Mental Retardation                |
|                 |                |                 |                | Seizure Disorder                  |
|                 |                |                 |                | Muscular Dystrophy                |
|                 |                |                 |                | Premature Senility<br>(Before 60) |
|                 |                |                 |                | Deafness<br>(Before 60)           |
|                 |                |                 |                | Blindness<br>(Before 60)          |
|                 |                |                 |                | Cataracts                         |
|                 |                |                 |                | Schizophrenia/Manic<br>Depression |
|                 |                |                 |                | Serious Birth<br>Defects          |
|                 |                |                 |                | Cleft Lip And/Or<br>Palate        |
|                 |                |                 |                | Huntington's<br>Disease           |
|                 |                |                 |                | Open Spine or Water<br>On Brain   |

|  |  |  |  |   |
|--|--|--|--|---|
|  |  |  |  | Two or More Miscarriages                        |
|  |  |  |  | Tuberous Sclerosis                              |
|  |  |  |  | Diabetes Mellitus                               |
|  |  |  |  | Polycystic Kidney Disease                       |
|  |  |  |  | Neurofibromatosis                               |
|  |  |  |  | Severe Bleeding Tendency                        |
|  |  |  |  | Same Cancer In More Than One Family Member      |
|  |  |  |  | Early Death Of Heart Attack Less Than Age 50    |
|  |  |  |  | More Than Five Coffee Colored Spots On The Skin |
|  |  |  |  | Cystic Fibrosis                                 |