

Reproductive Medicine Associates of Connecticut

10 Glover Avenue Norwalk, CT 06850 Phone (203) 750-7400 Fax (203) 846-9579

Donor Personal and Family History Questionnaire

The following questionnaire will ask important questions about you and your family. Please be honest and accurate. Your responses will help us to determine if egg donation is an appropriate process for you to begin. While our program is completely anonymous, the information reported in this questionnaire may be shared with a recipient couple in a non-identifying manner. Your name, place of birth, date of birth, telephone numbers, and mailing address will remain confidential.

Please send a recent photograph of yourself along with this questionnaire. This photograph is for staff's use only to help aid in the matching process and is not shown to any recipient couple. The absence of a photo may delay the matching process.

Thank you again for your effort and interest in our program. Please mail back the completed questionnaire and photograph in the self-addressed, stamped envelope enclosed.

Name _____

Address _____

Home Phone # _____ Work/cell # _____

Email address _____ May we contact you at this email address? _____

Where would you prefer to be contacted? _____

Date of Birth _____ Place of Birth _____

How did you find out about RMA's Egg Donation Program? (Please be specific as to name of magazine/newspaper, M.D.'s Office, etc.) _____

I to the best of my abilities, declare that all information provided in the following document is truthful, accurate and relevant.

Signature

Date

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Assigned Number _____ Date _____ Staff Initials _____

Physical Features

Age: _____ Year of Birth: _____

Race (i.e. Caucasian, Afro-American, Asian, etc.): _____

Ethnic Origin (i.e. Irish, Italian, etc.): Birth Mother _____ Birth Father _____

Religion: Self _____ Mother _____ Father _____

Place of Birth: _____ If born outside the US, year moved here: _____

Height: _____ Average Weight: _____

Please check appropriate response box ()

Bone Structure/Body Habitus: Petite Medium Large Very Large

Predominately: Right-handed Left-handed Ambidextrous

Eyes:

Color Brown Hazel Green Blue

Size Small Average Large

Shape Round Oval Almond

Hair:

Natural Color Blond Brown Black Red Other _____

Shade Light Medium Dark

Type Straight Wavy Curly

Fullness Thin Medium Thick

Skin:

Tone Light Med-Light Medium Med-Dark Dark

Tan Ability None Slight Medium Easy

Condition Oily Medium Dry Combination

Acne None Slight Medium Severe At what age: _____

Nose:

Size Small Medium Large

Nostril Flare Small Average Wide

Mouth:

Size Small Average Large

Lips Thin Average Full

Cheekbones:

Set Low Average High

Prominence Slight Medium Strong

Other Facial Features:

Freckles None Several Moderate Numerous

Dimples None Slight Average Deep

Cleft None Slight Average Strong

Physical Features (cont'd)

Eyesight:

Vision Normal Far-sighted Near-sighted
 Glasses None Single Bifocal
 Astigmatism Yes No Age Diagnosed _____ yrs.
 Corrective Surgery Yes No

Dental:

Device None Braces Retainer Other _____
 Reason Cosmetic Accident Disease Other _____
 Age(s) during use _____

Other Distinguishing Physical Characteristics:

List _____

Cosmetic Surgery (Body part, date, reason) _____

Describe your family by the following physical descriptions. Be sure to include only BIOLOGICAL RELATIVES (No non-blood related family members). If unknown, please indicate.

	Ethnicity	Eye Color	Hair Color	Skin Tone	Height	Weight
Mother						
Father						
Sister(s) 1						
2						
3						
Brother(s) 1						
2						
3						

Education

Please circle highest level attained

High School 1 2 3 4 GPA _____

College 1 2 3 4 GPA _____ Degree Attained: B.A. B.S.

Major area of study _____

Post Graduate 1 2 3 4 5+ GPA _____ Major _____

Post Graduate Degree Attained (or in progress): M.A. M.S. Ph.D. M.D. J.D. Other _____

Personal Characteristics

Occupation: _____

If you are a student please indicate your status here (full time/part time) _____

Have you spent 3 months or more in the United Kingdom (England, Scotland, Wales, Northern Ireland) from 1980 – 1996? _____

Have you lived anywhere in Europe (including time spent in the United Kingdom- England, Scotland, Wales, Northern Ireland from 1980 – 1996) cumulatively for 5 years or more from 1980 until the present? Europe includes: Belgium, France, Germany, Italy, Luxembourg, Netherlands, Denmark, Ireland, United Kingdom, Greece, Portugal, Spain, Austria, Finland, Sweden.

Are you a current or former U.S. military member, civilian employee or dependent of military or civilian employee who resided at U.S. military bases in Northern Europe for 6 months or more from 1980 through 1990? _____

Or at U.S. military bases elsewhere in Europe for 6 months or more from 1980 through 1996? _____

Northern Europe includes: Denmark, Estonia, Finland, Iceland, Ireland, Latvia, Lithuania, Norway, Sweden, United Kingdom.

What languages, other than English, do you speak? _____

How would you describe yourself? Athletic Active Average Inactive

What physical activities do you engage in? _____

Have you excelled in any physical activities/sports? _____

What musical instrument(s) do you play and for how long? _____

Do you have vocal abilities? If so, please describe _____

What is your favorite type of music? _____

What special hobbies or interests do you have? _____

Do you have any artistic talent? (painting, drawing, sculpture, etc.) _____

Do you like pets? If so, which is your favorite? _____

Where would you most like to travel and why? _____

How would you describe your personality? _____

What is your ultimate ambition or goal in life? _____

Why are you interested in becoming an Egg Donor? _____

Fertility History

Age at first period _____

Do you have regular menstrual cycles? _____ Number of days between periods _____

Have you ever been pregnant? Yes No Do you have any children? Yes No

If yes, how many boys? _____ How many girls? _____

For each pregnancy, please give the date, outcome, and describe any complication:

Year	Outcome	Complications

Did your mother take DES while she was pregnant with you? Yes No Unsure

Have you ever been diagnosed with infertility? (If yes, Please provide a detailed response) _____

Personal Health History

Do you have any allergies (food, medications, flowers, pollen, bee stings, etc.) _____

Describe all childhood allergies that you have outgrown _____

Do you have any hearing impairments? Yes No If yes, please explain _____

Do you have any medical illnesses (Asthma, Diabetes, Hepatitis, etc.)? _____

Do you have any history of mental illness requiring medication or psychological support? _____

List drugs, prescription/ non-prescription, that you take on a regular basis. _____

List any other medications taken in the last 5 years. Please include the reason you were taking them, how long did you take them, and when did you stop? _____

Have you ever received treatment by pituitary-derived human growth hormone? Yes No If yes, please explain _____

Do you have frequent nose bleeds, bleeding gums when you brush your teeth, and/or menstrual periods with blood clots? _____

Have you ever had surgery? Yes No If yes, please describe all surgeries and the year they were performed: _____

Have you had any hospitalizations not already mentioned? Yes No
If yes, please describe _____

Personal Health History (cont'd)

Have you ever had a Pap Smear? _____ If so, what were the results? _____

Have you ever been told of any gynecological problems (endometriosis, fibroids, ovarian cysts, etc.)? _____

Do you smoke cigarettes? _____ How much? _____

What types of alcoholic beverages do you drink? _____

How many drinks do you consume per day? _____ Per week? _____ Per month? _____

Have you ever used any kind of mind altering drugs such as marijuana, LSD, heroin or cocaine? If yes, please provide details and last date used. _____

Have you ever used an injected drug or had a sexual partner who did so? Yes No
If yes, please explain _____

Have you ever used antidepressants or neuroleptic agents (Valium, tranquilizers)? Yes No
If yes, please provide details and last date used _____

Have you acquired a tattoo or skin piercing procedure within the past 12 months? Yes No
If yes, when did you acquire the tattoo or skin piercing? _____

Are you Heterosexual or Homosexual? _____

Are you married? Yes No Do you live with your spouse? Yes No

Have you been sexually active during the past six months? Yes No

Are you currently sexually active? Yes No

Are you in a monogamous relationship? Yes No If yes, do you live with your partner? Yes No

If you are not in a monogamous relationship, what is the number of partners you have been sexually active with over the past six months? _____

Have you had more than ten sexual partners in your lifetime? Yes No

Have you ever had a sexual partner who was a gay male or bisexual male? Yes No

Have you or a partner of yours ever had a sexually transmitted disease (Gonorrhea, Syphilis, Chlamydia, Herpes, Condyloma, Trichomoniasis, etc.) Yes No If yes, please provide details regarding your diagnosis, year and treatment _____

Have you experienced any major stressor within the past year (death in family, divorce, etc.)? If so, please explain. _____

Have you been incarcerated for 72 consecutive hours or longer within the past year? Yes No
If yes, please explain _____

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Personal Health History (cont'd)

Have you engaged in prostitution at any time since 1977? Yes No

Have you been sexually involved with anyone during the past 12 months who was engaged in prostitution at any time after 1977? Yes No

Have you been sexually involved with an HIV-positive person within the last 5 years? Yes No

Is there any additional information you would like to share regarding your sexual practices?

Have you ever been refused as a blood donor? Yes No If yes, please explain _____

Have you ever received Factor VIII or Factor IX concentrates (blood transfusion) that were not heat treated or otherwise vial inactivated? Yes No

Have you received a blood transfusion within the past 12 months? Yes No When? _____

Have you received a bite from an animal suspect for rabies within the past 6 months? Yes No
If yes, please explain _____

Have you been exposed to radiation or toxic chemicals in your work or personal life? Yes No
If yes, please explain _____

Have you been exposed to or diagnosed with SARS or West Nile Virus? _____

Have you had small pox or received the small pox vaccination? Yes No If so, when: _____

Family Health History

Biological Relatives	Age (if alive)	Age at time of death	Medical problems or cause of death
Mother			
Father			
Sister(s) 1			
2			
3			
Brother(s) 1			
2			
3			
Children (if any) 1			
2			
3			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

Has any member of your family, including yourself, had a problem or defect at birth of any of the following body systems?

- | | | | |
|----|-------------------------------------|------------------------------|-----------------------------|
| 1. | Organ (heart, lung, kidney, etc.) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. | Blood circulation | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. | Respiratory system | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. | Gastrointestinal system | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. | Genital/urinary | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. | Metabolic (hormones, enzymes, etc.) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. | Nervous system, brain, spinal cord | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. | Bones, muscles, joints, limbs | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. | Other _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If you answered yes to any of the above, please list the specific defect in each case.

Type of Birth Defect	Affected Family Member	When did this happen?	Relevant Circumstances

Please read the following list of medical problems carefully and indicate which ones you or one of your relatives has had. Please consider each condition carefully for each family member. If neither you nor anyone in your family has had these medical problems please check here to indicate that you have reviewed the following medical conditions in detail.

Medical Problem	Yourself	Mother	Father	Siblings	Grandparents	Other Family	Please explain and include age when diagnosed and outcome
Heart							
A. Stroke							
B. heart attack							
C. heart disease							
1. from birth							
2. other							
D. hardening of arteries							
E. High blood pressure							
Blood							
A. Anemia							
B. Sickle-cell anemia							
C. Hemophilia or other bleeding problem							
D. Leukemia							
E. Immune deficiency							
F. other blood disorder							
Respiratory (lungs)							
A. hay fever							
B. Asthma							
C. Emphysema							
D. Tuberculosis							
E. Lung cancer							
F. Pneumonia							
G. other lung disease							
Gastro-intestinal							
A. ulcer of stomach or duodenum							
B. gall stones							
C. Hepatitis A (infectious)							
D. Hepatitis B (serum)							
E. other liver disease							
F. Colon cancer							
G. Ulcerative Colitis							
H. Crohn's disease							
I. Cystic Fibrosis							
J. intestinal cancer							
K. any other cancer/ problem of digestive system							

If neither you nor anyone in your family has had these medical problems please check here to indicate that you have reviewed the following medical conditions in detail.

Medical Problem	Yourself	Mother	Father	Siblings	Grandparents	Other Family	Please explain and include age when diagnosed and outcome
Metabolic/Endocrine							
A. Diabetes Mellitus							
B. Hypoglycemia							
C. Thyroid cancer							
D. Thyroid disease							
E. goiter							
F. adrenal dysfunction or disorder							
E. Hyperactivity							
Urinary							
A. kidney disease							
B. other disease of urinary tract (urethra, bladder, ureter)							
C. rectal disorder							
Genital /Reproductive							
A. undescended testicle							
B. Hypospadiasis							
C. Prostate cancer							
D. uterine fibroids							
E. ovarian cysts							
F. cancer of cervix, ovaries or uterus							
G. other reproductive disorders or diseases							
Neurological							
A. migraines							
B. mental retardation							
C. Dementia (senility)							
D. Multiple Sclerosis							
E. Cerebral Palsy							
F. Epilepsy							
G. Hydrocephalus							
H. disorder of the spinal cord							
I. Huntington's Chorea							
J. Gaucher's disease							
K. Wilson's disease							
L. Creutzfeldt-Jacob Disease							
M. "Mad Cow" Disease							
N. Alzheimer's Disease							
O. other diseases of the nervous system							
Mental Health							
A. Schizophrenia							
B. Manic Depressive							
C. Severe Depression							
D. Other mental health disorders							

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If neither you nor anyone in your family has had these medical problems please check here to indicate that you have reviewed the following medical conditions in detail.

Medical Problem	Yourself	Mother	Father	Siblings	Grandparents	Other Family	Please explain and include age when diagnosed and outcome
Muscular/Bones/Joints							
A. Muscular Dystrophy							
B. other chronic muscle disease							
C. Lupus							
D. deformity of the spine							
E. Osteoporosis							
F. dwarfism							
G. hereditary low back disease							
H. Arthritis							
I. gout							
Sight/Sound/Smell							
A. deafness before age 60							
B. deformity of the ear							
C. cataracts before age 50							
D. blindness							
E. color blindness							
F. Glaucoma							
G. deviated septum							
H. any other sight/sound/smell disorder							
Skin							
A. Acne							
B. Eczema							
C. Skin cancer							
D. pigmentation disorders							
E. other disorders of the skin							
Other							
A. Alcoholism							
B. drug abuse, misuse or addiction							
C. Breast cancer							
D. any other cancer not mentioned above							
E. any other condition not mentioned above							

Are there any known genetic diseases or conditions that run in your family? _____

Do you have any brothers or sisters who died in infancy or childhood? If yes, what was the cause? _____

Has anyone in your family, including yourself, experienced recurring and/or chronic physical symptoms that have not been evaluated by a physician? Yes No If Yes, Please describe all symptoms, even if you think they may not be important. _____

Is there anything else about your personal or medical history that you think we should or need to know ?
