

## INITIAL DONOR SCREENING FORM

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To become an egg donor, we need to learn some information about your personal and medical history. Your responses to these questions will help us to make sure that your health and medical history are compatible with the donation process and in particular for egg donors that it will not involve any increased risks for you. This effort will also help us to match you to an appropriate recipient.

Any information you provide during the donation process, will remain completely confidential. Some of the information from this questionnaire will be given to the recipient(s) as noted but all identifying information is removed. The accuracy of the information you will be giving will provide information to potential families you may help to create, please fill out all questions with your answers.

Also, please attach at least one recent photo of yourself. We would prefer one full body photo as well as one head shot or close-up.

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**First Name:** \_\_\_\_\_

**Last Name:** \_\_\_\_\_

**Home Phone:** (     ) \_\_\_\_\_ - \_\_\_\_\_

**Cell Phone:** (     ) \_\_\_\_\_ - \_\_\_\_\_

**Best number to reach you:** \_\_\_\_\_

**Is it alright to leave a message?** \_\_\_ YES \_\_\_ NO

**E-mail Address:** \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_

**How did you hear about us?** \_\_\_\_\_

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**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Height:** \_\_\_\_\_

**Weight:** \_\_\_\_\_

**Body Mass Index (BMI) must not exceed 27 for medical reasons (click on link below to find your BMI)**

[http://www.cdc.gov/nccdphp/dnpa/bmi/adult\\_BMI/english\\_bmi\\_calculator/bmi\\_calculator.htm](http://www.cdc.gov/nccdphp/dnpa/bmi/adult_BMI/english_bmi_calculator/bmi_calculator.htm)

**Hair Color (natural):** \_\_\_\_\_

**Eye Color:** \_\_\_\_\_

**Ethnicity (list countries):**

**Maternal Ethnicity:**

**Paternal Ethnicity:**

**Educational level attained thus far:** \_\_\_\_\_

**Grade Point Average:** \_\_\_\_\_

**S.A.T./A.C.T Score:** \_\_\_\_\_

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**Do you smoke? \_\_\_ YES \_\_\_ NO**

**If yes, how often?** \_\_\_\_\_

**Do you drink? \_\_\_ YES \_\_\_ NO**

**If yes, how often?** \_\_\_\_\_

**What is your caffeine usage? Number cups of coffee: \_\_\_ Soda \_\_\_ Tea \_\_\_  
Energy Drink \_\_\_**

**Have you used recreational drugs (you will be tested)? \_\_\_ YES \_\_\_ NO**

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

**Do you sleep well? \_\_\_ YES \_\_\_ NO**

**If no, how do you manage this?** \_\_\_\_\_

**Are you sexually active? \_\_\_ YES \_\_\_ NO**

**If yes, what form of birth control do you use?** \_\_\_\_\_

**How many sexual partners have you had in the past year?** \_\_\_\_\_

**Have you or any of your sexual partners been in contact with anyone or have you been personally tested or been treated for any sexually transmitted diseases (HIV, NSU, syphilis, gonorrhea, etc.)?**

**If so, you or your partner, please explain:** \_\_\_\_\_

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**Are your menstrual periods regular? \_\_\_ YES \_\_\_ NO**

**How long is your monthly cycle (first day of one period to first day of the next)?**  
\_\_\_\_\_ days

**Have you ever had any medical treatment for menstrual problems?**

\_\_\_ YES \_\_\_ NO

**Have you ever had a pelvic infection requiring treatment with antibiotics?**

\_\_\_ YES \_\_\_ NO

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Do you have any medical conditions? \_\_\_ YES \_\_\_ NO

Are you currently on any medications? \_\_\_ YES \_\_\_ NO

Please list any medications you have taken over the last five years:

\_\_\_\_\_

Have you ever had any surgeries? \_\_\_ YES \_\_\_ NO

Have you ever had any major illnesses such as blood clots, pneumonia, mononucleosis, etc.? \_\_\_ YES \_\_\_ NO

If yes, when? \_\_\_\_\_

Have you had any serious illness in the past? \_\_\_ YES \_\_\_ NO

If yes, please describe: \_\_\_\_\_

Did you have any complications or concerns with anesthesia?

\_\_\_\_\_

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

\_\_\_\_\_

Have you ever had any broken bones? \_\_\_ YES \_\_\_ NO

If yes, please list: \_\_\_\_\_

How many days in the preceding 12 months did you miss work because of illness (colds, flu, accidents, surgery, etc.)?

Please explain: \_\_\_\_\_

Has anyone in your family, including yourself, experienced recurring and/or chronic symptoms that have not been evaluated by a physician (Please included symptoms that you may not consider serious.)? \_\_\_ YES \_\_\_ NO

If yes, please describe: \_\_\_\_\_

Have you ever been seen by psychiatrist, psychologist, social worker, counselor, or any other mental health professional for any reason? \_\_\_ YES \_\_\_ NO

If yes, when, for how long and for what reason? \_\_\_\_\_

\_\_\_\_\_

Have you ever used medications such as antianxiety or antidepressants to treat an emotional or psychological problem? \_\_\_ YES \_\_\_ NO

If yes, list why and date last used: \_\_\_\_\_

Have you been vaccinated in the last 6 months? \_\_\_ YES \_\_\_ NO

If yes, what were you vaccinated for? \_\_\_\_\_

Have you ever taken anti-malarial drugs or had malaria?  YES  NO

Have you had a blood transfusion?  YES  NO

If yes, when? \_\_\_\_\_

Have you ever been refused or denied as a blood donor?  YES  NO

If yes, why? \_\_\_\_\_

Are you eligible to work in the United States?  YES  NO

Is your work schedule flexible?  YES  NO

Have you had radiation exposure or x-ray exposure?  YES  NO

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

Have you ever been exposed to "agent orange" or any other herbicides or chemicals (military, forestry, highway service, or elsewhere)?  YES  NO

If yes, which substance \_\_\_\_\_

When & Where? \_\_\_\_\_

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Have you been outside the United States for more than a 3 month period?

If yes, when & where: \_\_\_\_\_

Have you had a tattoo or piercing within the last 6 months?  YES  NO

If yes, describe: \_\_\_\_\_

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Have you ever been an egg donor?  YES  NO

If yes, do you know if the cycle resulted in a pregnancy?  YES  NO

Did you consult with your family when completing your family medical history?

YES  NO

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By returning this form to Golden Egg Donation Inc, you hereby certify that the information you provided on this form is true and accurate.

Thank you for your submission. After we review your form, we will contact you if you qualify to participate in our egg donor program.