FERTILITY
TREATMENT CENTER

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Uniform Donor Application Form for **Female** Donor -F
THIS SECTION WILL BE SHARED AND VIEWED BY RECIPIENTS

PHYSICAL CHARACTERISTICS

Are you adopted? ____Yes ____No Blood Type if known: _______ Height: _______ Weight: ______

Please circle responses that best describe you below:

Right-Handed Left-Handed Ambidextrous

Bone Structure: Small Medium Large Very Large

Complexion: Very Fair Fair Light Medium Olive Light Brown Dark Brown Ebony

Tan ability: None Slight Medium Easy Freckle

Skin Condition: Oily Medium Dry Combination Dimples? ____Yes ____No

Eye Color: Blue Brown Lt. Brown Dark Brown Green Hazel

Eye set: Narrow Average Wide **Eye Size:** Small Average Large **Shape:** Round Oval Almond

Natural Hair Color: Black Light Blonde Medium Blonde Dark Blonde Light Brown Medium Brown Dark Brown Red

Hair Type: Curly Wavy Straight **Hair Texture**: Fine Medium Coarse Fullness: Thin Medium Thick

Baldness: ____ Yes ____No **Baldness in Family**: ____ Yes ____ No

Premature Graying: ____Yes ____No If yes, at what age____

Body and Facial Features: Small Medium Large

Condition of your teeth: Poor Fair Good Excellent

Have you had any periodontal or orthodontic work? ____Yes ____No If yes, at what age? _____

Hearing (without corrective aids): Poor Fair Good Excellent

Vision (without corrective lenses): Poor Fair Good Excellent Prescription (If known): __________

PERSONAL HEALTH HISTORY

Do you wear glasses or contacts or have you had laser surgery? _____Yes _____No

If yes, are/were you: _____Nearsighted _____Farsighted ____Other (specify):_____________

Do you have astigmatism (blurred vision due to an irregularity in the curvature of the cornea.? ____Yes ____No

If yes, age diagnosed ______.

Do you have any Allergies? _____Yes _____No

If yes, are they to: ____Food(s)_____Medication(s) _____Environmental _____Latex

Please list any childhood allergies that you have outgrown: ____

____

____

SOCIAL HISTORY AND HABITS

Religion Born Into: ______________________________ Religion Practiced:______________________________

Grade Point Average (GPA): ___________ SAT Scores: Verbal _____ Math _____ ACT Score: _____

Education: _____ Did not Complete High School

_____ Received GED

_____ Completed high school

_____ Currently in college, pursuing degree in ____

_____ Completed college, degree in __________________________________ GPA:______________

_____ Currently pursuing an advanced degree in ____

_____ Completed advanced degree in ____

Did you have any learning disabilities or weaknesses in school? If yes, describe: _________________________________

Academic Strengths (i.e., math, reading):____

How many languages do you speak? _______________Which one (s): ____

Musical Talent or Instrument: ____Years Experience______

Artistic Talent: ____

Athletic Skills / Favorite Sports: ____

Other skills/hobbies/talents/interests do you have (i.e. writing, reading, ability to do games or crossword puzzles, handcrafts)? Describe: ____

Current Occupation: _________________________________ How long have you been at your current job? __________

HABITS

Exercise Habits: _____None _____Occasional _____Regular Type of Exercise: ________________________________

Your diet is: ____Vegetarian ____Non-vegetarian Your diet is: poor average excellent

Do you have any dietary restrictions? ____

FAMILY HISTORY

How many blood siblings are in your immediate family (including yourself and half siblings)? _________

Number of Brothers __________ Number of Sisters __________

Number of Maternal Aunts ___________ Number of Maternal Uncles ___________

Number of Paternal Aunts ___________ Number of Paternal Uncles ___________

Do you have any siblings that died in infancy or childhood? _____Yes _____No

If yes, what was the cause? ____

Are there any members of your family with a history of learning disabilities or autism? _____Yes _____No

If yes, please explain ____

REPRODUCTIVE HISTORY

YOUR CHILDREN	1	2	3	4
Age				
Sex				
Eye color				
Hair Color				
Frame size				
Grade in school				
Personality				
Artistic ability				
Intelligence				
Distinguishing characteristics				
Wears eyeglasses				
Discipline problems				
Any medication				
Dyslexia				
Reading difficulties				
Speech difficulties				
Any special services at school				
Seen by Social worker/ psychiatrist				
Grade functional level: Normal / Above/ Below Average				

GENETIC HISTORY

Ethnic origin (e.g., French, Irish)

Mother: ______________________________________ Father: ______________________________________

Race: Check all that apply for your ancestors:

African American ___Mother___Father___MGM___MGF___PGM___PGF
Eastern European (Ashkenazi) Jewish ___Mother___Father___MGM___MGF___PGM___PGF
Mediterranean (Greek, Italian) ___Mother___Father___MGM___MGF___PGM___PGF
Hispanic ___Mother___Father___MGM___MGF___PGM___PGF
Indian (from India) ___Mother___Father___MGM___MGF___PGM___PGF
Southeast Asian (Laotian, Vietnamese, Cambodian) ___Mother___Father___MGM___MGF___PGM___PGF
French Canadian ___Mother___Father___MGM___MGF___PGM___PGF
Cajun ___Mother___Father___MGM___MGF___PGM___PGF

(**MGM**=Maternal Grandmother, **MGF**=Maternal Grandfather; **PGM**=Paternal Grandmother, **PGF**=Paternal Grandfather)

Have you or anyone in your family ever been **tested positive** as a carrier **or had any** of any of the following diseases?

Blooms Syndrome No If yes: _____ disease _____carrier _____negative _____unknown
Canavan No If yes: _____ disease _____carrier _____negative _____unknown
Cystic Fibrosis No If yes: _____ disease _____carrier _____negative _____unknown
Fabry Disease No If yes: _____ disease _____carrier _____negative _____unknown
Familial Dysautonomia No If yes: _____ disease _____carrier _____negative _____unknown
Familial Mediterranean Fever No If yes: _____ disease _____carrier _____negative _____unknown
Fanconi Anemia Grp. C: No If yes: _____ disease _____carrier _____negative _____unknown
Gaucher No If yes: _____ disease _____carrier _____negative _____unknown

Niemann-Pick type A No If yes: _____ disease _____carrier _____negative _____unknown
Mucolipidosis type IV No If yes: _____ disease _____carrier _____negative _____unknown
Sickle Cell No If yes: _____ disease _____carrier _____negative _____unknown
Tay-Sachs No If yes: _____ disease _____carrier _____negative _____unknown
Thalassemia No If yes: _____ disease _____carrier _____negative _____unknown

Is there anything else we should know about your family?
____
____

FAMILY HEALTH HISTORY

Describe genetic family members according to the following characteristics. Use natural eye and hair color; fair/dark, etc. complexion. If they are deceased, please list cause of death. Please do not put "natural" as a cause of death. If unknown, write "unknown."

	Eye Color	Hair Color	Complexion	Height	Weight	Bone Structure	Occupation/ Education	Age if living	Age at time of death	Cause of death
Sister(s)										
Brother(s)										
Mother										
Father										
Maternal Grandmother										
Maternal Grandfather										
Paternal Grandmother										
Paternal Grandfather										

PERSONAL AND MOTIVATIONAL

In your own words, describe your personality, temperament, and character:____
____
____
____
____

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

What are your present and future career goals:_______________________________________
____

What are your present and future personal goals: ______________________________________

____

____

____

List the 3 achievements you are most proud of: ____________________________________

____

____

What is your favorite movie? ____

What is your favorite book? ____

What is your favorite color? ____

What is your favorite food? ____

What is one of your most memorable moments and why?

____

____

If you could change one thing about yourself, what would it be and why?

____

____

Is there a person alive or dead whom you admire and why?

____

____

What would you do on a “perfect” day if you could do anything you wanted?

____

____

Describe your personality and temperament as a child:

____

____

____

What was your favorite thing to do as a child?

____

____

What did your parents teach you to value?

____

____

How were you in comparison to other children?

____

____

Describe your personality and temperament as a teenager:

____

____

Did you have any problems as a child and/ or as a teenager? Explain:

____

____

Who was the most important influence on you and why?

____

____

What were your ambitions/ goals as a teenager?

____

____

What were your best and worst subjects in school?

____

____

Please provide the following information about your family:

	Intellectual/Academic Achievements	Artistic Achievements
Mother		
Father		
Sisters		
Brothers		

Reasons for wanting to donate embryo(s): ____

____

____

____

____

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

____

____

____

____

If you could write a message to the child born through your participation as an egg or sperm donor for when he/she turns 18 years old, what would you tell him/her?

____

____

____

____

FAMILY HEALTH HISTORY

Carefully review the following list of medical problems and identify which ones you or one of your genetic relatives have or had. Please consider each condition carefully for each family member. Explain any conditions you check below, indicating which side of the family (maternal or paternal), the age at the time of onset, and any other pertinent information. If you and none of your indicated family members have a history of the specific medical condition, please indicate none.

	None	Self	Mother	Father	Sibling	Grand-parents	Aunt/ Uncle	Cousin	Explanation (which side of family, age of onset, etc.)
CANCER									
Breast									
Colon or Intestinal									
Lung									
Ovarian or Uterine									
Prostate or Testicular									
Skin									
Stomach									
Thyroid									
Blood (e.g., leukemia)									
Other									
HEART									
Stroke									
Heart Attack									
Congenital Heart Disease									
Heart Disease or Defect									
Hardening of the Arteries									
High Blood Pressure									
High cholesterol level									
BLOOD									
Anemia									
Sickle-Cell Anemia									
Factor V Leiden thrombpphilia (Blood clots or strokes)									
Hemophilia or other Bleeding/Clotting Disorders such as Von Willebrand's Disease									
Immune Deficiency									
Leukemia									
Lymphoma or Swollen Lymph Nodes									
HIV									
Thalassemia									
Polyarteritis Nodosa									
Other Blood Disorder									
RESPIRATORY									
Asthma									
Hay Fever									
Emphysema									
Tuberculosis									
Pneumonia									
Alpha-1 antitrypsin Disorder									
Blood in Sputum									
Other Lung Disease									
GASTRO-INTESTINAL									
Appendicitis									
Ulcer of Stomach or Duodenum									
Gallstones									
Hepatitis A,B or C									
Cirrhosis of the Liver									
Other Liver Disease									
Ulcerative Colitis									
Crohns Disease									
Pyloric Stenosis									
Multiple Polyps of the Colon									
Rectal Disorder									
Inflammatory Bowel Disease									
Any other problem of the digestive system									
METABOLIC/ENDOCRINE									
Diabetes requiring insulin therapy									

	None	Self	Mother	Father	Sibling	Grand-parents	Aunt/ Uncle	Cousin	Explanation (which side of family, age of onset, etc.)
Diabetes not requiring insulin therapy									
Childhood Diabetes									
Thyroid disorder									
Goiter									
Hypoglycemia									
Adrenal Dysfunction or Disorder									
Phenyl Ketonuria (PKU) or inherited Metabolism Disorder									
Obesity									
Dwarfism									
URINARY									
Kidney Problems									
Polycystic Kidney Disease									
Other disease/defect of urinary tract (urethra, bladder, ureter)									
GENITAL/REPRODUCTIVE									
Hermaphroditism/ Ambiguous Genitals									
Hypospadias or undescended testicle									
Uterine Fibroids									
Ovarian Cysts or Ruptured									
Lumps or Cysts in Breast or Discharge									
Polycystic Ovarian Syndrome (PCOS)									
Pelvic Inflammatory Disease (PID)									
Endometriosis									
REPRODUCTIVE OUTCOMES									
2 or more Miscarriages									
Stillborn									
Premature Menopause									
Death of a newborn infant									
Childhood death									
Birth defects									
Infertility									
Premature Birth									
NEUROLOGICAL									
Migraines									
Intellectual disabilities									
Senility or Mental Deterioration before age 50									
Multiple Sclerosis									
Cerebral Palsy									
Neurofibromatosis									
Epilepsy / Seizures									
Attention Deficit Disorder/ Hyperactivity									
Autism / Asperger’s									
Alzheimer’s Disease/Dementia									
Hydrocephalus									
Tuberous Sclerosis									
Parkinson’s Disease									
Creutzfeldt-Jakob Disease									
Scoliosis									
Myasthenia Gravis									
Huntington’s or Wilson’s Disease									
Tourette’s syndrome									
Other diseases of the nervous system									
MENTAL HEALTH									
Anxiety / Panic Attacks									
Anorexia / Bulemia/ other eating disorders									
Depression									

	None	Self	Mother	Father	Sibling	Grand-parents	Aunt/ Uncle	Cousin	Explanation (which side of family, age of onset, etc.)
Schizophrenia									
Manic Depressive or Bipolar Disorder									
Other mental health disorder requiring hospitalization									
Suicide Attempts									
Other mental health problems that warranted counseling (please list)									
MUSCLE/BONE/JOINTS									
Muscular Dystrophy									
Achondroplasia – form of dwarfism with abnormal bone growth									
Other Chronic Muscle Disease									
Osteogenesis imperfecta (brittle bone disease)									
Loss of Muscle Coordination									
Osteoporosis									
Marfan Syndrome									
Arthritis									
Rheumatoid or Juvenile Arthritis									
Spinal Muscular Atrophy									
Hereditary Low Back Disorder or Deformity of Spine									
Reiter’s Disease									
Myasthenia Gravis									
Gout									
Metabolic Bone Disease (be more specific)									
Lupus (systemic lupus erythematosis – SLE)									
SIGHT/SOUND/SMELL									
Deafness before age 60									
Deformity of the ear									
Cataracts before age 50									
Blindness									
Color Blindness									
Severe Myopia									
Glaucoma									
Retinoblastoma									
Retinitis Pigmentosa									
Deviated Septum									
Any other Sensory Disorder									
SKIN									
Acne									
Albinism									
Eczema									
Excessive Facial Hair (Hirsutism)									
Pigmentation Disorders									
Psoriasis									
Neurofibromatosis									
Other disorders of the skin									
Infectious Skin Disease									
More than 5 purple- or coffee- colored spots on skin (size of quarter or larger)									
CONGENITAL ABNORMALITIES/BIRTH DEFECTS									
Cleft Lip / Palate									
Congenital Hip Problems									
Club Feet									
Heart Defect									
Hearing Problems									
Spina Bifida -Neural Tube (open spine)									
Microcephaly									

	None	Self	Mother	Father	Sibling	Grand-parents	Aunt/ Uncle	Cousin	Explanation (which side of family, age of onset, etc.)
Holoprosencehpaly-a single-lobed brain structure and severe skull and facial defects									
Other									
CHROMOSOMAL ABNORMALITIES									
Down Syndrome									
Other (i.e., Turner, Fragile X, Klinefelter's etc.)									
OTHER									
Alcoholism									
Drug abuse, Misuse or Addiction									
Premature degeneration of any organ system									
Any other condition not mentioned above									