REPRODUCTIVE MEDICINE & SURGERY CENTER OF VIRGINIA

EGG DONOR APPLICATION

Date:
Name:
Address:
City
State, Zip Code

Date of Birth ____/____/_____

Phone Numbers:	okay to leave a detailed message?
Cell#	____yes ____no
Home#	____yes ____no
Work#	____yes ____no

Email address: _____
okay to send a detailed message? ____yes ____no

Health Insurance Information
Health insurance company: _____
Policy Holder's name: _____
Group Number: _____

PERSONAL DESCRIPTION:

_____ HEIGHT
_____ WEIGHT

Religion: _____

Eye color _____
Hair color _____
Race _____
Ethnic background (ex. French, Irish, African-American, Latino, Italian, Japanese, etc) _____
_____
Skin tone (medium, dark, light, fair, olive, freckles, etc)
_____
Hair type: (curly, straight, wavy, fine, thick, frizzy)
_____

Years of completed education: _____
Colleges attended: _____
Degrees obtained/currently pursuing: _____
_____
Current Occupation: _____
Previous Occupations: _____

SOCIAL HISTORY

Tobacco use currently:
_____ yes _____ no
If yes, how much? _____
If no, have you smoked in the past? How much? How long ago did you quit?
_____

Alcohol use:
_____ yes _____ no
If yes, how much? _____
If no, did you drink in the past? How much?
_____

Recreational/illegal drug use currently:
_____ yes _____ no
If yes, what specifically and how frequently?
_____
If no, have you used in the past? If yes, what specifically and how frequently? When was the last time?
_____
_____

Are you currently:
____Single
____Married
____Living w/a partner

Does your significant other know of your interest in egg donation?
_____ Yes
_____ No
If no, do you plan to tell your partner?
____ Yes
____ No
____ Undecided

How many times have you been pregnant?
____ never
____ once
____ twice
____ three times or more

How many children do you have?
____ none
____ one
____ two
____ three or more

Have you ever been convicted of a crime (other than a traffic violation)?
_____ yes _____ no
If yes, how what specifically and when?
_____

Have you ever been in jail/prison?
_____ yes _____ no
If yes, for what specifically, when and length of stay?
_____

PERSONAL ABILITIES/TALENTS:

How would you rank your ….

Mathematical abilities:
__ fair
__ average
__ good
__ excellent

Literary skills:
__ fair
__ average
__ good
__ excellent

Scientific abilities:
__ fair
__ average
__ good
__ excellent

Athletic abilities:
__ fair
__ average
__ good
__ excellent

Artistic skills:
__ fair
__ average
__ good
__ excellent

Musical skills:
__ fair
__ average
__ good

__ excellent

List any special talents, skills or hobbies:
_____
_____
_____

Your favorite sport: _____

Your favorite type of music: _____

Your favorite color: _____

Your favorite food(s): _____

Personal Medical History

Do you have any medical conditions currently? _____yes _____no
If yes, please describe:
_____
_____

Were you born with any handicaps or genetic conditions? ____yes ____no
If yes, please describe:
_____
_____

Have you ever been hospitalized? ____yes ____no
If yes, please describe:
_____
_____

Have you ever had surgery? ____yes ____no
If yes, please describe:
_____
_____

Have you ever been diagnosed with any psychiatric illness? ____yes ____no
If yes, please describe, including treatment:
_____
_____

Have you ever been diagnosed with a STD (sexually transmitted disease)?
____yes ____no
If yes, please describe:
_____
_____

Have you ever been pregnant before? ____yes ____no
If yes, how many times? _____
Please describe the outcome of each pregnancy with dates, including any complications w/pregnancy, labor and delivery (ex. Elective termination, spontaneous miscarriage, premature birth, full term live birth, stillborn, etc.):
_____
_____
_____
_____

Have you ever received a blood transfusion? _____yes _____no
If yes, why and when? _____

Please list all **prescribed** medications you take and the reason:
_____
_____
_____
_____
_____
_____

Please list all "over the counter" medications and herbal supplements you take and the reason:
_____
_____
_____
_____
_____
_____

Please list all tattoos and dates acquired:
_____
_____
_____
_____
_____

Have you ever been excluded from blood donation?
_____yes _____no
If yes, why and when? _____

Have you ever donated your eggs elsewhere? _____yes _____no
If yes, when and where? _____

If yes, how many eggs were retrieved? _____

Family Medical History:

Relative	Alive?	Current age or age of death	Occupation	Years of completed education	Health problems: detailed description
Mother					
Father					
Maternal grandmother					
Maternal grandfather					
Paternal Grandmother					
Paternal Grandfather					
Sibling 1					
Sibling 2					
Sibling 3					
Aunt					
Aunt					
Uncle					
Uncle					

Other relatives w/significant medical history: _____

_____

_____

_____

_____

If you have children, please complete the following:

Age Current Health Birth Problems Medical Problems

First child:_____

_____

Second child:_____

_____

Third child: _____

_____

Fourth child: _____

_____

Has anyone in your family had any of the following conditions?

	YES	NO
Down's Syndrome		
Mental retardation		
Seizure disorder		
Cleft lip and/or cleft palate		
Spina bifida (open spine)		
Hydrocephalus (water on the brain)		
Congenital heart defects		
Cystic fibrosis		
Mental illness (schizophrenia, bipolar, depression)		
Diabetes mellitus (onset prior to age 50)		
Club feet		
Congenital hip problems		
Thyroid disease		
Progressive kidney disease		
Skin disease		
Neurofibromatosis (lumps under the skin)		
Arthritis		
Alcoholism		
Colon cancer (before age 65)		
Hypertension		
Blood clotting disorder		
Breast cancer		
Ovarian cancer		
Huntington's disease		
Marfan's syndrome		
3 or more miscarriages or any stillbirths		
Blindness		
Deafness		
Cataracts		
Premature senility (before age 50)		
Muscle weakness/atrophy/dystrophy		
Light color patches on skin (tuberous sclerosis)		
Any other genetic conditions		

If yes is answered to any of the above questions, please explain:

Specific relation Specific Condition Age affected

_____

_____

_____

_____

_____

_____

_____

_____

Please write and tell us why you are interested in egg donation:

Please write and tell us your goals, hopes and dreams for the future:

Please attach a recent photo of yourself to the application (that you do not need returned….)

Thank you so much for taking the time to fill out this detailed application!

Please send to: **Reproductive Medicine & Surgery Center of Virginia**
ATTN: Stephanie Barrix, RN
595 Martha Jefferson Drive
Suite 390
Charlottesville, VA 22911