



Application Form-Recipient

Today's Date: _____

Blood Type:

Female: _____

Male: _____

Name _____
Last First

Home Address: _____

Marital Status: Single _____ Partner/Married _____ Divorced _____ Widowed _____

Birth date _____ / _____ / _____ Age _____
Month Day Year

Birthplace _____ Ethnicity _____

Phone # _____ Fax # _____ Email: _____

Cell Phone # _____

Social Security # _____ Passport # _____

Allergies: _____ / _____ / _____ / _____ / _____

Current

Medications: 1. _____

2. _____

Primary Care Physician: Name: _____

Address: _____

Phone #: _____

OB/GYN Physician: Name: _____

Address: _____

Phone #: _____

Are you Currently under medical care for any reason(s) ? If yes, please explain:

Reason(s) for Egg Donation _____

OB/GYN History- Please include all documentation available.

Please include the results of most recent hormonal profile.

FSH E2 LH Prolactin Testosterone DHEAS TSH T4 DATE

1. Age when menstrual periods began _____
2. # of pregnancies _____ # of deliveries _____ # of abortions _____ # of miscarriage _____
3. How many children born alive? _____
4. Last PAP Smear-Date _____ Normal - Yes _____ No _____
5. Mammogram (40 yrs. & over) - Date _____ Normal - Yes _____ No _____
6. Do you still have periods? Yes _____ No _____ If not, when did they stop? _____

Spouse/ partner's name: _____

Please include results of most recent Semen Analysis. (printed documentation).

Date _____

Volume _____

Concentration _____

Motility _____

N.Z.

Who/ Kruger _____

Years Married: _____ Years Infertile _____

Menes: Length _____ AMT. of days _____

Are your periods regular? _____ How often? _____

How many days do your period last? _____

Hysteroscopy (documentation) _____

Surgery: (Gynecological) _____

Hysterosalpingogram (HSG)(documentation) _____

Hysterosonogram (SIS)(date) _____

Drug Use: Are you or others concerned about your use of non-prescription or illicit drugs? If so, please explain _____

Alcohol Use: None _____ Rarely _____ Occassionally _____ Frequently _____

Estimated number of drinks per week _____

Smoking: None _____ Rarely _____ Occassionally _____ Frequently _____

Amount/Type _____ Number of years _____

General History - Please include all documentation available.

Please check if any relative (parents, siblings, grandparents, childrens) have had any of the conditions listed below:

High blood pressure: _____	Kidney: _____	Asthma: _____
Stroke: _____	Bleeding Disease: _____	Tuberculosis: _____
Cancer: _____	Seizures: _____	Colitis: _____
Emphysema: _____	Heart Disease: _____	Anemia: _____
Ulcers: _____	Diabetes: _____	Gout: _____
Mental Illness: _____	Other Serious Illness: _____	

Have you had any of the following illness: (Please Circle):

Rubella (German Measles)	Diabetes	Typhoid
Measles	Goiter, Thyroid Disease	Malaria
Mumps	Hives	Hepatitis
Whooping Cough	Eczema	Venereal Disease
Scarlet Fever	Rheumatic Fever	Seizures
Tonsillitis	Polio	Meningitis
Diphtheria	Pleurisy	Heart Murmur
Asthma	Bronchitis	High Blood Pressure
Glaucoma	Influenza	Low Blood Pressure
Cancer	Tuberculosis	Heart Attack
Angina Pectoris	Phlebitis	Kidney Stones
Ulcer	Headaches	Cholesterol
Bladder or Kidney Infection	Arthritis	Substance Abuse

Other serious illnesses: Please explain: _____

Surgery (non-Gynecological): _____

Signature

Date

DONOR REQUEST FORM

This form was created in an effort to assist our patients to indicate the criteria they think most important when choosing a donor. Please feel free to add any items may not be mentioned that you feel would be important when a donor is chosen for you. Please include a recent picture of yourselves with this form.

Type of Cycle: _____ Exclusive _____ Shared _____ Neither

Preference of Season: _____ Winter _____ Spring _____ Summer _____ Fall

Attributes of Donor:

	Very Important	Neutral	Not Important
Height			
Weight			
Complexion			
Eye Color			
Hair Color			
Body Type (bone structure)			
Religion			
Age			
Marital Status			
Education			
Athletic Activity			
Musical Ability			
Blood Type			
Other			

Recipient Checklist

Female

Patient Name: _____ Date: _____

- _____ HIV
- _____ HTLV
- _____ VDRL (RPR)
- _____ HEP A
- _____ HEP B (Ag)
- _____ HEP C
- _____ Blood type & Rh
- _____ PAP
- _____ Cultures (G/C)
- _____ SHG
- _____ TSH
- _____ CBC
- _____ SMA 7
- _____ Rubella
- _____ Other _____

- Recipient over 40 yrs.
- _____ Fasting lipid profile _____
 - _____ EKG _____
 - _____ Chest X-Ray _____
 - _____ Mammogram _____

- Recipients over 45 yrs.
- _____ Treadmill _____
 - _____ Bone Densitometry _____

Male

Patient Name: _____

- _____ Semen Analysis
- _____ Blood Type & Rh
- _____ HIV
- _____ HTLV
- _____ VDRL (RPR)
- _____ HEP A
- _____ HEP B (Ag)
- _____ HEP C
- _____ Cystic Fibrosis
- _____ Other _____

The above is a list of preliminary test to be completed prior to proceeding with your treatment regimen. Thank you for your cooperation.

Consent Forms: _____
Signature of MD Date