

## EGG DONOR PROFILE



**UNIVERSITY FERTILITY CONSULTANTS**  
 Center for Health & Healing, CH10F  
 3303 SW Bond Avenue, 10<sup>th</sup> Floor  
 Portland, OR 97239-4501  
 (503) 418-3700

|   |        |   |                           |                    |              |   |                 |   |      |                    |      |    |                      |
|---|--------|---|---------------------------|--------------------|--------------|---|-----------------|---|------|--------------------|------|----|----------------------|
| Year of Birth:  |        | Birthplace (State, or country if outside U.S.): |                           |                    |              |   |                 |   |      |                    |      |    |                      |
| <b>RACIAL GROUP:</b>                                    |        | Caucasian                                       | Black                     | Asian              | Hispanic     | Other – specify:  |                 |   |      |                    |      |    |                      |
| Ethnic Origin/Ancestry:<br>(e.g., Irish/German/Swedish) |        | <b>Mother:</b>                                  |                           |                    |              |   |                 |   |      |                    |      |    |                      |
|   |        | <b>Father:</b>                                  |                           |                    |              |   |                 |   |      |                    |      |    |                      |
| <b>FERTILITY HISTORY</b>                                |        |   |                           |                    |              |   |                 |   |      |                    |      |    |                      |
| Number of Pregnancies ➡                                 |        |   | Number of Live Births ➡   |                    |              |   |                 |   |      |                    |      |    |                      |
| <b>CHILDREN</b>   |        |   |                           |                    |              |   |                 |   |      |                    |      |    |                      |
| ↓ Age ↓   |        |   |                           |                    |              |   |                 |   |      |                    |      |    |                      |
| Mos.  | Yrs.   | Sex   | Eye Color                 | Hair Color         |              |   | Health Concerns |   |      |                    |      |    |                      |
|   |        |   |                           |                    |              |   |                 |   |      |                    |      |    |                      |
|   |        |   |                           |                    |              |   |                 |   |      |                    |      |    |                      |
|   |        |   |                           |                    |              |   |                 |   |      |                    |      |    |                      |
|   |        |   |                           |                    |              |   |                 |   |      |                    |      |    |                      |
|   |        |   |                           |                    |              |   |                 |   |      |                    |      |    |                      |
|   |        |   |                           |                    |              |   |                 |   |      |                    |      |    |                      |
| <b>PHYSICAL CHARACTERISTICS</b>                         |        |   |                           |                    |              |   |                 |   |      |                    |      |    |                      |
| Height:   |        | Weight:   |                           | Eye Color:         |              | Natural Hair Color:   |                 | Blood Type:   |      | Your vision is 20/ |      |    |                      |
| ↓ Hair Texture ↓  |        |   | ↓ Hair Type ↓             |                    |              | Do you wear corrective lenses?  |                 | What is your vision quality <u>without</u> corrective lens? |      |                    |      |    |                      |
| Thick   | Thin   | Average   | Curly                     | Wavy               | Straight     | No  | Yes             | Excellent   | Good | Fair               | Poor |    |                      |
| ↓ Bone Structure ↓                                      |        |   | ↓ Are you predominately ↓ |                    |              | Other distinguishing features, e.g., dimples, cleft chin, Roman nose, etc.: |                 |   |      |                    |      |    |                      |
| Small   | Medium | Large   | Right-handed              | Left-handed        | Ambidextrous |   |                 |   |      |                    |      |    |                      |
| <b>SKIN CHARACTERISTICS</b>                             |        |   |                           |                    |              |   |                 |   |      |                    |      |    |                      |
| <b>Freckles/Moles:</b>                                  |        | None  | Few                       | Numerous           |              |   |                 |   |      |                    |      |    |                      |
| Very Fair (little or no ability to tan on sun exposure) |        |   |                           |                    |              |   |                 |   |      |                    |      |    |                      |
| Fair (skin will tan slightly on sun exposure)           |        |   |                           |                    |              |   |                 |   |      |                    |      |    |                      |
| Medium (light color, but will tan moderate-to-dark)     |        |   |                           |                    |              |   |                 |   |      |                    |      |    |                      |
| <b>Olive (pigmentation of unexposed skin):</b>          |        |   |                           | Slight             |              | Moderate  |                 | Dark  |      |                    |      |    |                      |
| <b>Dark (unexposed skin):</b>                           |        |   |                           | Light tan          |              | Dark tan  |                 | Black   |      |                    |      |    |                      |
| <b>EDUCATIONAL BACKGROUND</b>                           |        |   |                           |                    |              |   |                 |   |      |                    |      |    |                      |
| Indicate highest education level attained:              |        |   |                           |                    |              |   |                 |   |      |                    |      |    |                      |
| High School   |        |   |                           | College/University |              |   |                 | Post-graduate   |      |                    |      |    |                      |
| 1   | 2      | 3   | 4                         | 1                  | 2            | 3   | 4               | 1   | 2    | 3                  | 4    | 5+ | Major Area of Study: |
| Degree(s) attained:                                     |        |   |                           |                    |              |   |                 |   |      |                    |      |    |                      |
| <b>OCCUPATION:</b>                                      |        |   |                           |                    |              |   |                 |   |      |                    |      |    |                      |
| <b>REASON FOR DONATING:</b>                             |        |   |                           |                    |              |   |                 |   |      |                    |      |    |                      |

# EGG DONOR №

| PERSONAL CHARACTERISTICS   |               |         |               |        |                |          |               |  |           |
|--|---------------|---------|---------------|--------|----------------|----------|---------------|--|-----------|
| Do you work outside of the home? If yes, what type of work?                          |               |         |               |        |                |          |               |  |           |
| Are you  |               | Married |               | Single |                | Divorced |               |  |           |
| What languages do you speak?   |               |         |               |        |                |          |               |  |           |
| Special Hobbies/Talents:   |               |         |               |        |                |          |               |  |           |
| Describe your artistic abilities:  |               |         |               |        |                |          |               |  |           |
| Describe your athletic skills?   |               |         |               |        |                |          |               |  |           |
| Describe your mechanical skills?   |               |         |               |        |                |          |               |  |           |
| Your favorite sport?   |               |         |               |        |                |          |               |  |           |
| Your favorite foods?   |               |         |               |        |                |          |               |  |           |
| Your favorite color?   |               |         |               |        |                |          |               |  |           |
| Your favorite type of music?   |               |         |               |        |                |          |               |  |           |
| Do you like pets? If yes, which is your favorite?                                    |               |         |               |        |                |          |               |  |           |
| <b>↓ CHECKMARK ALL OF THE FOLLOWING PERSONALITIES AND TRAITS THAT APPLY TO YOU ↓</b> |               |         |               |        |                |          |               |  |           |
|  | Honest        |         | Inventive     |        | Funny          |          | Dreamer       |  | Ambitious |
|  | Light-hearted |         | Creative      |        | Humorous       |          | Helpful       |  | Able      |
|  | Leader        |         | Thrilling     |        | Sad            |          | Simple-minded |  | Quiet     |
|  | Expert        |         | Independent   |        | Selfish        |          | Humble        |  | Curious   |
|  | Brave         |         | Intelligent   |        | Unselfish      |          | Friendly      |  | Reserved  |
|  | Conceited     |         | Compassionate |        | Self-confident |          | Adventurous   |  | Pleasing  |
|  | Mischievous   |         | Gentle        |        | Respectful     |          | Hard-working  |  | Bossy     |
|  | Demanding     |         | Proud         |        | Considerate    |          | Timid         |  | Witty     |
|  | Thoughtful    |         | Wild          |        | Imaginative    |          | Shy           |  | Fighter   |
|  | Keen          |         | Messy         |        | Busy           |          | Bold          |  | Tireless  |
|  | Happy         |         | Neat          |        | Patriotic      |          | Daring        |  | Energetic |
|  | Disagreeable  |         | Joyful        |        | Fun-loving     |          | Dainty        |  | Cheerful  |
|  | Simple        |         | Strong        |        | Popular        |          | Cooperative   |  | Smart     |
|  | Fancy         |         | Bright        |        | Successful     |          | Lovable       |  | Impulsive |
|  | Excited       |         | Courageous    |        | Responsible    |          | Prim          |  | Loyal     |
|  | Studious      |         | Serious       |        | Lazy           |          | Proper        |  |           |
| <b>WHAT ARE YOUR LIFE'S GOALS?</b>   |               |         |               |        |                |          |               |  |           |
|  |               |         |               |        |                |          |               |  |           |

| FAMILY HISTORY OF DONOR   |  |                     |        |        |                     |                  |             |                     |        |                  |                     |        |             |                     |        |             |      |                  |  |  |
|---|--|---------------------|--------|--------|---------------------|------------------|-------------|---------------------|--------|------------------|---------------------|--------|-------------|---------------------|--------|-------------|------|------------------|--|--|
|   | Mother   |                     |        | Father |                     |                  | Sibling № 1 |                     |        | Sibling № 2      |                     |        | Sibling № 3 |                     |        | Sibling № 4 |      |                  |  |  |
|   |  | Male                | Female |        | Male                | Female           |             | Male                | Female |                  | Male                | Female |             | Male                | Female |             | Male | Female           |  |  |
|   |  | Half-brother/sister |        |        | Half-brother/sister |                  |             | Half-brother/sister |        |                  | Half-brother/sister |        |             | Half-brother/sister |        |             |      |                  |  |  |
|   |  | Adopted             |        |        | Adopted             |                  |             | Adopted             |        |                  | Adopted             |        |             | Adopted             |        |             |      |                  |  |  |
| <b>Year of Birth</b>  |  |                     |        |        |                     |                  |             |                     |        |                  |                     |        |             |                     |        |             |      |                  |  |  |
| <b>Birthplace</b> (State, or country if outside U.S.)                                 |  |                     |        |        |                     |                  |             |                     |        |                  |                     |        |             |                     |        |             |      |                  |  |  |
| <b>Racial Group</b>   |  | Caucasian           |        |        |                     | Caucasian        |             |                     |        | Caucasian        |                     |        |             | Caucasian           |        |             |      | Caucasian        |  |  |
|   |  | Black               |        |        |                     | Black            |             |                     |        | Black            |                     |        |             | Black               |        |             |      | Black            |  |  |
|   |  | Asian               |        |        |                     | Asian            |             |                     |        | Asian            |                     |        |             | Asian               |        |             |      | Asian            |  |  |
|   |  | Hispanic            |        |        |                     | Hispanic         |             |                     |        | Hispanic         |                     |        |             | Hispanic            |        |             |      | Hispanic         |  |  |
|   |  | Other - specify:    |        |        |                     | Other - specify: |             |                     |        | Other - specify: |                     |        |             | Other - specify:    |        |             |      | Other - specify: |  |  |
| <b>Height</b>   |  |                     |        |        |                     |                  |             |                     |        |                  |                     |        |             |                     |        |             |      |                  |  |  |
| <b>Weight</b>   |  |                     |        |        |                     |                  |             |                     |        |                  |                     |        |             |                     |        |             |      |                  |  |  |
| <b>Eye Color</b>  |  |                     |        |        |                     |                  |             |                     |        |                  |                     |        |             |                     |        |             |      |                  |  |  |
| <b>Blood Type</b>   |  |                     |        |        |                     |                  |             |                     |        |                  |                     |        |             |                     |        |             |      |                  |  |  |
| <b>Natural Hair Color</b>   |  |                     |        |        |                     |                  |             |                     |        |                  |                     |        |             |                     |        |             |      |                  |  |  |
| <b>Hair Texture</b>   |  | Thick               |        |        |                     | Thick            |             |                     |        | Thick            |                     |        |             | Thick               |        |             |      | Thick            |  |  |
|   |  | Thin                |        |        |                     | Thin             |             |                     |        | Thin             |                     |        |             | Thin                |        |             |      | Thin             |  |  |
|   |  | Average             |        |        |                     | Average          |             |                     |        | Average          |                     |        |             | Average             |        |             |      | Average          |  |  |
| <b>Hair Type</b>  |  | Curly               |        |        |                     | Curly            |             |                     |        | Curly            |                     |        |             | Curly               |        |             |      | Curly            |  |  |
|   |  | Wavy                |        |        |                     | Wavy             |             |                     |        | Wavy             |                     |        |             | Wavy                |        |             |      | Wavy             |  |  |
|   |  | Straight            |        |        |                     | Straight         |             |                     |        | Straight         |                     |        |             | Straight            |        |             |      | Straight         |  |  |
| <b>Bone Structure</b>   |  | Small               |        |        |                     | Small            |             |                     |        | Small            |                     |        |             | Small               |        |             |      | Small            |  |  |
|   |  | Medium              |        |        |                     | Medium           |             |                     |        | Medium           |                     |        |             | Medium              |        |             |      | Medium           |  |  |
|   |  | Large               |        |        |                     | Large            |             |                     |        | Large            |                     |        |             | Large               |        |             |      | Large            |  |  |
| <b>Other Distinguishing Features</b><br>(e.g., dimples, cleft chin, Roman nose, etc.) |  |                     |        |        |                     |                  |             |                     |        |                  |                     |        |             |                     |        |             |      |                  |  |  |
| <b>Freckles/Moles</b>   |  | None                |        |        |                     | None             |             |                     |        | None             |                     |        |             | None                |        |             |      | None             |  |  |
|   |  | Few                 |        |        |                     | Few              |             |                     |        | Few              |                     |        |             | Few                 |        |             |      | Few              |  |  |
|   |  | Numerous            |        |        |                     | Numerous         |             |                     |        | Numerous         |                     |        |             | Numerous            |        |             |      | Numerous         |  |  |
| <b>Skin</b><br>Choices continue on next page ↓  | <b>VERY FAIR</b> =Little or no ability to tan on sun exposure ♦ <b>FAIR</b> =Skin will tan slightly on sun exposure ♦ <b>MEDIUM</b> =Light color, but will tan moderate-dark |                     |        |        |                     |                  |             |                     |        |                  |                     |        |             |                     |        |             |      |                  |  |  |
|   |  | Very fair           |        |        |                     | Very fair        |             |                     |        | Very fair        |                     |        |             | Very fair           |        |             |      | Very fair        |  |  |
|   |  | Fair                |        |        |                     | Fair             |             |                     |        | Fair             |                     |        |             | Fair                |        |             |      | Fair             |  |  |

**FAMILY HISTORY OF DONOR**

| Mother   |           | Father  |           | Sibling № 1                           |           | Sibling № 2                           |           | Sibling № 3                           |           | Sibling № 4                           |           |
|--|-----------|---|-----------|---------------------------------------|-----------|---------------------------------------|-----------|---------------------------------------|-----------|---------------------------------------|-----------|
|  | Medium    |   | Medium    |                                       | Medium    |                                       | Medium    |                                       | Medium    |                                       | Medium    |
| Olive w/pigment of unexposed skin as:                |           | Olive w/pigment of unexposed skin as:             |           | Olive w/pigment of unexposed skin as: |           | Olive w/pigment of unexposed skin as: |           | Olive w/pigment of unexposed skin as: |           | Olive w/pigment of unexposed skin as: |           |
|  | Slight    |   | Slight    |                                       | Slight    |                                       | Slight    |                                       | Slight    |                                       | Slight    |
|  | Moderate  |   | Moderate  |                                       | Moderate  |                                       | Moderate  |                                       | Moderate  |                                       | Moderate  |
|  | Dark      |   | Dark      |                                       | Dark      |                                       | Dark      |                                       | Dark      |                                       | Dark      |
| Dark w/pigment of unexposed skin as:                 |           | Dark w/pigment of unexposed skin as:              |           | Dark w/pigment of unexposed skin as:  |           | Dark w/pigment of unexposed skin as:  |           | Dark w/pigment of unexposed skin as:  |           | Dark w/pigment of unexposed skin as:  |           |
|  | Light tan |   | Light tan |                                       | Light tan |                                       | Light tan |                                       | Light tan |                                       | Light tan |
|  | Dark tan  |   | Dark tan  |                                       | Dark tan  |                                       | Dark tan  |                                       | Dark tan  |                                       | Dark tan  |
|  | Black     |   | Black     |                                       | Black     |                                       | Black     |                                       | Black     |                                       | Black     |
| <b>Occupation or if retired, from doing what?</b>    |           | <b>Occupation or if retired, from doing what?</b> |           | <b>Occupation:</b>                    |           | <b>Occupation:</b>                    |           | <b>Occupation:</b>                    |           | <b>Occupation:</b>                    |           |
| <b>Indicate highest level of education attained:</b> |           |   |           |                                       |           |                                       |           |                                       |           |                                       |           |
| High School:   |           | High School:                                      |           | High School:                          |           | High School:                          |           | High School:                          |           | High School:                          |           |
|  | 1-year    |   | 1-year    |                                       | 1-year    |                                       | 1-year    |                                       | 1-year    |                                       | 1-year    |
|  | 2-years   |   | 2-years   |                                       | 2-years   |                                       | 2-years   |                                       | 2-years   |                                       | 2-years   |
|  | 3-years   |   | 3-years   |                                       | 3-years   |                                       | 3-years   |                                       | 3-years   |                                       | 3-years   |
|  | 4-years   |   | 4-years   |                                       | 4-years   |                                       | 4-years   |                                       | 4-years   |                                       | 4-years   |
| College/University:                                  |           | College/University:                               |           | College/University:                   |           | College/University:                   |           | College/University:                   |           | College/University:                   |           |
|  | 1-year    |   | 1-year    |                                       | 1-year    |                                       | 1-year    |                                       | 1-year    |                                       | 1-year    |
|  | 2-years   |   | 2-years   |                                       | 2-years   |                                       | 2-years   |                                       | 2-years   |                                       | 2-years   |
|  | 3-years   |   | 3-years   |                                       | 3-years   |                                       | 3-years   |                                       | 3-years   |                                       | 3-years   |
|  | 4-years   |   | 4-years   |                                       | 4-years   |                                       | 4-years   |                                       | 4-years   |                                       | 4-years   |
| Post-graduate:                                       |           | Post-graduate:                                    |           | Post-graduate:                        |           | Post-graduate:                        |           | Post-graduate:                        |           | Post-graduate:                        |           |
|  | 1-year    |   | 1-year    |                                       | 1-year    |                                       | 1-year    |                                       | 1-year    |                                       | 1-year    |
|  | 2-years   |   | 2-years   |                                       | 2-years   |                                       | 2-years   |                                       | 2-years   |                                       | 2-years   |
|  | 3-years   |   | 3-years   |                                       | 3-years   |                                       | 3-years   |                                       | 3-years   |                                       | 3-years   |
|  | 4-years   |   | 4-years   |                                       | 4-years   |                                       | 4-years   |                                       | 4-years   |                                       | 4-years   |
|  | 5+-years  |   | 5+-years  |                                       | 5+-years  |                                       | 5+-years  |                                       | 5+-years  |                                       | 5+-years  |

**Education**

Continues to next page



| FAMILY HISTORY OF DONOR                  |                           |                       |                           |                       |                           |                       |                           |                       |                           |                       |                           |                       |
|--|---------------------------|-----------------------|---------------------------|-----------------------|---------------------------|-----------------------|---------------------------|-----------------------|---------------------------|-----------------------|---------------------------|-----------------------|
|  | Mother                    |                       | Father                    |                       | Sibling № 1               |                       | Sibling № 2               |                       | Sibling № 3               |                       | Sibling № 4               |                       |
|  | Degree(s) - specify:      |                       | Degree(s) - specify:      |                       | Degree(s) - specify:      |                       | Degree(s) - specify:      |                       | Degree(s) - specify:      |                       | Degree(s) - specify:      |                       |
|  | Study major(s) - specify: |                       | Study major(s) - specify: |                       | Study major(s) - specify: |                       | Study major(s) - specify: |                       | Study major(s) - specify: |                       | Study major(s) - specify: |                       |
|  | <input type="checkbox"/>  | Trade School graduate | <input type="checkbox"/>  | Trade School graduate | <input type="checkbox"/>  | Trade School graduate | <input type="checkbox"/>  | Trade School graduate | <input type="checkbox"/>  | Trade School graduate | <input type="checkbox"/>  | Trade School graduate |
|  | OTHER – specify:          |                       | OTHER – specify:          |                       | OTHER – specify:          |                       | OTHER – specify:          |                       | OTHER – specify:          |                       | OTHER – specify:          |                       |
| <b>Special Skills or Characteristics</b> |                           |                       |                           |                       |                           |                       |                           |                       |                           |                       |                           |                       |
| <b>Health Status</b>                     | <input type="checkbox"/>  | Excellent             | <input type="checkbox"/>  | Excellent             | <input type="checkbox"/>  | Excellent             | <input type="checkbox"/>  | Excellent             | <input type="checkbox"/>  | Excellent             | <input type="checkbox"/>  | Excellent             |
|  | <input type="checkbox"/>  | Good                  | <input type="checkbox"/>  | Good                  | <input type="checkbox"/>  | Good                  | <input type="checkbox"/>  | Good                  | <input type="checkbox"/>  | Good                  | <input type="checkbox"/>  | Good                  |
|  | <input type="checkbox"/>  | Fair                  | <input type="checkbox"/>  | Fair                  | <input type="checkbox"/>  | Fair                  | <input type="checkbox"/>  | Fair                  | <input type="checkbox"/>  | Fair                  | <input type="checkbox"/>  | Fair                  |
|  | Deceased – cause:         |                       | Deceased – Cause:         |                       | Deceased – Cause:         |                       | Deceased – Cause:         |                       | Deceased – Cause:         |                       | Deceased – Cause:         |                       |

**EGG DONOR №**

**PERSONAL HEALTH HISTORY**

Describe biological family members according to the following characteristics:

| Biological Family Members: | Eye Color | Natural Hair Color | Complexion (e.g., fair, dark) | Height | Body (e.g., small frame) | Wears Corrective Lens? |                          |    |
|----------------------------|-----------|--------------------|-------------------------------|--------|--------------------------|------------------------|--------------------------|----|
| Mother                     |           |                    |                               |        |                          | Yes                    | <input type="checkbox"/> | No |
| Father                     |           |                    |                               |        |                          | Yes                    | <input type="checkbox"/> | No |
| Maternal Grandmother       |           |                    |                               |        |                          | Yes                    | <input type="checkbox"/> | No |
| Maternal Grandfather       |           |                    |                               |        |                          | Yes                    | <input type="checkbox"/> | No |
| Paternal Grandmother       |           |                    |                               |        |                          | Yes                    | <input type="checkbox"/> | No |
| Paternal Grandfather       |           |                    |                               |        |                          | Yes                    | <input type="checkbox"/> | No |

Number of biological siblings in your immediate family (including yourself) ➡  Number of Males ➡  Number of Females ➡

Are you adopted?  No  Yes  
 Any twins or triplets in your family?  No  Yes, & their relation to me is: \_\_\_\_\_

| Biological Family Members | Age if Surviving | Age at Time of Death | Cause of Death |
|---------------------------|------------------|----------------------|----------------|
| Mother                    |                  |                      |                |
| Father                    |                  |                      |                |
| Brother(s)                | <b>Adopted</b>   |                      |                |
|                           |                  |                      |                |
|                           |                  |                      |                |
|                           |                  |                      |                |
| Sister(s)                 | <b>Adopted</b>   |                      |                |
|                           |                  |                      |                |
|                           |                  |                      |                |
|                           |                  |                      |                |
| Maternal Grandmother      |                  |                      |                |
| Maternal Grandfather      |                  |                      |                |
| Paternal Grandmother      |                  |                      |                |
| Paternal Grandfather      |                  |                      |                |

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

No  Yes – Identify: \_\_\_\_\_

**ONLY IF YOU ARE OF JEWISH ANCESTRY, AFRO-AMERICAN, OR ITALIAN-GREEK DO YOU NEED TO ANSWER THE FOLLOWING APPLICABLE TO YOU.**

| Have you ever been tested as a carrier of: | No                       | Yes, and the result:     |                          |                          |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
|  |                          | Carrier                  | Non-carrier              | Unknown                  |
| Tay-Sach's disease (if of Jewish ancestry) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sickle Cell disease (if Afro-American)     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Thalassemia (if Italian-Greek)             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**EGG DONOR №**

**CAREFULLY REVIEW THE FOLLOWING LIST OF MEDICAL PROBLEMS AND ✓MARK ANY WHICH ARE PRESENT IN BIOLOGICAL FAMILY MEMBERS:**

| MGM = Maternal Grandmother<br>MGF = Maternal Grandfather                                | PGM = Paternal Grandmother<br>PGF = Paternal Grandfather | MA = Maternal Aunt<br>MU = Maternal Uncle | PA = Paternal Aunt<br>PU = Paternal Uncle |         |         | M<br>G<br>M | M<br>G<br>F | P<br>G<br>M | P<br>G<br>F | M<br>A | M<br>U | P<br>A | P<br>U | Other<br>Family<br>Member |
|---|--|---|---|---------|---------|-------------|-------------|-------------|-------------|--------|--------|--------|--------|---------------------------|
| Medical Problems  | You  | Mother                                    | Father                                    | Sibling | Sibling |             |             |             |             |        |        |        |        |                           |
| <b>HEART</b>  |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |
| Stroke  |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |
| Heart Attack  |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |
| Heart Disease from: 1 = Birth, or 2 = Other<br><b>WRITE A "1" OR A "2" IN THE BOX →</b> |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |
| Hardening of the Arteries   |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |
| High Blood Pressure   |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |
| High Cholesterol Level  |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |
| <b>BLOOD</b>  |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |
| Anemia  |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |
| Sickle-cell Anemia  |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |
| Hemophilia or Other Bleeding Disorder   |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |
| HIV virus/AIDS  |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |
| Other Blood Disorder  |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |
| <b>MUSCLE/BONE/JOINTS</b>   |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |
| Muscular Dystrophy  |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |
| Other Chronic Muscle Disease  |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |
| Loss of Muscle Coordination   |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |
| Lupus   |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |
| Osteoporosis  |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |
| Dwarfism  |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |
| Arthritis   |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |
| <b>SIGHT/SOUND/SMELL</b>  |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |
| Deafness before age 60  |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |
| Deformity of the Ear  |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |
| Cataracts before age 50   |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |
| Blindness   |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |
| Color Blindness   |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |
| Glaucoma  |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |
| Any Other Sight/Sound/Smell Disorder  |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |

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|--|--|---|---|---------|---------|-------------|-------------|-------------|-------------|--------|--------|--------|--------|---------------------------|--|
| Medical Problems   | You  | Mother                                    | Father                                    | Sibling | Sibling | M<br>G<br>M | M<br>G<br>F | P<br>G<br>M | P<br>G<br>F | M<br>A | M<br>U | P<br>A | P<br>U | Other<br>Family<br>Member |  |
| <b>SKIN</b>  |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| Acne   |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| Eczema   |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| Pigmentation Disorders                                   |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| Neurofibromatosis  |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| Other Disorders of the Skin                              |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| <b>CONGENITAL ABNORMALITIES</b>                          |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| Cleft Lip/Palate   |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| Congenital Hip Problems                                  |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| Club Feet  |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| Other  |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| <b>GENITAL/REPRODUCTIVE</b>                              |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| Birth Defect of Genitals                                 |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| Uterine Fibroids   |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| Ovarian Cysts  |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| <b>REPRODUCTIVE OUTCOMES</b>                             |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| 2 or More Miscarriages                                   |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| Stillborn  |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| Death of a Newborn Infant                                |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| Endometriosis  |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| Infertility  |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| <b>NEUROLOGICAL</b>                                      |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| Migraines  |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| Mental Retardation                                       |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| Senility before age 50                                   |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| Multiple Sclerosis                                       |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| Cerebral Palsy   |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| Epilepsy/Seizure   |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| Hydrocephalus  |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| Spina Bifida Neural Tube Defect                          |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| Parkinsonism   |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| Scoliosis  |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| Other Diseases   |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |

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|--|--|---|---|---------|---------|-------------|-------------|-------------|-------------|--------|--------|--------|--------|---------------------------|--|
| Medical Problems   | You  | Mother                                    | Father                                    | Sibling | Sibling | M<br>G<br>M | M<br>G<br>F | P<br>G<br>M | P<br>G<br>F | M<br>A | M<br>U | P<br>A | P<br>U | Other<br>Family<br>Member |  |
| <b>MENTAL HEALTH</b>                                     |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| Schizophrenia  |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| Manic Depressive or Bipolar Disorder                     |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| Other Mental Health Disorder Requiring Hospitalization   |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| <b>RESPIRATORY</b>                                       |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| Asthma   |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| Emphysema  |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| Tuberculosis   |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| <b>GASTRO-INTESTINAL</b>                                 |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| Ulcer of Stomach or Duodenum                             |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| Hepatitis  |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| Cirrhosis  |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| Other Liver Disease                                      |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| Ulcerative Colitis                                       |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| Crohn's Disease  |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| Cystic Fibrosis  |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| Pyloric Stenosis   |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| Rectal Disorder  |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| <b>METABOLIC/ENDOCRINE</b>                               |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| Diabetes   |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| Thyroid Disease  |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| Goiter   |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| Hyperactivity  |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| <b>URINARY</b>   |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| Kidney Disease   |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| Other Disease of Urinary Tract (Urethra/Bladder/Ureter)  |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| <b>CHROMOSOMAL ABNORMALITIES</b>                         |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| Down's Syndrome  |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| Other (i.e., Turner's, Fragile X, etc.)                  |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| <b>CANCER</b>  |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| Breast   |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| Ovarian  |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |
| Colon  |  |   |   |         |         |             |             |             |             |        |        |        |        |                           |  |

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|--|-----|--|--------|---|---------|---|-------------|-------------|-------------|--------|--------|--------|--------|---------------------------|
| Medical Problems   | You | Mother   | Father | Sibling                                   | Sibling | M<br>G<br>M                               | M<br>G<br>F | P<br>G<br>M | P<br>G<br>F | M<br>A | M<br>U | P<br>A | P<br>U | Other<br>Family<br>Member |
| Skin   |     |  |        |   |         |   |             |             |             |        |        |        |        |                           |
| Thyroid  |     |  |        |   |         |   |             |             |             |        |        |        |        |                           |
| Cervical   |     |  |        |   |         |   |             |             |             |        |        |        |        |                           |
| Uterine  |     |  |        |   |         |   |             |             |             |        |        |        |        |                           |
| Other  |     |  |        |   |         |   |             |             |             |        |        |        |        |                           |
| <b>OTHER</b>   |     |  |        |   |         |   |             |             |             |        |        |        |        |                           |
| Alcoholism   |     |  |        |   |         |   |             |             |             |        |        |        |        |                           |
| Drug Abuse, Misuse or Addiction                          |     |  |        |   |         |   |             |             |             |        |        |        |        |                           |

**EGG DONOR №**

| MENSTRUAL HISTORY                                       |  |                             |     |    |
|---|--|-----------------------------|-----|----|
| Last menstrual period:                                  |  | Duration of flow (days):    |     |    |
| Average length between the start of each period (days): |  | Do you have regular cycles? | Yes | No |
| Age of first menstrual period:                          |  | Pain with periods?          | Yes | No |
| CONTRACEPTIVE HISTORY                                   |  |                             |     |    |
| Methods Used  |  | Years Used                  |     |    |
| <i>Current Form:</i>                                    |  |                             |     |    |

|                         |  |
|-------------------------|--|
| <i>Previously Used:</i> |  |
|                         |  |
|                         |  |
|                         |  |

| PREGNANCY HISTORY            |               |                         |               |                    |
|------------------------------|---------------|-------------------------|---------------|--------------------|
| Total number of pregnancies: |               | Number of Miscarriages: |               | Ectopic Pregnancy: |
| Number of Living Children:   |               | Abortions:              |               |                    |
| Pregnancy                    | Delivery Date | Place                   | Complications |                    |
| 1                            |               |                         |               |                    |
| 2                            |               |                         |               |                    |
| 3                            |               |                         |               |                    |
| 4                            |               |                         |               |                    |
| 5                            |               |                         |               |                    |
| 6                            |               |                         |               |                    |

Have you ever been treated for a sexually transmitted disease?  Yes  No

| Have you or your partner(s) ever had: | Yourself<br>(✓) | Partner<br>(✓) | Dates |
|---------------------------------------|-----------------|----------------|-------|
| NSU (non-specific urethritis)         |                 |                |       |
| Chlamydia                             |                 |                |       |
| Venereal Warts - HPV                  |                 |                |       |
| Herpes                                |                 |                |       |
| Syphilis                              |                 |                |       |
| Hepatitis-B                           |                 |                |       |
| Gonorrhea                             |                 |                |       |
| AIDS                                  |                 |                |       |
| Tuberculosis                          |                 |                |       |

|   |
|---|
| <b>Do you have any chronic medical problems/conditions?</b> |
|   |

**EGG DONOR №**

|  |                          |    |                          |                  |
|--|--------------------------|----|--------------------------|------------------|
| Are you currently under a physician's care for any reason? | <input type="checkbox"/> | No | <input type="checkbox"/> | Yes – Describe ↓ |
|  |                          |    |                          |                  |

|                            |                          |    |                          |                            |
|----------------------------|--------------------------|----|--------------------------|----------------------------|
| Have you ever had surgery? | <input type="checkbox"/> | No | <input type="checkbox"/> | Yes – List all surgeries ↓ |
| TYPE                       |                          |    |                          | YEAR                       |
|                            |                          |    |                          |                            |
|                            |                          |    |                          |                            |
|                            |                          |    |                          |                            |
|                            |                          |    |                          |                            |
|                            |                          |    |                          |                            |
|                            |                          |    |                          |                            |

| <b>List any prescription, non-prescription, or recreational drugs that you have used or are currently using ↓</b> |              |            |                  |          |
|---|--------------|------------|------------------|----------|
| Name of Drug  | Date Started | Date Ended | Frequency of Use | How Used |
|   |              |            |                  |          |
|   |              |            |                  |          |
|   |              |            |                  |          |
|   |              |            |                  |          |
|   |              |            |                  |          |
|   |              |            |                  |          |

|                                   |                          |      |                          |               |
|-----------------------------------|--------------------------|------|--------------------------|---------------|
| <b>Do you have any allergies?</b> |                          |      |                          |               |
| <input type="checkbox"/>          | No                       |      |                          |               |
| Yes, to                           | <input type="checkbox"/> | Food | <input type="checkbox"/> | Drugs         |
|                                   | <input type="checkbox"/> |      | <input type="checkbox"/> | Plants/Pollen |

| <b>Please list specific substances and reaction(s) produced ↓</b> |          |
|---|----------|
| Substance   | Reaction |
|   |          |
|   |          |
|   |          |
|   |          |

|   |
|---|
| <b>Describe any childhood allergies that you had:</b> |
|   |

|                    |
|--------------------|
| <b>EGG DONOR №</b> |
|--------------------|

|   |                          |           |                          |                             |                          |                 |                          |      |
|---|--------------------------|-----------|--------------------------|-----------------------------|--------------------------|-----------------|--------------------------|------|
| Do you wear Corrective Lenses?                        | <input type="checkbox"/> | No        | <input type="checkbox"/> | Yes                         |                          |                 |                          |      |
| How is your vision (without corrective lenses)?       | <input type="checkbox"/> | Excellent | <input type="checkbox"/> | Good                        | <input type="checkbox"/> | Fair            | <input type="checkbox"/> | Poor |
| Your vision is: 20/                                   |                          |           |                          |                             |                          |                 |                          |      |
| Do you have any hearing impairments?                  | <input type="checkbox"/> | No        | <input type="checkbox"/> | Yes                         |                          |                 |                          |      |
| How many drinks per average week do you consume?      |                          |           |                          |                             |                          |                 |                          |      |
| Have you ever had a drinking problem?                 |                          |           |                          |                             |                          |                 |                          |      |
| Have you ever been treated for alcohol or drug abuse? |                          |           |                          |                             |                          |                 |                          |      |
| Do you smoke cigarettes?                              | <input type="checkbox"/> | No        | <input type="checkbox"/> | Yes, & number of packs/day? | <input type="checkbox"/> | & for how long? | <input type="checkbox"/> |      |
| Have you had a recent weight loss or gain?            | <input type="checkbox"/> | No        | <input type="checkbox"/> | Yes                         |                          |                 |                          |      |

**DONOR'S:**

- **Name:** \_\_\_\_\_
- **Address:**  
\_\_\_\_\_
- **Phone Numbers (Include the Area Code)**
  - **Work** \_\_\_\_\_ **Ext.** \_\_\_\_\_
  - **Home** \_\_\_\_\_
  - **Cell** \_\_\_\_\_
- **Date of Birth:** \_\_\_\_\_
- **Social Security №** \_\_\_\_\_
- **Name of Insurance Company:** \_\_\_\_\_

**Contact name & number of friend/family member who is aware of your OHSU program participation:**

\_\_\_\_\_

- Yes**  **No** Would you consider sharing a photograph of yourself with a recipient couple?
- Yes**  **No** Would you consider meeting with a recipient couple?
- Yes**  **No** Would you want to know of any adverse outcomes of the pregnancy?

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

**Is there a better time (day/evening/Saturday) for you to attend the orientation session?**

\_\_\_\_\_