

Donor ID# _____ (Assigned by ECII staff)

Please answer the following questions with as much detail and thoroughness as possible. Please return the completed questionnaire to the clinic using the included pre paid envelope. If you are completing an electronic form please resave the document and email back to the clinic with *Donor Questionnaire* as the subject. We thank you for your interest in becoming a donor with our program, and look forward to working together in the future.

PHYSICAL CHARACTERISTICS:

Month / Year of Birth _____
 Occupation (do not indicate a specific company) _____
 Height _____
 Weight _____

Please list known countries of origin, race, and religion for the following family members.

	<u>Country of Origin</u>	<u>Race</u>	<u>Religion</u>
Mother	_____	_____	_____
Maternal Grandmother	_____	_____	_____
Maternal Grandfather	_____	_____	_____
Father	_____	_____	_____
Paternal Grandmother	_____	_____	_____
Paternal Grandfather	_____	_____	_____

Mark one answer for each of the following

- | | | | | |
|--------------------------------------|---------------------------------------|--|--|---------------------------------|
| <u>Complexion</u> | <u>Natural Hair Color</u> | <u>Hair Texture</u> | <u>Eye Color</u> | <u>Body Build</u> |
| <input type="checkbox"/> Fair | <input type="checkbox"/> Light Blonde | <input type="checkbox"/> Wavy | <input type="checkbox"/> Gray | <input type="checkbox"/> Small |
| <input type="checkbox"/> Light | <input type="checkbox"/> Blonde | <input type="checkbox"/> Curly | <input type="checkbox"/> Blue | <input type="checkbox"/> Medium |
| <input type="checkbox"/> Medium | <input type="checkbox"/> Dark Blonde | <input type="checkbox"/> Straight | <input type="checkbox"/> Hazel | <input type="checkbox"/> Large |
| <input type="checkbox"/> Dark | <input type="checkbox"/> Light Brown | | <input type="checkbox"/> Green | |
| <input type="checkbox"/> Olive | <input type="checkbox"/> Brown | | <input type="checkbox"/> Brown | |
| <input type="checkbox"/> Light Olive | <input type="checkbox"/> Dark Brown | | | |
| <input type="checkbox"/> Dark Olive | <input type="checkbox"/> Black | | | |
| | <input type="checkbox"/> Auburn | | | |
| | <input type="checkbox"/> Red | | | |
| <u>Blood Type</u> | <u>RH Factor</u> | <u>Freckles</u> | <u>Sun Exposure</u> | |
| <input type="checkbox"/> A | <input type="checkbox"/> Positive | <input type="checkbox"/> No | <input type="checkbox"/> Burn easily | |
| <input type="checkbox"/> B | <input type="checkbox"/> Negative | <input type="checkbox"/> Light on face only | <input type="checkbox"/> Tan easily | |
| <input type="checkbox"/> AB | | <input type="checkbox"/> Heavy on face only | <input type="checkbox"/> Burn then tan | |
| <input type="checkbox"/> O | | <input type="checkbox"/> Light all over body | <input type="checkbox"/> Don't tan or burn | |
| | | <input type="checkbox"/> Heavy all over body | | |

Indicate your tanning habits for the following periods of time

	<u>Birth – 13 years old</u>	<u>13-20 years old</u>	<u>Current Habits</u>
Spray Tan	_____	_____	_____
UV Bed	_____	_____	_____
Excessive exposure with several severe burns	_____	_____	_____
Moderate exposure with few minor burns	_____	_____	_____
Minimal exposure few to no burns	_____	_____	_____

Are you predominantly:

_____ Right Handed _____ Left Handed _____ Ambidextrous

EDUCATION

Please indicate number of years you attended

High School	___ 1	___ 2	___ 3	___ 4	___ >4
Technical School	___ 1	___ 2	___ 3	___ 4	___ >4
College	___ 1	___ 2	___ 3	___ 4	___ >4
Post Graduate	___ 1	___ 2	___ 3	___ 4	___ >4

Please indicate your GPA for your levels of education

High School _____
 Technical School _____
 College _____
 Post Graduate _____

Please list the universities / colleges you have attended and the degree received:

<u>Name of Institution</u>	<u>Degree</u>	<u>Area of Study</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

PERSONAL ATTRIBUTES

Please describe your personality and character

Please list your hobbies

Please describe any musical, artistic or athletic abilities

Do you feel you have any leadership qualities? How have they been demonstrated in your life?

Do you speak any other languages? Please list them and your degree of fluency

What are your future goals and aspirations?

Please complete the following statements:

I am proud of...

What I value most is...

What I dislike most is...

My best subjects in school are / were...

My Favorite....

Book	_____
Movie	_____
Type of Music	_____
Musical Artist/Group	_____
Food	_____
Color	_____
Season	_____
Holiday	_____
Sport	_____
TV Program	_____
Childhood Memory	_____

MEDICAL HISTORY

Please list and ongoing or chronic medical conditions or indicate NONE

Please list any allergies you have or have had in the past or indicate NONE

Have you ever had the following?

	NO	YES	AGE
Braces	_____	_____	_____
Prescription treatment for acne	_____	_____	_____
Lasik or another corrective eye surgery	_____	_____	_____
Gastric Bypass or stomach surgery for weight loss	_____	_____	_____
Plastic surgery for cosmetic enhancement	_____	_____	_____
Plastic Surgery to correct a physical anomaly	_____	_____	_____
Chemotherapy and / or radiation	_____	_____	_____

	NO	YES
Have you ever or do you currently wear eye glasses	_____	_____
Have you ever or do you currently wear contact lenses	_____	_____

What is your current vision without corrective lenses _____

At what age did you begin wearing corrective lenses _____

Do you have a history of any of the following?

	NO	YES
Farsightedness	_____	_____
Nearsightedness	_____	_____
Stigmatism	_____	_____
Double Vision	_____	_____
Poor Night Vision	_____	_____
Glaucoma	_____	_____

Please list any medications you have take in the past three months:

<u>Medication Name</u>	<u>Dose / Frequency</u>	<u>Reason</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please indicate the frequency of use for the following substances:

Alcohol	_____
Tobacco	_____
Marijuana	_____
Cocaine	_____
Other Recreational Drugs	_____
Herbal Medications	_____

Please list any surgeries you have or have had in the past or indicate NONE:

Please list any anesthesia complications you have or have had in the past or indicate NONE:

Please indicate if you have experienced any of the following:

	<u>YES</u>	<u>NO</u>	
Abnormal PAP Smear	_____	_____	If YES, "x" if you had treatment _____
Anemia	_____	_____	
Amenorrhea (no menstrual period)	_____	_____	
Appendicitis	_____	_____	
Back Problems (requiring surgery)	_____	_____	
Milky discharge from breast	_____	_____	
Chronic Headaches	_____	_____	
Endometriosis	_____	_____	
Hearing Issues	_____	_____	
Hirsutism (excessive hair growth)	_____	_____	
Irregular periods	_____	_____	
Kidney Infection	_____	_____	
Ovarian Cysts	_____	_____	
Pelvic Inflammatory Disease (PID)	_____	_____	
Rheumatic Fever	_____	_____	
Tubal Disease	_____	_____	
Tuberculosis	_____	_____	
Vaginitis (Trichomoniasis, yeast)	_____	_____	If YES indicate # of episodes _____
Venereal Warts	_____	_____	
Visual Disturbances	_____	_____	

FERTILITY HISTORY

	<u>NO</u>	<u>YES</u>	<u>Please explain if YES</u>
Is there a family history of infertility?	_____	_____	_____
Is there a family history of hormonal disorders?	_____	_____	_____
Have you been treated for infertility before?	_____	_____	_____

What is your current method of birth control and how long have you used this method?

At what age was your first period? _____

	<u>NO</u>	<u>YES</u>	
Do you have a period every month? (how often if No)	_____	_____	_____
Do you have spotting/bleeding between periods?	_____	_____	
Have you ever been pregnant (if NO skip to Sexual History)	_____	_____	
How many times have you been pregnant?	_____		
How many miscarriages have you had?	_____		
How many pregnancies have you elected to terminate?	_____		
How many live births have you had?	_____		
How many of your children are living with you currently?	_____		

Please list any birth defects, illnesses (other than usual childhood) for each child. If you have experienced the death of a child please tell us their age and cause of death. Please omit any names or birth dates.

CHILD #1 _____
 CHILD #2 _____
 CHILD #3 _____
 CHILD #4 _____

SEXUAL HISTORY

Please indicate your sexual orientation ___ Heterosexual ___ Homosexual ___ Bisexual

When was your last HIV test (NONE if you have never had one)? _____

What were the results of your latest test? ___ Positive ___ Negative ___ Not Tested

How many sexual partners have you had _____ How many were in the past 12 months? _____

Have you or any of your sexual partners ever had any of the following:

	<u>YES</u>	<u>NO</u>	Who had the disease? You/Partner/Both	Month/Year of infection	Was the disease treated?
Gonorrhea	_____	_____	_____	_____	_____
Syphilis	_____	_____	_____	_____	_____
Hepatitis A	_____	_____	_____	_____	_____
Hepatitis B	_____	_____	_____	_____	_____
Hepatitis C	_____	_____	_____	_____	_____
Chlamydia	_____	_____	_____	_____	_____
Genital Warts	_____	_____	_____	_____	_____
Genital Herpes	_____	_____	_____	_____	_____

FAMILY HISTORY

Are you adopted? ___ Yes ___ No

Are you familiar with you biological family's medical history? (YES proceed / NO skip to next section) ___ Yes ___ No

	Are they living?		Their Age (or age at death)	Medical Conditions / Cause of Death
	YES	NO		
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Brother #1	_____	_____	_____	_____
Brother #2	_____	_____	_____	_____
Brother #3	_____	_____	_____	_____
Sister #1	_____	_____	_____	_____
Sister #2	_____	_____	_____	_____
Sister #3	_____	_____	_____	_____
Maternal Grandmother	_____	_____	_____	_____
Paternal Grandmother	_____	_____	_____	_____
Maternal Grandfather	_____	_____	_____	_____
Paternal Grandfather	_____	_____	_____	_____

To the best of your knowledge please complete the following table:

	<u>Eye Color</u>	<u>Hair Color</u>	<u>Hair Texture</u>	<u>Skin Tone</u>	<u>Height</u>	<u>Weight</u>
Mother	_____	_____	_____	_____	_____	_____
Father	_____	_____	_____	_____	_____	_____
Brother #1	_____	_____	_____	_____	_____	_____
Brother #2	_____	_____	_____	_____	_____	_____
Brother #3	_____	_____	_____	_____	_____	_____
Sister #1	_____	_____	_____	_____	_____	_____
Sister #2	_____	_____	_____	_____	_____	_____
Sister #3	_____	_____	_____	_____	_____	_____
Maternal Grandmother	_____	_____	_____	_____	_____	_____
Paternal Grandmother	_____	_____	_____	_____	_____	_____
Maternal Grandfather	_____	_____	_____	_____	_____	_____
Paternal Grandfather	_____	_____	_____	_____	_____	_____

Please list any genetic diseases that run in your family or indicate NONE:

Please indicate below if you or any member of your biological family has had any of these medical conditions or diseases. In the space provided please list the family member(s) who is/are affected.

	YES	NO	Individual(s) Affected
Cleft Palate	_____	_____	_____
Cleft Lip	_____	_____	_____
Spina Bifida	_____	_____	_____
Congenital heart disease	_____	_____	_____
Congenital hip dislocation	_____	_____	_____
Club foot	_____	_____	_____
Other Birth Defects (please specify)	_____	_____	_____
Albinism	_____	_____	_____
Hemophilia	_____	_____	_____
Carrier for Hemophilia trait	_____	_____	_____
Hemoglobin Disorder	_____	_____	_____
Hemochromatosis	_____	_____	_____
Hereditary Hypercholesterolemia	_____	_____	_____
Neurofibromatosis (von Recklinghausen's disease)	_____	_____	_____
Tuberous Sclerosis	_____	_____	_____
Asthma	_____	_____	_____

	<u>YES</u>	<u>NO</u>	Individual(s) Affected
Juvenile diabetes	_____	_____	_____
Adult onset diabetes	_____	_____	_____
Epilepsy	_____	_____	_____
Hypertension	_____	_____	_____
Psychiatric disorder	_____	_____	_____
Rheumatoid arthritis	_____	_____	_____
Sever eye refractive disorder	_____	_____	_____
Early coronary disease	_____	_____	_____
Cystic Fibrosis	_____	_____	_____
Carrier for Cystic Fibrosis trait	_____	_____	_____
G6P Deficiency	_____	_____	_____
Thalassemia	_____	_____	_____
Sickle Cell Anemia	_____	_____	_____
Carrier for Sickle Cell trait	_____	_____	_____
Tay-Sachs disease	_____	_____	_____
Abnormal Chromosome arrangement	_____	_____	_____
Mental Retardation	_____	_____	_____
Huntington's Chorea	_____	_____	_____
Congenital Adrenal Hyperplasia	_____	_____	_____
Fascioscapulohumeral Muscular Dystrophy	_____	_____	_____
Adult onset polycystic kidney disease	_____	_____	_____
Hypertropic Idiopathic Subaortic Stenosis (HISS)	_____	_____	_____
Amyotrophic Lateral Sclerosis (AMLS)	_____	_____	_____
Hereditary Spherocytosis	_____	_____	_____
Myotonic Dystrophy	_____	_____	_____
Duchene's Muscular Dystrophy	_____	_____	_____
Becker's Muscular Dystrophy	_____	_____	_____
Aqueductal Hydrocephalus	_____	_____	_____
Fragile X Syndrome	_____	_____	_____
Retinitis Pigmentosa	_____	_____	_____
Multiple Ployposis of the colon	_____	_____	_____
Marfan Syndrome	_____	_____	_____
Retinoblastoma	_____	_____	_____
Alport's Disease	_____	_____	_____
Cataracts before age 40	_____	_____	_____
Deafness before age 60	_____	_____	_____
Cancer – list type next to individual	_____	_____	_____

PHILOSOPHY ABOUT EGG DONATION

Would you be willing to meet a child / children in the future if they wanted to know about their genetic roots? _____ Yes _____ No

Are you willing to contact the fertility center if any significant medical information comes to light in your family? _____ Yes _____ No

If you could pass a message to the recipient couple what would it be?

DEMOGRAPHIC INFORMATION

The following information will not be disclosed to any potential recipients. If you are completing this form electronically please print out this form, sign it where indicated and mail it back to 200 White Road Suite 214, Little Silver, NJ 07739, attention Donor Program. **Please do not complete this section and send it back electronically**

First Name _____

Last Name _____

Contact Number #1 _____

Contact Number #2 _____

Address where correspondence can be sent _____

e-mail address _____

Date of birth (MM/DD/YYYY) _____

Age at Application _____

Marital Status _____

By signing below, I verify that the information provided in this document is truthful and accurate to the best of my knowledge. I have answered honestly to all questions including my age, medical, sexual, and family history.

Signature

Date

Please attach a picture(s) of yourself as an infant or toddler. These can be sent as attachments with an electronic submission or mailed under separate cover. Please note original photos mailed in will not be returned unless requested.

IF YOU HAVE ANY QUESTIONS PLEASE CONTACT OUR OFFICE (732) 758-6511.

Thank you for your time and effort – shortly after receiving your application we will contact you by phone.