Egg Donation Screening Form

Arkansas Fertility & Gynecology
9101 Kanis Road, Suite 300
Little Rock, Arkansas 72205

Thank you for choosing to become an egg donor. This is one of the most fulfilling and honorable decisions that a woman can make. Egg donors like you help couples to create their families that would otherwise only remain a dream.

In order to qualify for the program, the two most basic requirements are that you are between 22 and 31 years of age and you must also have a Body Mass Index (BMI) of less than or equal to 30. Click here to figure your BMI

If you meet these two basic requirements please continue to fill out the screening form. Fill the entire form out completely and include detailed information about any personal or family illnesses and diseases. If the form is incomplete it could cause you to be denied or cause the review process to be much longer so that additional information can be obtained. Once the form has been submitted the review process will begin. You will be notified via e-mail of the approval or denial of your submission.

First Name Last Name Birth Date Social Security Number

Address City State Zip Code

Mobile telephone # E-mail Address

Your occupation Your employer & location

Marital Status Maiden Name Partner's first and last name

Highest Level of Education College Major / Minor / Area of interest / Future plans for education

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PERSONAL CHARACTERISTICS & TRAITS

Race If "Other" please describe

Mother's ethnic background. Please check all that apply.

African	British	Chinese	European	German	Irish
Italian	Japanese	Jewish	Mexican	Scottish	Swiss
Mediterranean	Indian (Middle Eastern)		Indian (Native American)		Other

If "other" please describe

Father's ethnic background. Please check all that apply.

African	British	Chinese	European	German	Irish
Italian	Japanese	Jewish	Mexican	Scottish	Swiss
Mediterranean	Indian (Middle Eastern)		Indian (Native American)		Other

If "other" please describe

Height   Weight (lbs)   BMI   Body Build

Complexion   Eye Color   Hair Color   Hair Type

Include any additional information about your physical characteristics that you would like to share

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CLINICAL INFORMATION

Do you SMOKE?   YES   NO

Have you ever smoked?   YES   NO

If "yes" please explain how often and how much you smoked and how many months since the last time you smoked. *If you have never smoked, enter N/A*

Do you DRINK alcohol?   YES   NO

If "yes" how often?

Are you currently using a method of birth control?   YES   NO

If "yes" what method are you using?

Are you currently on ANY medications? *This includes both prescription and over the counter medications.*

If "yes" please provide more information below. *Include birth control pills, Ortho-Evra patch, Nuva Ring, etc.*

Name of Medication	Daily dosage	Diagnosis (Reason for medication)	Any additional information

Have you ever had surgery? *(This includes c-sections)*   YES   NO

If "yes" please provide more information below.

Year	Procedure (Type of surgery)	Diagnosis (Reason for surgery)	Outcome / Complications Any additional information

FDA SCREENING QUESTIONS

Have you ever had a sexually transmitted disease?

YES NO

If "yes" check all that apply

HPV Herpes Chlamydia Gonorrhea Syphilis Genital warts

If "yes" what date(s):

In the past 5 years have you or a male partner ever had sexual contact with a male homosexual, bisexual, or IV drug user?

YES NO

Has your current male partner ever been in jail or prison?

YES NO

In the past 12 months have you been in jail for more than 3 days in a row?

YES NO

Have you ever received or given money or drugs in exchange for any sexual act?

YES NO

In the past 12 months have you had sexual relations with anyone who could answer "yes" to any of the above questions?

YES NO

In the past 12 months have you had sexual contact with a person known or suspected to have HIV, Hepatitis B, or Hepatitis C?

YES NO

In the past 12 months have you been in contact with a person known or suspected to have active viral Hepatitis?

YES NO

Have you had sexual contact with anyone who was born or lived in any African country anytime between 1977 and today?

YES NO

Were you born in, lived in, or traveled to any African country anytime between 1977 and today?

YES NO

After age 11 were you diagnosed with or treated for viral Hepatitis, Hepatitis B, or Hepatitis C?

YES NO

Have you ever been told that you could not donate blood?

YES NO

If "yes" please explain:

Have you or your current partner ever received a blood transfusion?

YES NO

If "yes" please list the date(s) and the country:

FDA SCREENING (CONTINUED)

Have you ever used marijuana? YES NO

Have you ever used cocaine? YES NO

Have you ever use heroine? YES NO

Have you ever used LSD? YES NO

Have you ever used methamphetamine? YES NO

Have you ever used ecstasy? YES NO

If "yes" to any of the questions above on THIS page, please describe when and how often:

Have you ever used or are you using ANY prescription medication for reasons other than its medical purpose?

YES NO If "yes" please explain

Have you ever used ANY illicit drug not listed above?

YES NO If "yes" please explain

During work are you exposed to toxic or radioactive substances? YES NO

Have you ever had a needle stick injury? YES NO

If "yes" please explain (when, where, how, testing):

Have you ever been tested for HIV / AIDS? YES NO

If "yes" when & results?

Have you recently received any vaccinations? YES NO

If "yes" what type and when?

In the past 7 days have you had any of the following symptoms? Check all that apply.

Flu like symptoms Swollen glands Fatigue Headache(s) Fever of more than 101°

Have you or your partner ever been diagnosed with West Nile Virus? YES NO

Have you ever received a dura mater (brain covering) graft? YES NO

Have you or your partner ever been diagnosed with CJD? YES NO

Between the years 1988 and 1996 were you a member of the US Military, a civilian military employee, or a depended of a member of the US Military?

YES NO

Have you been treated for SARS within the last 28 days? YES NO

Within the past 12 months have you received any of the following? Check all that apply.

None Tattoos Permanent makeup Body piercing Acupuncture

If "yes" please list the date, business used, and business location (city and state):

SCREENING QUESTIONS

Please answer each of the following questions and provide additional information where it is necessary.

TRAVEL

1. Between 1988 and today have you traveled to any of the following European countries? Check all that apply.

None

England	France	The Isle of Man
Wales	Scotland	The United Kingdom
Gibraltar	The Falkland Islands	The Channel Islands

Please provide the following information for any location that is marked above:

Location	Date(s)	Total # of Days

2. Have you spent a total of 6 months or more associated with a military base in any of the following countries? Check all that apply.

None

Belgium	Italy	Portugal	Turkey
Germany	Spain	Greece	The Netherlands

Please provide the following information for any location that is marked above:

Location	Date(s)	Total # of Days

3. **During the last 6 months have you, or any sexual partner that you've had during the last 6 months, resided in or traveled to any of the locations listed below for ANY amount of time?**

This includes cruise ship travel, regardless of whether or not you disembarked from the ship at the port of call

Mexican Riviera None

Cape Verde   Mexico (any part of the country)

The Caribbean None

Aruba	Barbados	Bonaire	Cuba	Curacao
Dominica	Dominican Republic	Guadeloupe	Haiti	Jamaica
Martinique	Puerto Rico	Saint Maarten	Saint Martin	
Trinidad & Tobago	US Virgin Islands	Saint Vincent & the Grenadines		

Central America None

Costa Rica El Salvador Guatemala Honduras Nicaragua Panama

Pacific Islands None

American Samoa Marshall Islands New Caledonia Samoa
Fiji Tonga Kosrae (Federated States of Micronesia)

South America None

Bolivia Paraguay Brazil Ecuador Suriname
Colombia Venezuela French Giuana Guyana

United States None

California Florida New York Texas

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If you marked any of the boxes above, please give more detail about your travel in the boxes below.

Location	**Traveler**	**Arrival Date**	**Departure Date**	*For clinic use only*

Additional information that you would like to include about your travel:
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MEDICAL HISTORY

The following is related to your own personal medical history

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Have you ever been diagnosed with or treated for any of the following conditions?
Check all that apply.

NONE

Allergies – Drug	Clubfeet	Hydrocephalus
Allergies - Seasonal	Congenital heart disease	Kidney problems
Anemia	Congenital hip dislocation	Kidney stones
Anxiety	Depression	Migraine headaches
Arthritis	Diabetes	Neurofibromatosis
Asthma – childhood	Epilepsy	Schizophrenia
Asthma – current	Gastrointestinal disorder	Sickle cell disease
Bipolar disease	Hearing problems	Skin problems
Birth defects	High blood pressure	Skin rashes
Bleeding disorder	High cholesterol	Substance abuse
Cancer	Human organ transplant	Thalassemia
Chromosomal abnormality	Human tissue transplant	Thyroid disease

Other:

Please describe any of the above conditions that you have checked. Include the age at which you were diagnosed or treated, any treatment that you received, and the physician providing your care.

Condition	Age	Physician	Information about the condition/treatment

Any additional information that you would like to include

FAMILY MEDICAL HISTORY

The following is related to the medical history of your family

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Have any family members ever been diagnosed with or treated for any of the following conditions?
Check all that apply.

NONE

Adrenoleukodystrophy
Albinism
Alport disease
Alzheimer's disease
Anxiety
Bipolar disorder
Bleeding disorder
Bipolar disease
Birth defects
Bleeding disorder
Blindness – childhood
Blindness – adulthood
Blood clots / clotting
Chromosomal abnormality
Cleft lip
Cleft palate
Clubfeet
Colon polyps
Color blindness
Congenital heart problems
Congenital hip dislocation
Congestive heart failure
CJD
Crib death
Cystic Fibrosis

Deafness – childhood
Deafness - adulthood
Depression
Developmental delay – physical
Developmental delay – mental
Diabetes
Down Syndrome
Dwarfism
Early death (before age 35)
Endometriosis
Fibromyalgia
Fragile X Syndrome
Glactosemia
Hemacromatosis
Heart attack (before age 35)
Heart attack (after age 35)
High blood pressure
High cholesterol
Huntington's disease
Hydrocephalus
Hypospadias
Infertility
Joint disorder
Kleinfelter's syndrome
Manic disorder

Marfan's syndrome
Menopause (before age 40)
Mental retardation
Multiple sclerosis
Muscular Dystrophy
Neural tube defect(s)
PKU
Polycystic kidney disease
Polycystic ovarian disease
Retinitis pigmentosis
Retinoblastoma
Rheumatoid arthritis
Schizophrenia
Sickle cell anemia
SIDS
Suicide
Tay-Sachs disease
Thalassemia
Thyroid disease
Tuberculosis
Unexplained death (any age)
Cancer
- Breast
- Ovarian
- Colon
- Uterine
- Other:

Other condition not listed above:

Please include as much information as you can in the boxes below.

Condition / Disease	Relation	When diagnosed (age, year, etc.)

GYNECOLOGICAL HISTORY

How old were you when you started your first period?

How many days from the start of one period until the start of the next?

How many days does your flow last?

Do any of the following apply to you? Check as many as necessary.

Irregular cycles	Pain with periods	Bleeding between periods	Missed periods
Excessive acne	Excessive hair growth	Bleeding after intercourse	Breast discharge

Have you ever been diagnosed with any of the following?

Endometriosis	Polycystic ovaries	PID (Pelvic Inflammatory Disease)
Pelvic adhesions	Infertility	

Have you ever had a mammogram? YES NO

If "yes" please explain why, when, and the results

When was your most recent pap smear? What were the results?

Have you ever had an abnormal pap smear? YES NO

Are you currently sexually active? YES NO # of sexual partners in the last 2 years

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PREGNANCY INFORMATION

Have you ever been pregnant? YES NO

# of pregnancies

Have you completed your childbearing? YES NO

Pregnancy #1 Pregnancy #2 Pregnancy #3

List any additional pregnancy information (including any complications) below:

FAMILY HISTORY

If any member of your family is listed as deceased, give their age at the time of death in the "Age" box and explain their cause of death.

If you are unsure of a family member's age, you can estimate. Enter "4s" if you know that they are between 4 - 5 years old.

Your siblings

Age Health issues/cause of death

Age Health issues/cause of death

Age Health issues/cause of death

*If you have more than 3 siblings use the space at the end of this section to enter the additional information.

MOTHER'S FAMILY

Mother Age Health issues / Cause of death

Your mother's siblings

Age Health issues/cause of death

Age Health issues/cause of death

Age Health issues/cause of death

*If your mother has more than 3 siblings use the space below to enter the additional information.

Maternal Grandmother Age Health issues/Cause of death

Maternal Grandfather Age Health issues/Cause of death

FATHER'S FAMILY

Father Age Health issues / Cause of death

Your father's siblings

Age Health issues/cause of death

Age Health issues/cause of death

Age Health issues/cause of death

*If your father has more than 3 siblings use the space at the end of this section to enter the additional information.

Paternal Grandmother Age Health issues/Cause of death

Paternal Grandfather Age Health issues/Cause of death

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Additional information about you and/or your family
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EGG DONATION INFORMATION AND NOTIFICATION

Have you previously been an egg donor? YES NO

If "yes" please give details of the cycle:

Please answer the following questions: (Note – The duration of a cycle is 6-8 weeks)

I can and will discontinue my form of birth control for the duration of the cycle. YES NO

I can and will abstain from intercourse for the duration of the cycle. YES NO

I have a support person to assist me during the cycle process, *including injections and transportation*. YES NO

I have a flexible schedule to allow for frequent early morning appointments during the cycle. YES NO

Do you have knowledge of and the ability to complete the following tasks related to the donation process?

Self injectable medications YES NO

Early morning appointments YES NO

Frequent lab testing YES NO

Frequent vaginal ultrasounds YES NO

Complete a psychological evaluation YES NO

Use an alternate form of contraception when instructed YES NO

Commit to the timeframe once a donation cycle has started YES NO

Include any additional family information that you would like to share

Include any additional information about yourself that you would like to share (hobbies, talents, etc.)

What led you to choose egg donation?

When submitting your screening form for review, please also include a few photos of yourself that you wouldn't mind sharing.

By giving my physical or electronic signature below I attest that the information that I have provided in this screening form is true and accurate to the best of my knowledge.

Submit your **saved** form to arkansasfertility@gmx.com

Date (mm/dd/yy)