Egg Donation Screening Form

Arkansas Fertility & Gynecology
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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 the ages of 21 and 32 years 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 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” when was the last time you smoked?

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.*
☐ YES ☐ NO

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" please list date (month & year) and results:

Have you recently received any vaccinations?

☐ YES ☐ NO

If "yes" please explain (type of vaccination and when received)

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

FDA SCREENING (CONTINUED)

Between the years 1980 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.

☐ 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 1980 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	Arrival Date	Departure Date	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	Arrival Date	Departure Date	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

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

Location	**Traveler** (You, your partner, or both)	**Arrival Date**	**Departure Date**	*For clinic use only*

Additional information that you would like to include:

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

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
- ☐ Other condition not listed above:
- ☐ 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 50)
- ☐ Heart attack (after age 50)
- ☐ 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:

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 period(s)
- [ ] 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 partners in the last 2 years [ ]

PREGNANCY INFORMATION

Have you ever been pregnant? [ ] YES [ ] NO

# of pregnancies [ ]

Have you completed your childbearing? [ ] YES [ ] NO

Pregnancy #1	Pregnancy #2	Pregnancy #3
Year _____________	Year _____________	Year _____________
[ ] Live birth [ ] Still birth	[ ] Live birth [ ] Still birth	[ ] Live birth [ ] Still birth
[ ] Miscarriage [ ] Abortion	[ ] Miscarriage [ ] Abortion	[ ] Miscarriage [ ] Abortion
[ ] Ectopic	[ ] Ectopic	[ ] Ectopic
# weeks gestation __________	# weeks gestation __________	# weeks gestation __________
[ ] Male [ ] Female	[ ] Male [ ] Female	[ ] Male [ ] Female
Weight ___________________	Weight ___________________	Weight ___________________
[ ] Complications *(please explain)*	[ ] Complications *(please explain)*	[ ] Complications *(please explain)*

List any additional pregnancy information 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 "40s" if you know that they are between 40 - 50 years old.

Do you have any siblings? ☐ YES ☐ NO

If "yes" how many? ☐

Gender	☐Male ☐Female	☐Male ☐Female	☐Male ☐Female	☐Male ☐Female
Relation	☐Full ☐Half	☐Full ☐Half	☐Full ☐Half	☐Full ☐Half
Age				
Health Problems				

*If you have more than 4 siblings use the space at the end of this section to enter the additional information.

MOTHER'S FAMILY

Mother -- ☐ Living ☐ Deceased

Age ☐

Does your mother have siblings? ☐ YES ☐ NO

If "yes" how many? ☐

Health issues / Cause of death ☐

Gender	☐Male ☐Female	☐Male ☐Female	☐Male ☐Female	☐Male ☐Female
Relation	☐Full ☐Half	☐Full ☐Half	☐Full ☐Half	☐Full ☐Half
Age				
Health Problems				

*If your mother has more than 4 siblings use the space at the end of this section to enter the additional information.

Maternal Grandmother ☐ Living ☐ Deceased

Age ☐

Health issues / Cause of death ☐

Maternal Grandfather ☐ Living ☐ Deceased

Age ☐

Health issues / Cause of death ☐

FATHER'S FAMILY

Father -- ☐ Living ☐ Deceased

Does your father have siblings? ☐ YES ☐ NO

Age

If "yes" how many?

Health issues / Cause of death

Gender	☐Male ☐Female	☐Male ☐Female	☐Male ☐Female	☐Male ☐Female
Relation	☐Full ☐Half	☐Full ☐Half	☐Full ☐Half	☐Full ☐Half
Age				
Health Problems				

*If your father has more than 4 siblings use the space at the end of this section to enter the additional information.

Paternal Grandmother
☐ Living ☐ Deceased

Age

Health issues / Cause of death

Paternal Grandfather
☐ Living ☐ Deceased

Age

Health issues / Cause of death

Additional Information:

Your sibling(s)

Mother's sibling(s)

Father's sibling(s)

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 flexibility with my 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.

______________________________	_________________________________	___________________
Print Name	Signature	Date