



Egg Donor Program of Michigan

Phone: 989.239.4550
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5220 State Street
Suite 250
Saginaw, MI 48603

Questionnaire

Please carefully complete the attached questionnaire in pen and answer each question as thoroughly as possible. Also, you should consult with members of your biological family for any answers to which you are unsure regarding their medical history.

Recipients that are interested in choosing you as their egg donor will receive a copy of this questionnaire, not including any identifying information (your name, address, etc.). For this reason we ask you to take some time in answering these questions. Potential egg recipients will be choosing you based on your answers, so please answer each question to the best of your ability.

Thank you. Please call us if you have any questions.

Donor Egg Questionnaire

Date filled out _____/_____/_____

Name _____

SS# _____ - _____ - _____

Date of birth _____/_____/_____ Age _____

Marital Status () Single () Engaged () Married () Divorced () Widowed

Mailing Address _____
Street or P.O. Box

City

State initials

Zip Code

Home Telephone () _____ Ok to leave a message? Yes or no

Work Telephone () _____ Ok to leave a message? Yes or no

Mobil number () _____ Ok to leave a message? Yes or no

Email Address _____

Would you be willing to travel out of the state to donate? _____
(If you are traveling a long distance, the majority of your travel costs will not be your responsibility)

Do you drive and have a valid driver license? _____ Do you own a car? _____

What is your current occupation? _____

How long have you been employed in this occupation? _____

Prior Donor History:

(We will need copies of these records sent to us – blood tests, psych screen, cycle sheet)

Have you ever been an oocyte donor before? () No () Yes

If yes, when? _____

Where? _____

Do you know how many eggs were produced each time? _____

Do you know how many births have resulted from these donations? _____

Personal Characteristics:

Race _____ Height _____ Weight _____

Natural Hair Color _____ Natural Eye Color _____

Hair- ____ Thick	Hair- ____ Curly	Complexion- ____ Fair
____ Thin	____ Wavy	____ Medium
____ Average	____ Straight	____ Dark

Blood Type (if known) _____

Are you _____ Right handed _____ Left handed _____ Ambidextrous

Do you have any dimples, freckles, birthmarks? If yes, explain where

Body Type: Small _____ Medium _____ Large _____ Other _____

Were you adopted? _____

Ethnic Origin/Ancestry: Mother's side _____
(Example: French, Irish, Brazilian, etc.) Father's side _____

Religion by birth _____ Religion now _____

Pregnancy History:

Have you ever had a miscarriage and/or abortion? If so, when? _____

Are you currently breastfeeding? _____

If you have been pregnant before, please fill out the table below:

Year/Your Age - Sex of child/age of child - Duration - Complications/Healthy?

1. _____

2. _____

3. _____

4. _____

Reproductive History:

1. Age of first period _____ () Regular () Irregular

2. Interval between period (count start of flow to start of next flow)
Days? _____

3. Do you have menstrual cramps? () Yes () No
If yes, describe _____

4. Do you have any bleeding in between your periods? () No () Yes

5. When was your last pap smear? Month-_____Year-_____

If over a year, would you be willing to have it repeated? _____

6. Have you ever had an abnormal pap smear? () No () Yes
If yes, when? _____

Have you had a normal pap smear since? When? _____

7. Do you have discharge from one or both breasts? () No () Yes

8. Have you ever had endometriosis? () No () Yes

9. Have you ever had pelvic inflammatory disease? () No () Yes

10. Have you ever had any of the following?

	Date	Age	Treatment
Gonorrhea			
Chlamydia			
Condyloma (venereal warts)			
Syphilis			
Herpes			
Other			

9. Did your mother take DES when she was pregnant with you?

No Yes Not sure

10. Is there a history of infertility in your family?

No Yes Not sure

If yes, explain _____

Contraceptive/Sexual History:

What contraceptives have you used?

<i>Type</i>	<i>When</i>	<i>How Long</i>	<i>Reaction</i>
The Pill			
IUD			
Diaphragm			
Condom			
The Patch			
Depo Provera			

1. What method do you currently use? _____

2. Which method does your partner currently use? _____

8. Your diet (check one) Vegetarian Non-vegetarian
Your appetite (check one) Poor Average Excellent
9. How much do you currently exercise? (check one)
 None Some Regularly
What type of exercise do you enjoy? _____
10. Have you ever had surgery? () No () Yes If yes, please explain:

11. Have you had any hospitalization not previously mentioned? () No () Yes
If yes, explain _____
12. Have you had major radiation or x-ray exposure? () No () Yes
If yes, explain _____
13. Have you ever had a blood transfusion? () No () Yes
If yes, when? _____
14. Have you ever smoked cigarettes? () No () Yes
If yes, complete below:
() Current Smoker () Former Smoker
age started _____ number per day _____ age quit _____
15. Have you ever had any complication resulting from surgery (bleeding embolism, coma) or anesthesia? () No () Yes
If yes, explain _____
16. Have you or any member of your family had malignant hyperthermia or high fevers after surgery, injury, or exercise? () No () Yes
If yes, explain _____
17. Do you take any medications at the present time? () No () Yes
If yes, which ones? _____
18. Have you ever been advised to have any diagnostic testing, hospitalization, or surgery which was not completed? () No () Yes
If yes, explain _____
19. Have you ever had any serious trauma? () No () Yes
If yes, explain _____
20. Have you gained or lost more than 10 pounds in the past year?
() No () Yes. If yes, explain _____

21. Have you ever participated in mental health counseling? () No () Yes
If yes, explain _____
22. What kind of alcoholic beverages do you drink? _____
23. How many drinks (beer, wine, alcohol) do you consume?
_____ per day _____ per week _____ per month?
24. Have you ever used intravenous drugs? () No () Yes
25. Have you ever been with a partner who may have used intravenous drugs?
() No () Yes
26. Have you had and/or been treated for a substance/alcohol abuse/addiction problem?
() No () Yes
27. Do you have any legal cases pending against you? () No () Yes
If yes, explain: _____
28. Have you ever filed bankruptcy? () No () Yes
29. Have you ever been convicted of a crime? () No () Yes
If yes, explain: _____

Would you prefer to do an anonymous donation? () Yes () No () Either

Do you prefer, or are you willing, to talk to or meet the prospective parents? () Yes () No

If so, please elaborate: _____

Would you be willing to meet a child conceived as a result of your donation? _____

Have you told any family or friends about your decision to donate? _____

If so, who have you told, and are they supportive? _____

Are you willing to donate to gay prospective parents? _____

Are you willing to donate to international prospective parents? _____

Are you willing to donate to all ethnicities? _____

Are you willing to donate to a single prospective parent? _____

Are there any types of prospective parents who you will not donate to? _____

If so, please elaborate: _____

Education:

Please include GPA if known:

_____ Completed grade school

_____ Completed High School

List any clubs, sports, school activities, honors, etc.: _____

_____ Completed some college/area of study _____

_____ Currently in college/area of study _____

List any clubs, sports, activities, honors, etc. _____

_____ Completed college/degree: _____

List any clubs, sports, activities, honors, etc. _____

_____ Currently pursuing postgraduate degree: _____

List any clubs, sports, activities, honors, etc. _____

_____ Completed advanced degree: _____

Individual Questions:

Your personality and character. Check those that apply:

Extrovert _____ Aggressive _____ Passive _____ Warm _____

Slight Extrovert _____ Assertive _____ Sensitive _____ Happy _____

Introvert _____ Shy _____ Moody _____ Lonely _____

Slight Introvert _____ Quiet _____ Dependent _____ Energetic _____

Average _____ Independent _____

Other qualities that stand out unique to your personality: _____

Why do you want to be an egg donor?

What do you like most about yourself?

What are your personal interests, talents, special skills, or activities you enjoy:

What are you doing at this point in your life?

What are your future goals?

What else would you like the recipient of your donation to know about you?

As an adult my favorites are:	As a child my favorites were:
Food: _____	
Color: _____	
Season: _____	
Book: _____	
TV Program: _____	
Music: _____	
Movies: _____	

What is your favorite memory as a child?

When you were a child, what did you want to be when you grew up?

Have you ever been tested to determine if you carry the Cystic Fibrosis gene? _____

Are you or any of your family members known carriers of the Cystic Fibrosis gene? _____

Have you ever been tested to determine if you carry the Tay Sachs gene? _____

Are you or any of your family members known carriers of the Tay Sachs gene? _____

Have you ever been tested to determine if you carry the Fragile X gene? _____

Are you or any of your family members known carriers of the Fragile X gene? _____

Family Characteristics:

Biological Mother: Age if alive _____ or Age at death _____

Medical problems or cause of death _____

Occupation and/or Schooling: (If retired, what did she do before retiring?) _____

Eye color: _____ Hair color (If gray now, what was it before) _____

Complexion: (fair, med, dark) _____ Body type: (small, med, large) _____

Height: _____ Weight: _____

Biological Father: Age if alive _____ or Age at death _____

Medical problems or cause of death _____

Occupation and/or Schooling: (If retired, what did he do before retiring?) _____

Eye color: _____ Hair color (If gray now, what was it before) _____

Complexion: (fair, med, dark) _____ Body type: (small, med, large) _____

Height: _____ Weight: _____

Biological Maternal Grandmother: Age if alive _____ or Age at death _____

Medical problems or cause of death _____

Eye color: _____ Hair color (If gray now, what was it before) _____

Complexion: (fair, med, dark) _____ Body type: (small, med, large) _____

Height: _____ Weight: _____

Biological Maternal Grandfather: Age if alive _____ or Age at death _____

Medical problems or cause of death _____

Eye color: _____ Hair color (If gray now, what was it before) _____

Complexion: (fair, med, dark) _____ Body type: (small, med, large) _____

Height: _____ Weight: _____

Biological Paternal Grandmother: Age if alive _____ or Age at death _____

Medical problems or cause of death _____

Eye color: _____ Hair color (If gray now, what was it before) _____

Complexion: (fair, med, dark) _____ Body type: (small, med, large) _____

Height: _____ Weight: _____

Biological Paternal Grandfather: Age if alive _____ or Age at death _____

Medical problems or cause of death _____

Eye color: _____ Hair color (If gray now, what was it before) _____

Complexion: (fair, med, dark) _____ Body type: (small, med, large) _____

Height: _____ Weight: _____

Sibling: Male / Female Age if alive _____ or Age at death _____

Medical problems or cause of death _____

Occupation and/or Schooling: _____

Eye color: _____ Natural Hair color _____

Complexion: (fair, med, dark) _____ Body type: (small, med, large) _____

Height: _____ Weight: _____

Sibling: Male or female Age if alive _____ or Age at death _____

Medical problems or cause of death _____

Occupation and/or Schooling: _____

Eye color: _____ Natural Hair color _____

Complexion: (fair, med, dark) _____ Body type: (small, med, large) _____

Height: _____ Weight: _____

Sibling: Male or female Age if alive _____ or Age at death _____

Medical problems or cause of death _____

Occupation and/or Schooling: _____

Eye color: _____ Natural Hair color _____

Complexion: (fair, med, dark) _____ Body type: (small, med, large) _____

Height: _____ Weight: _____

Sibling: Male or female Age if alive _____ or Age at death _____

Medical problems or cause of death _____

Occupation and/or Schooling: _____

Eye color: _____ Natural Hair color _____

Complexion: (fair, med, dark) _____ Body type: (small, med, large) _____

Height: _____ Weight: _____

(Please add additional pages to the back of this questionnaire outlining the above information if there are any additional siblings and ½ siblings in your family.)

Have twins or other multiple births occurred in your family? () No () Yes

If yes, explain _____

Medical Background:

In the next several pages indicate if your *grandparents, parents, siblings, children, aunts, uncles, cousins* or other extended family members (blood relatives) have had or now have any of the following medical conditions listed below. Please note with aunts, uncles, or cousins if on the maternal or paternal side of the family. Where appropriate, give age at onset, treatment, medication, etc. Use additional space on the back page if needed.

Medical Problem	Self No/Yes	Family No/Yes	If yes, please describe
Heart			
1. <u>Stroke</u>			
2. <u>Heart attack</u>			
3. <u>Heart disease</u>			
a. <u>from birth</u>			
b. <u>other</u>			
4. <u>Heart murmur</u>			
5. <u>Hardening of the arteries</u>			
6. <u>High blood pressure</u>			
7. <u>High cholesterol</u>			

Blood

1. <u>Anemia</u>			
2. <u>Sickle-cell anemia</u>			
3. <u>Hemophilia or other bleeding problem</u>			
4. <u>Leukemia</u>			
5. <u>Immune deficiency</u>			
6. <u>Thalassemia</u>			
7. <u>Other blood disorder</u>			

Respiratory (Lungs)

1. <u>Hay fever</u>			
2. <u>Asthma</u>			
3. <u>Emphysema</u>			
4. <u>Tuberculosis</u>			
5. <u>Lung cancer</u>			
6. <u>Pneumonia</u>			
7. <u>Cystic Fibrosis</u>			
8. <u>Other Lung disease</u>			

Medical Problem	Self No/Yes	Family No/Yes	If Yes, Please describe
Gastro-Intestinal			
1. <u>Ulcer of stomach or Duodenum</u>			
2. <u>Gallstones</u>			
3. <u>Hepatitis A (infectious)</u>			
4. <u>Hepatitis B (serum)</u>			
5. <u>Hepatitis C</u>			
6. <u>Other liver disease</u>			
7. <u>Colon cancer</u>			
8. <u>Ulcerative colitis</u>			
9. <u>Crohn's disease</u>			
10. <u>Intestinal cancer</u>			
11. <u>Cirrhosis</u>			
12. <u>Pyloric Stenosis</u>			
13. <u>Rectal disorder</u>			
14. <u>Any other problem of the digestive system</u>			

Metabolic/Endocrine

1. <u>Diabetes mellitus</u>			
2. <u>Hypoglycemia</u>			
3. <u>Thyroid disease</u>			
4. <u>Thyroid cancer</u>			
5. <u>Goiter</u>			
6. <u>Adrenal dysfunction</u>			
7. <u>Phenyl Ketonuris (PKU)</u>			

Urinary

1. <u>Kidney disease</u>			
2. <u>Kidney stones</u>			
3. <u>Other diseases of the urethra, bladder, ureter</u>			

Medical Problem	Self No/Yes	Family No/Yes	If Yes, Please describe
Genital/Reproductive			
1. <u>Undescended testicle</u>			
2. <u>Hypospadias</u>			
3. <u>Prostate cancer</u>			
4. <u>Uterine fibroids</u>			
5. <u>Endometriosis</u>			
6. <u>Cervical cancer</u>			
7. <u>Ovarian cancer</u>			
8. <u>Ovarian cysts</u>			
9. <u>Uterine cancer</u>			
10. <u>Spontaneous abortion, miscarriage, stillbirth</u>			
11. <u>Early infant death</u>			
12. <u>Premature menopause</u>			
13. <u>Hermaphroditism</u>			
14. <u>Ambiguous Genitals</u>			

Neurological

1. <u>Migraines</u>			
2. <u>Mental Retardation</u>			
3. <u>Down's syndrome</u>			
4. <u>Turner's syndrome</u>			
5. <u>Fragile X</u>			
6. <u>Multiple sclerosis</u>			
7. <u>Cerebral palsy</u>			
8. <u>Epilepsy, seizures</u>			
9. <u>Hydrocephalus</u>			
10. <u>Spinal Cord disorder</u>			
11. <u>Huntington's chorea</u>			
12. <u>Gaucher's disease</u>			
13. <u>Canavan's disease</u>			
14. <u>Tay sach's</u>			
15. <u>Wilson's disease</u>			
16. <u>Parkinson's disease</u>			
17. <u>Alzheimer's disease</u>			
18. <u>Senility before age 50</u>			
19. <u>Other diseases of the Nervous system</u>			

Medical Problem	Self No/Yes	Family No/Yes	If Yes, Please describe
Mental Health			
1. <u>Schizophrenia</u>			
2. <u>Manic depression</u>			
3. <u>Depression</u>			
4. <u>Suicide</u>			
5. <u>Other mental health disorders requiring hospitalization</u>			

Muscular/Bones/Joints

1. <u>Muscular dystrophy</u>			
2. <u>Other chronic Muscle disease</u>			
3. <u>Lupus</u>			
4. <u>Deformity of spine/ Spina Bifida</u>			
5. <u>Osteoporosis</u>			
6. <u>Dwarfism</u>			
7. <u>Rheumatoid arthritis</u>			
8. <u>Osteoarthritis</u>			
9. <u>Gout</u>			
10. <u>Cleft Palate/Cleft lip</u>			
11. <u>Marfan syndrome</u>			

Sight/Sound/Smell

1. <u>Deafness before age 60</u>			
2. <u>Deformity of the ear</u>			
3. <u>Cataracts before age 50</u>			
4. <u>Blindness</u>			
5. <u>Color blindness</u>			
6. <u>Deviated septum</u>			
7. <u>Glaucoma</u>			
8. <u>Retinitis Pigmentosa</u>			
9. <u>Any other sight/sound/smell disorder</u>			

Medical Problem	Self No/Yes	Family No/Yes	If Yes, Please describe
Skin			
1. <u>Acne</u>			
2. <u>Eczema</u>			
3. <u>Skin cancer</u>			
4. <u>Pigmentation disorder</u>			
5. <u>Neurofibromatosis</u>			
6. <u>Other disorders of the skin</u>			

Other

<u>Alcoholism</u>			
<u>Drug abuse, misuse or addiction</u>			
<u>Breast cancer</u>			
<u>Early death, Before age 50</u>			
<u>Any other cancer not mentioned</u>			
<u>Congenital hip problems</u>			
<u>Club feet</u>			
<u>Any other condition not mentioned: Explain</u>			

Donor Consent

I have answered all the questions to the best of my ability and the answers to my knowledge are correct.

I am aware that all the information on the preceding pages (except for identifying information on page one) can be released to the potential recipient of my donated oocytes.

Signed _____

Date _____

Legal Notice

Personal Information/Photo Release

(This is to be reviewed, signed, and returned to
Egg Donor Program of Michigan with your application)

I as an egg donor applicant, acknowledge, understand, and agree, by the act of submitting this application, whether electronically or via hard copy, to have non-identifying information about me listed on the Egg Donor Program of Michigan website (last name, address, social security number and driver's license number are kept confidential and will not be listed on the website). I understand that Egg Donor Program of Michigan, Inc uses photographs to facilitate the matching process between oocyte ("egg") donors and recipients. I understand that the term "photograph" as used herein encompasses both still photographs and motion picture footage. I further consent to the reproduction and/ or authorization by Egg Donor Program of Michigan of-said photographs or motion picture footage for use in all domestic and foreign markets.

The information listed on the website or provided to the recipient may include a picture(s) of me and other information that may be of an identifying nature. Confidential information such as last name, address, phone numbers, and social security numbers data are not provided on-line or in information distributed to potential recipients. However, applicant acknowledges and understands that the information provided on-line is available for review by the general public after they have called the office and secured a password, and could be sufficient for the donor to be identified by any other party. Egg Donor Program of Michigan cannot guarantee that your confidentiality will be maintained or protected because you have provided detailed information about your background, which may be of an identifying nature.

The egg donor applicant acknowledges, understands, and agrees to the best of their knowledge to provide accurate and complete profile information as requested on the application form. In addition, the applicant agrees to provide, accurate social, medical, biographical, and historical information as requested by Egg Donor Program of Michigan.

Egg Donor Program of Michigan relies upon the accuracy of information provided by the applicant, and makes no representation or warranty, express or implied, as to the accuracy or authenticity of information provided to the applicant, or furnished on behalf of the applicant. Verification of the accuracy and authenticity of this information lies solely with the applicant.

Egg Donor Program of Michigan does not guarantee or promise that the applicant will be matched with a family/individual who is seeking egg donor assistance, or promise any time frame in which this selection will occur. Applicant understands and acknowledges that there is a risk that they may never be matched with a family/individual.

Applicant agrees to take full responsibility for researching and obtaining medical and other information concerning the possible risks of the procedures involved in egg donation. Egg Donor Program of Michigan is not a medical clinic or a legal office and cannot provide medical or legal advice.

Applicant understands and acknowledges that laws concerning assisted reproduction vary from state to state and country to country. These laws and regulations may also change frequently. Applicant understands and accepts full responsibility for researching these laws and regulations concerning the legality of egg donation.

Applicant agrees to hold Egg Donor Program of Michigan harmless and free from any liability as a result of any violation of any such law or regulation. Applicant hereby releases Egg Donor Program of Michigan and any of its associated or affiliated companies, their directors, officers, agents, employees and customers, and appointed advertising agencies, their directors, officers, agents and employees from all claims of every kind on account of such violation.

Applicant understands, acknowledges, and agrees that Egg Donor Program of Michigan has the right to remove the profile of any applicant in their sole discretion.

I affirm that this release was not obtained through duress or undue influence.

I have been encouraged to ask questions and all questions have been answered to my satisfaction.

Signature _____

Date _____