


**NEW HOPE FERTILITY CENTER
DONOR APPLICATION FORM**

Date filled out: ____ / ____ / ____ (Month/Day/Year)

To become an egg donor or sperm (known/directed only), we need to learn some information about your personal and medical history. Your responses to these questions will help us to make sure that your health and medical history are compatible with the donation process and, in particular for egg donors, that it will not involve any increased risks for you. This effort will also help us to match you to an appropriate recipient.

Please provide complete and accurate information to these questions. If you do not know the answer, ask a parent or family member. Any information you provide during the donation process, will remain completely confidential. Some of the information from this questionnaire will be given to the recipient(s) as noted but all identifying information is removed.

Please write legibly. Do not leave any question unanswered. Write "N/A" if the question does not apply to you.

Anonymous Donor **Directed Donor- Name of Recipient:** _____

Are you willing to be contacted by the child that may be born from this donation when he/she reaches maturity (about 18-21 years old)? This is not a binding decision but your inclination as of today.

Yes No, I prefer to be completely anonymous. Undecided

You are requested to provide your baby and adult pictures as this increase your chances of being matched. Are you willing to show these pictures to possible recipients? (Recipients will not be allowed to keep these pictures.)

Yes No

DEMOGRAPHICS

Last Name: _____ First Name: _____ Middle Initial: _____

Sex: Male Female

Date of Birth: ____ / ____ / ____ Age: _____

Place of Birth: _____

Year arrived in the US (if not born here): _____

Soc. Security #: _____

Are you a US citizen or permanent resident? Yes No

If no, what is your Visa status? _____

MAILING ADDRESS:

Street: _____ City: _____

State/Province: _____ Zip Code: _____ Country: _____

Email Address: _____

OK to leave message?

Home Phone Number: () _____ - _____

Yes No

Work Phone Number: () _____ - _____ ext: _____

Yes No

Cell Phone Number: () _____ - _____

Yes No

Marital Status: single married divorced widowed engaged partnered

Length of Current Relationship: _____ years

Are you eligible to work in the United States? Yes No Current school/work location: _____

Name of college/university attended for undergrad and/or graduate degree: _____

Is your work/school schedule flexible? Yes No List current school/work schedule? _____

Do you have medical insurance? Yes No

If yes, name of carrier: _____ ID#: _____

Employer: _____

DONATION HISTORY:

Have you applied or been screened to be an egg or sperm donor before? Yes No

If yes, list name and location of donor program (s): _____

Have you successfully donated before? Yes No If yes, how many times did you donate or cycle? _____

What was the outcome of your donation? _____

Are you currently enrolled as an egg or sperm donor in another program? Yes No

How did you hear about our program?

- | | |
|--|---|
| <input type="checkbox"/> Radio (which station) _____ | <input type="checkbox"/> Friend (name) _____ |
| <input type="checkbox"/> Newspaper (which one) _____ | <input type="checkbox"/> Magazine (which one) _____ |
| <input type="checkbox"/> Website (which one) _____ | <input type="checkbox"/> Other (specify) _____ |

I hereby certify that the information I provided in this form, which were voluntarily given, as well as the answers in the following Health and Family History form, are correct. I understand that the answers regarding my health and family history will be used to determine my appropriateness as a donor and to help match me with a prospective recipient.

I will allow New Hope Fertility Center to share any of the information in the health and family history questionnaire with potential recipient couples except any of my identifying information. I am not aware of any problems in myself, my family, or my current or previous sexual partners that were not answered in the following questionnaire.

Print Name of Applicant

Signature

INCLUDE THE FOLLOWING ATTACHMENTS BEFORE SUBMITTING THIS FORM:

1. Copy of valid photo ID showing your date of birth
2. Signed W-9 form- proof of your SSN (You cannot donate without a SSN)
3. Soft copy of pictures (see Photo Submission Instructions)

PERSONAL HEALTH HISTORY

Are you currently under a physicians care for any reason? Yes No If yes, explain: _____

Have you ever had any major illnesses such as amoebic dysentery (infection of the intestine), hypertension, blood clots, pneumonia, mononucleosis, etc.? Yes No If yes, when? _____

Have you had any serious illness in the past? Yes No If yes, please describe: _____

Did you have any complications or concerns with anesthesia? _____

Have you had any hospitalization(s) not mentioned above? _____

Please list any surgical procedures: _____

Have you ever had any broken bones? Yes No If yes, please list: _____

How many days in the preceding 12 months did you miss work because of illness (colds, flu, accidents, surgery, etc.)?
Please explain: _____

Has anyone in your family, including yourself, experienced recurring and/or chronic physical symptoms that have not been evaluated by a physician (Please include those symptoms that you may not consider serious.)? Yes No
If yes, please describe: _____

Have you ever been seen by psychiatrist, psychologist, social worker, counselor, or any other mental health professional for any reason? Yes No If yes, when, for how long and for what reason? _____

List all **prescription medications** that you have taken in the proceeding 12 months:

Medication	How Often	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all **current over-the-counter medications** (include hormones, vitamins, aspirin, antacids, laxatives, herbal & sports supplements, performance-enhancing supplements including steroids, etc.):

Medication	How Often	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever taken anti-malarial drugs or had malaria? Yes No

Have you had a blood transfusion? Yes No If yes, when? _____

Have you ever been refused or denied as a blood donor? Yes No If yes, why? _____

List all the jobs you held in the past five years:

	Jobs/Duties	Year Began	Year End
1.			
2.			
3.			
4.			
5.			

Have you had radiation exposure or x-ray exposure? Yes No If yes, please explain: _____

Have you ever been exposed to "agent orange" or any other herbicides or chemicals (military, forestry, highway service, or elsewhere)?
 Yes No If yes, which substance(s)? _____
When? _____ Where? _____

In the preceding six months, were you exposed to the following in your job, living environment or while involved in hobbies? If yes to any of these, give dates and how often you have been exposed. Please consider carefully.

Exposed to:	Response		When?	How Often?
Toxic Chemicals or Substances	Yes	No		
Sprays	Yes	No		
Fumes/Exhaust	Yes	No		
Radiation	Yes	No		
Flea Powder/Sprays	Yes	No		
Lead/Lead products	Yes	No		
Asbestos/Asbestos products	Yes	No		
Pesticides/Herbicides	Yes	No		
Cleaning solutions/solvents	Yes	No		

Do you take hot baths, saunas, hot tubs, or steam baths? Daily Weekly Occasionally Never

Within the past 6 months have you been exposed to UV rays in a tanning booth? Yes No

What is your caffeine usage? Coffee Soda Tea Energy Drinks (# of cups/glasses per day? _____)

Have you ever smoked cigarettes? Yes No If you stopped, what year/month did you stop? _____
How many years did you smoke? _____

Do you currently smoke cigarettes? Daily Occasionally Rarely Never
If yes, how many sticks per day? _____

What best describes your alcohol consumption? Never drink Rarely drink/Drink in small amounts
 Even amounts through the week Drink in concentrated periods

What type of alcohol do you usually consume? Beer Wine Liquor

If you do drink, how many drinks do you usually consume in a week? 1-3 4-9 10-15 16 or more

Have you ever used recreational or illicit drugs (cocaine, marijuana, LSD, heroin, barbiturates, narcotics, opiates, amphetamines, hallucinogens, tranquilizers, PCP, steroids, or etc.)? Yes No
If yes, which one(s) and when did you last use them? _____

Do you sleep well? Yes No If no, how do you manage this? _____

Have you had acupuncture, ear and/or body piercing or tattooing in which sterile procedures may not have been used? Yes No

Please list and describe all of your tattoos and body piercing:

Date Received:	Description:	Location on Body:	Sterile Needles Used?
1.			
2.			
3.			
4.			
5.			

Have you ever had any problems with the law (i.e. DUI, custody issues, lawsuits)? Yes No
If yes, please explain: _____

Please list any arrests, convictions, sentences, incarcerations, etc.: _____

SEXUAL AND CONTRACEPTIVE HISTORY

Sexual Orientation: Homosexual Heterosexual Bisexual

Number of current sexual partners: _____ Number of sexual partners during the last six months: _____

Total number of past sexual partners: _____

In the last 6 months, have you had unprotected sex (intercourse without a condom) with a new partner? Yes No

Have you ever injected drugs or had a sexual partner who did so? Yes No

CONTRACEPTIVE HISTORY:

Currently use: IUD Type Diaphragm Condom Birth Control Pills Rhythm
 Spermicide Depo-Provera Tubal Ligation None Other: _____

If Birth Control Pills (Name): _____ How long on Birth Control Pills? _____

Why did you start taking Birth Control Pills? _____ If Depo-Provera, when was your last injection? _____

To your knowledge, have you or any of your sexual partners been in contact with anyone or have you been personally tested or been treated for any of the following: Yes No N/A

	Self	Partner	If yes, when?	How many times?	When was the last time?
HIV (AIDS)					
NSU (non specific urethritis)					
Syphilis					
Gonorrhea					
Chlamydia					
Trichomonas					
Venereal Warts					
Herpes, Genital					
Viral Hepatitis B or C					
Genital Sores					
Penis Discharge					
Other sexually transmissible diseases					

MENSTRUAL AND REPRODUCTIVE HISTORY

Age at onset of menses: _____ Date of Last Menstrual Period: _____

Are your menstrual periods regular: Yes No Do you bleed or spot between periods? Yes No

How long is your monthly cycle (first day of one period to first day of the next)? _____ days

Are you periods regular when you are not on any type of hormonal birth control such as the pill, etc.? Yes No

If no, how many times per year do you menstruate? _____
 How many days does your period usually last? _____ days

Do you get menstrual cramps before, during, or after your period? Yes No
 If yes, are your cramps: mild moderate severe

If yes, do you use medication alleviate the pain? Yes No If yes, what medications do you use? _____

Have you ever had any medical treatment for menstrual problems? _____

Date of last Pap Smear: _____ Result: _____

Have you ever had an abnormal PAP: Yes No If yes, when & why: _____

Have you ever been told you were infertile: Yes No If yes, when & why: _____

Have you ever had a pelvic infection requiring treatment with antibiotics: Yes No

Do you have any children? Yes No Do you want children in the future? Yes No

Boy/Girl (No names)	Delivery Date	Vaginal or C-Section	Complications	Weeks pregnant when delivered	Height / Weight
1					
2.					
3.					

PHYSICAL CHARACTERISTICS
THIS WILL BE SHARED AND VIEWED BY RECIPIENTS

Are you adopted? Yes No Blood Type, if known: _____ Height: _____ Weight: _____

Recent weight loss/gain? Yes No If yes, _____ lbs loss/gain

Are you? Right Handed Left Handed Ambidextrous

Bone Structure: Small Medium Large Very Large

Complexion: Very Fair Fair Light Medium Olive Light Brown Dark Brown Ebony

Tan ability: None Slight Medium Easy Freckle

Skin Condition: Oily Medium Dry Combination **Dimples?** Yes No

Eye Color: Blue Brown Lt. Brown Dark Brown Green Hazel

Eye Set: Narrow Average Wide **Eye Size:** Small Average Large

Eye Shape: Round Oval Almond

Natural Hair Color: Black Light Blonde Medium Blonde Dark Blonde Light Brown Medium Brown
 Dark Brown Red

Hair Type: Curly Wavy Straight **Hair Texture:** Fine Medium Coarse

Hair Fullness: Thin Medium Thick **Premature Graying:** Yes No If yes, at what age: _____

Baldness: Yes No **Baldness in Family:** Yes No

Body and Facial Features: Small Medium Large

Condition of your teeth: Poor Fair Good Excellent

Have you had any periodontal or orthodontic work? Yes No If yes, at what age? _____

Hearing (without corrective aids): Poor Fair Good Excellent

Vision (without corrective lenses): Poor Fair Good Excellent

PERSONAL HEALTH HISTORY
THIS WILL BE SHARED AND VIEWED BY RECIPIENTS

Do you wear glasses or contacts or have you had laser surgery? Yes No
If yes, are/were you: Nearsighted Farsighted Other (specify): _____

Do you have astigmatism (blurred vision due to an irregularity in the curvature of the cornea)? Yes No If yes, age diagnosed: _____

Do you have any allergies? Yes No If yes, are they to: Food(s) Medication(s) Environmental Latex

Please list any childhood allergies that you have outgrown: _____

For each medication allergy, describe specific substance and reaction(s) and age first noticed:

Substance: _____	Reaction(s): _____	Age: _____
Substance: _____	Reaction(s): _____	Age: _____
Substance: _____	Reaction(s): _____	Age: _____

SOCIAL HISTORY AND HABITS
THIS WILL BE SHARED AND VIEWED BY RECIPIENTS

Religion Born Into: _____ Religion Practiced: _____

Grade Point Average (GPA): _____ SAT Scores: Verbal _____ Math _____ ACT Score: _____

Education: Did not complete high school Received GED
 Completed high school
 Currently in college, pursuing degree in _____
 Completed college, degree in _____ GPA: _____
 Currently pursuing an advanced degree _____
 Completed advanced degree in _____

Did you have any learning disabilities or weaknesses in school? If yes, describe: _____

Academic Strengths (i.e. math, reading): _____

Languages spoken: _____

Musical Talent or Instrument: _____ Years Experience: _____

Artistic Talent: _____

Athletic Skills / Favorite Sports: _____

Other skills/hobbies/talents/interests do you have (i.e. writing, reading, ability to do games or crossword puzzles, handicrafts)?
Describe: _____

Current Occupation: _____ How long have you been at your current job? _____

HABITS:

Exercise Habits: None Occasional Regular Type of Exercise: _____

Your diet is: Vegetarian Non-vegetarian Your diet is: Poor Average Excellent

Do you have any dietary restrictions? _____

REPRODUCTIVE HISTORY
THIS WILL BE SHARED AND VIEWED BY RECIPIENTS

YOUR CHILDREN	1	2	3	4
Age/ Sex				
Eye color				
Hair Color				
Frame size				
Grade in school				
Distinguishing characteristics				
Wears eye glasses				
Discipline problems				
Any medication				
Dyslexia				
Reading difficulties				
Speech difficulties				
Seen by Social worker/ psychiatrist				
Grade functional level: Normal / Above/ Below Average				

FAMILY HEALTH HISTORY
THIS WILL BE SHARED AND VIEWED BY RECIPIENTS

How many blood siblings are in your immediate family (including yourself and half siblings)? _____

Number of Brothers: _____ Number of Sisters: _____
 Number of Half-brothers: _____ Number of Half-sisters: _____
 Number of Maternal Aunts: _____ Number of Maternal Uncles: _____
 Number of Paternal Aunts: _____ Number of Paternal Uncles: _____

Are there any twins or triplets in your family? Yes No Relation: _____

Describe genetic family members according to the following characteristics. Use natural eye and hair color.

Do not include half siblings.

	Eye	Hair	Skin	Height	Weight	Bone Structure	Education	Occupation
Mother								
Father								
Maternal GM								
Maternal GF								
Paternal GM								
Paternal GF								
Brother 1								
Brother 2								
Brother 3								
Brother 4								
Sister 1								
Sister 2								
Sister 3								
Sister 4								

Indicate cause of death (do not write "natural"). If unknown, write "unknown".

	Age Living	Age Died	Cause		Age Living	Age Died	Cause
Mother				Brother(s)			
Father							
Maternal GM							
Maternal GF				Sister(s)			
Paternal GM							
Paternal GF							

Carefully review the following list of medical problems and identify which ones you or one of your genetic relatives have or had. Please consider each condition carefully for each family member. Explain any conditions you check below, indicating which side of the family (maternal or paternal), the age at the time of onset, and any other pertinent information. If you and none of your indicated family members have a history of the specific medical condition, please indicate none.

Did you consult with your family when completing your family medical history? Yes No

	None	Self	MOM	DAD	BRO/SIS	MGM/MGF PGM/PGF	Aunt/Uncle	Cousin	Comments
CANCER									
Breast									
Colon or intestinal									
Lung									
Ovarian or Uterine									
Prostate or Testicular									
Skin									
Stomach									
Thyroid									
Blood (i.e. Leukemia)									
Other									
HEART									
Stroke									

	None	Self	MOM	DAD	BRO/ SIS	MGM/MGF PGM/PGF	Aunt/ Uncle	Cousin	Comments
Heart attack									
Heart disease or defect									
Congenital Heart Disease									
Hardening of the Arteries									
High blood pressure									
High cholesterol level									
BLOOD									
Anemia									
Sickle-Cell Anemia									
Factor V Leiden thrombophilia (Blood clots or strokes)									
Hemophilia or other Bleeding/Clotting Disorders such as Von Willebrand's Disease									
Immune Deficiency									
Leukemia									
Lymphoma or Swollen Lymph Nodes									
HIV									
Thalassemia									
Polyarteritis Nodosa									
Other Blood Disorder									
RESPIRATORY									
Asthma									
Emphysema									
Hay fever / environmental allergy									
Alpha-1 antitrypsin Disorder									
Blood in Sputum									
Lung cancer									
Pneumonia									
Tuberculosis									
Other lung disease									
GASTROINTESTINAL									
Appendicitis									
Ulcer of Stomach or Duodenum									
Gallstones									
Hepatitis A,B or C									
Cirrhosis of the Liver									
Other Liver Disease									
Ulcerative Colitis									
Crohns Disease									
Pyloric Stenosis									
Multiple Polyps of the Colon									
Rectal Disorder									
Inflammatory Bowel Disease									
Any other problem of the digestive system									
METABOLIC/ ENDOCRINE									
Diabetes requiring insulin therapy									
Diabetes not requiring insulin therapy									
Childhood Diabetes									
Thyroid disorder									
Goiter									
Hypoglycemia									
Adrenal Dysfunction or Disorder									

	None	Self	MOM	DAD	BRO/ SIS	MGM/MGF PGM/PGF	Aunt/ Uncle	Cousin	Comments
Phenyl Ketonuria (PKU) or inherited Metabolism Disorder									
Obesity									
Dwarfism									
URINARY									
Kidney Problems									
Polycystic Kidney Disease									
Other disease/ defect of urinary tract (urethra, bladder, ureter)									
GENITAL/ REPRODUCTIVE									
Hermaphroditism/ Ambiguous Genitals									
Hypospadias or undescended testicle									
Uterine Fibroids									
Ovarian Cysts or Ruptured									
Lumps/Cysts/ Discharge									
Polycystic Ovarian Syndrome (PCOS)									
Pelvic Inflammatory Disease (PID)									
Endometriosis									
REPRODUCTIVE OUTCOMES									
2 or more miscarriages									
Stillborn									
Premature Menopause									
Death of a newborn infant									
Childhood death									
Birth defects									
Infertility									
Premature Birth									
NEUROLOGICAL									
Migraines									
Mental retardation									
Senility or Mental Deterioration before age 50									
Multiple Sclerosis									
Cerebral Palsy									
Neurofibromatosis									
Epilepsy / Seizures									
Attention Deficit Disorder/ Hyperactivity									
Autism / Asperger's									
Alzheimer's Disease/Dementia									
Hydrocephalus									
Tuberous Sclerosis									
Parkinson's Disease									
Creutzfeldt-Jakob Disease									
Scoliosis									
Myasthenia Gravis									
Huntington's or Wilson's Disease									
Tourette's syndrome									
Other diseases of the nervous system									
MENTAL HEALTH									
Anxiety / Panic Attacks									
Anorexia / Bulemia/other eating disorders									

	None	Self	MOM	DAD	BRO/ SIS	MGM/MGF PGM/PGF	Aunt/ Uncle	Cousin	Comments
Depression									
Manic Depressive or Bipolar Disorder									
Other mental health disorder requiring hospitalization									
Suicide Attempts									
Other mental health problems that warranted counseling (please list)									
MUSCLE/BONE/JOINTS									
Muscular Dystrophy									
Achondroplasia – form of dwarfism with abnormal bone growth									
Other Chronic Muscle Disease									
Osteogenesis imperfecta (brittle bone disease)									
Loss of Muscle Coordination									
Osteoporosis									
Marfan Syndrome									
Arthritis									
Rheumatoid or Juvenile Arthritis									
Spinal Muscular Atrophy									
Hereditary Low Back Disorder or Deformity of Spine									
Reiter's Disease									
Myasthenia Gravis									
Gout									
Metabolic Bone Disease (be more specific)									
Lupus (systemic lupus erythematosus – SLE)									
SIGHT/SOUND/SMELL									
Blindness									
Cataracts before age 50									
Color blindness									
Congenital word blindness									
Deafness before age 60									
Deformity of the ear									
Deviated septum									
Glaucoma									
Retinoblastoma									
Severe Myopia									
Retinitis Pigmentosa									
Any other Sensory Disorder									
SKIN									
Acne									
Albinism									
Eczema									
Excessive Facial Hair (Hirsutism)									
Pigmentation disorders									
Neurofibromatosis									
Psoriasis									
Other disorders of the skin									
Infectious Skin Disease									
More than 5 purple/coffee-colored spots on skin									
CONGENITAL ANOMALIES/ BIRTH DEFECTS									

	None	Self	MOM	DAD	BRO/SIS	MGM/MGF PGM/PGF	Aunt/ Uncle	Cousin	Comments
Cleft lip/palate									
Congenital hip problems									
Club foot									
Heart Defect									
Hearing Problems									
Spina Bifida -Neural Tube (open spine)									
Microcephaly									
Holoprosencephaly – a single-lobed brain structure and severe skull and facial defects									
Other congenital anomalies									
CHROMOSOMAL ABNORMALITIES									
Down Syndrome									
Turner's syndrome									
Klinefelter's syndrome									
Other									
GENETIC DISORDERS									
Cri du chat syndrome									
Trisomy 18									
Trisomy 13									
Fragile X syndrome									
Other genetic defects									
OTHER									
Alcoholism									
Drug abuse or addiction									
Early childhood/infancy death									
Learning disorder									
Premature degeneration of any organ system									
Recurring or chronic physical disorder									
Any other cancer not mentioned									
Any other conditions not mentioned									
Explain:									

GENETIC HISTORY

THIS WILL BE SHARED AND VIEWED BY RECIPIENTS

List all your ethnic origin (e.g., French, Irish)

Mother: _____

Father: _____

Race: Check all that apply for your ancestors:

- | | | | | | | | | | | | | |
|-------------------------------------|--------------------------|--------|--------------------------|--------|--------------------------|-----|--------------------------|-----|--------------------------|-----|--------------------------|-----|
| African American | <input type="checkbox"/> | Mother | <input type="checkbox"/> | Father | <input type="checkbox"/> | MGM | <input type="checkbox"/> | MGF | <input type="checkbox"/> | PGM | <input type="checkbox"/> | PGF |
| Eastern European (Ashkenazi) Jewish | <input type="checkbox"/> | Mother | <input type="checkbox"/> | Father | <input type="checkbox"/> | MGM | <input type="checkbox"/> | MGF | <input type="checkbox"/> | PGM | <input type="checkbox"/> | PGF |
| Middle Eastern Jewish | <input type="checkbox"/> | Mother | <input type="checkbox"/> | Father | <input type="checkbox"/> | MGM | <input type="checkbox"/> | MGF | <input type="checkbox"/> | PGM | <input type="checkbox"/> | PGF |
| Mediterranean (Greek, Italian) | <input type="checkbox"/> | Mother | <input type="checkbox"/> | Father | <input type="checkbox"/> | MGM | <input type="checkbox"/> | MGF | <input type="checkbox"/> | PGM | <input type="checkbox"/> | PGF |
| Caucasian | <input type="checkbox"/> | Mother | <input type="checkbox"/> | Father | <input type="checkbox"/> | MGM | <input type="checkbox"/> | MGF | <input type="checkbox"/> | PGM | <input type="checkbox"/> | PGF |
| Hispanic | <input type="checkbox"/> | Mother | <input type="checkbox"/> | Father | <input type="checkbox"/> | MGM | <input type="checkbox"/> | MGF | <input type="checkbox"/> | PGM | <input type="checkbox"/> | PGF |
| East Indian | <input type="checkbox"/> | Mother | <input type="checkbox"/> | Father | <input type="checkbox"/> | MGM | <input type="checkbox"/> | MGF | <input type="checkbox"/> | PGM | <input type="checkbox"/> | PGF |
| Southeast Asian | <input type="checkbox"/> | Mother | <input type="checkbox"/> | Father | <input type="checkbox"/> | MGM | <input type="checkbox"/> | MGF | <input type="checkbox"/> | PGM | <input type="checkbox"/> | PGF |
| Asian | <input type="checkbox"/> | Mother | <input type="checkbox"/> | Father | <input type="checkbox"/> | MGM | <input type="checkbox"/> | MGF | <input type="checkbox"/> | PGM | <input type="checkbox"/> | PGF |
| French Canadian | <input type="checkbox"/> | Mother | <input type="checkbox"/> | Father | <input type="checkbox"/> | MGM | <input type="checkbox"/> | MGF | <input type="checkbox"/> | PGM | <input type="checkbox"/> | PGF |
| Cajun | <input type="checkbox"/> | Mother | <input type="checkbox"/> | Father | <input type="checkbox"/> | MGM | <input type="checkbox"/> | MGF | <input type="checkbox"/> | PGM | <input type="checkbox"/> | PGF |

Have you or anyone in your family ever been tested positive as a carrier or had any of any of the following diseases?

- Blooms Syndrome No If yes: disease carrier negative unknown
- Canavan No If yes: disease carrier negative unknown
- Cystic Fibrosis No If yes: disease carrier negative unknown
- Fabry Disease No If yes: disease carrier negative unknown
- Familial Dysautonomia No If yes: disease carrier negative unknown
- Familial Mediterranean Fever No If yes: disease carrier negative unknown
- Fanconi Anemia Grp. C: No If yes: disease carrier negative unknown
- Gaucher No If yes: disease carrier negative unknown
- Niemann-Pick type A No If yes: disease carrier negative unknown
- Mucopolidosis type IV No If yes: disease carrier negative unknown
- Sickle Cell No If yes: disease carrier negative unknown
- Tay-Sachs No If yes: disease carrier negative unknown
- Thalassemia No If yes: disease carrier negative unknown

Do you have copies of these tests? _____ Testing facility/ location: _____

PERSONAL AND MOTIVATIONAL
THIS WILL BE SHARED AND VIEWED BY RECIPIENTS

In your own words, describe your personality, temperament, and character:

What physical, artistic, intellectual or social abilities do you feel best about?

What are your present and future career goals?

What are your present and future personal goals?

List the 3 achievements you are most proud of:

What is your favorite movie? _____

What is your favorite book? _____

What is/are your favorite color(s)? _____

What is your favorite food? _____

What is one of your most memorable moments and why?

If you could change one thing about yourself, what would it be and why?

Is there a person alive or dead whom you admire and why?

What would you do on a "perfect" day if you could do anything you wanted?

Describe your personality and temperament as a child:

What was your favorite thing to do as a child?

What did your parents teach you to value?

How were you in comparison to other children?

Describe your personality and temperament as a teenager:

Did you have any problems as a child and/or as a teenager? Explain:

Who was the most important influence on you and why?

What were your ambitions/ goals as a teenager?

What were your best and worst subjects in school?

Reasons for wanting to donate eggs or sperm:

If you could pass on a message to the recipient(s) of your eggs or sperm, what would that message be?

If you could write a message to the child born through your participation as an egg or sperm donor for when he/she turns 18 years old, what would you tell him/her?

Thank you!

Please complete all required attachments before submitting this form.