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.

	Country of Origin	Race	Religion
Mother			
Maternal Grandmother			
Maternal Grandfather			
Father			
Paternal Grandmother			
Paternal Grandfather			

Mark one answer for each of the following

Complexion
- ☐ Fair
- ☐ Light
- ☐ Medium
- ☐ Dark
- ☐ Olive
- ☐ Light Olive
- ☐ Dark Olive

Natural Hair Color
- ☐ Light Blonde
- ☐ Blonde
- ☐ Dark Blonde
- ☐ Light Brown
- ☐ Brown
- ☐ Dark Brown
- ☐ Black
- ☐ Auburn
- ☐ Red

Hair Texture
- ☐ Wavy
- ☐ Curly
- ☐ Straight

Eye Color
- ☐ Gray
- ☐ Blue
- ☐ Hazel
- ☐ Green
- ☐ Brown

Body Build
- ☐ Small
- ☐ Medium
- ☐ Large

Blood Type
- ☐ A
- ☐ B
- ☐ AB
- ☐ O

RH Factor
- ☐ Positive
- ☐ Negative

Freckles
- ☐ No
- ☐ Light on face only
- ☐ Heavy on face only
- ☐ Light all over body
- ☐ Heavy all over body

Sun Exposure
- ☐ Burn easily
- ☐ Tan easily
- ☐ Burn then tan
- ☐ Don't tan or burn

Indicate you tanning habits for the following periods of time

	Birth – 13 years old	13-20 years old	Current Habits
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 you 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:

Name of Institution	Degree	Area of Study

PERSONAL ATTRIBUTES

Please describe you 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 <u>past three months</u>:

Medication Name	Dose / Frequency	Reason

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:

	YES	NO	
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

	NO	YES	Please explain if YES
Is there a family history of infertility?	☐	☐	
Is there a family history of hormonal disorders?	☐	☐	
Have you been treated for infertility before?	☐	☐	

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

At what age was your first period? _____

	NO	YES	
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 you 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:

	YES	NO	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? YES	NO	Their Age (or age at death)	Medical Conditions / Cause of Death
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:

	Eye Color	Hair Color	Hair Texture	Skin Tone	Height	Weight
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	☐	☐	

	YES	NO	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	☐	☐	
Aquaductal 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.