**THE MIDWEST CENTER FOR REPRODUCTIVE HEALTH, P.A.**

Arbor Lakes Medical Building, Suite 350
12000 Elm Creek Blvd North
Maple Grove, MN 55369

**Phone** 763.494.7700
**Toll Free** 800.508.9763
**Fax** 763.494.7706
**Web Site** www.mcrh.com

# DONOR APPLICATION & MEDICAL/GENETIC HISTORY

To: Prospective Oocyte Donor

Thank you for your interest in becoming an oocyte donor. All prospective oocyte donors must complete this application and medical/genetic history questionnaire. We thank you for your honesty in supporting our efforts to maintain a safe donor population for our community.

To proceed with this process, we ask that you complete the requested information and return it in the enclosed stamped envelope. Once your returned questionnaire is received, it will be reviewed by our staff to evaluate your potential as a donor candidate.

We pledge our best efforts to be accommodating, and to make this a positive experience for all involved. If you have any questions, please feel free to contact our office at (763) 494-7762 and leave a message or 1-800-508-9763, option #7, if outside the metropolitan area.

The undersigned agrees that, to the best of your knowledge and belief, the information provided in this application is complete and correct. The undersigned furthermore agrees to report to our clinic any significant changes in the status of your health, especially in regards to sexually transmitted disease.

I certify that, to the best of my knowledge and belief, the following information provided by me in this document is complete and correct.

| _____ | _____ | _____ |
|---|---|---|
| Oocyte Donor Name (Printed) | Oocyte Donor Signature | Date |

Donor Application Number (Clinic will complete):_____

| _____ | _____ |
|---|---|
| Reviewed By Third Party Coordinator: In Office / Telephone Interview | Date |

| _____ | _____ |
|---|---|
| Reviewed By MCRH Staff Member: In Office / Telephone Interview | Date |

## THE DONOR OOCYTE PROCESS

### Becoming a donor

Upon completion and review of your questionnaire, we will contact you regarding your qualification status. If you meet our acceptance criteria for further evaluation, our Donor Coordinator will contact you to discuss the next steps.

Your New Patient Consultation will be with our physician. This consultation can either be in person, or by phone if you are not from the metropolitan area. If this visit is at The Midwest Center for Reproductive Health, P.A. (MCRH), an ultrasound may also be performed on this day to assure that your ovaries are accessible for aspiration. If this visit is not at MCRH, other arrangements will be made for your ultrasound. You will also be informed of other screening tests required for you to complete. You will have these tests done at MCRH on the day of your new patient consultation.

Part of our screening includes a consultation with our Social Worker. Sally Sibbitt, MSW, LICSW, is a licensed, independent, clinical Social Worker with twenty plus years of post Master Degree work with individuals, couples, children and families. To schedule an appointment with Sally, call (952) 925-3533.

Screening tests performed include: urine sample of gonorrhea, chlamydia, and toxicology screen; blood work that includes HIV, Hepatitis B, Hepatitis C and Syphilis screen; day-3 estradiol and follicle stimulating hormone tests and vaginal ultrasound to access your ovaries.

All test results are reviewed by the MCRH staff. Our Donor Coordinator will notify you of your acceptance status.

You will view an instructional video of the in- vitro process. You will have a medication outline and injection teaching with directions from one of our nurses.

### Oocyte Donation

Our goal is to safely monitor your stimulation and retrieve multiple oocytes (eggs) from your ovaries during the retrieval process. You will need to be on oral contraceptives for one to two months. You will then be given medications over a period of 10-20 days, to stimulate multiple oocytes to grow. We will need to monitor your particular response with periodic hormone assessments, (blood tests), and ultrasound examinations of your ovaries, during this period of time. We will need you to be available to come into our office, or your satellite clinic, for a 30-minute appointment to perform these. This monitoring will occur approximately 3-5 times during your treatment cycle. Each afternoon (usually between 2:00 – 4:00 p.m.) you will need to access your voice mail provided by The Midwest Center, to receive medication instructions by telephone and each morning and evening you will be administering your injectable medications.

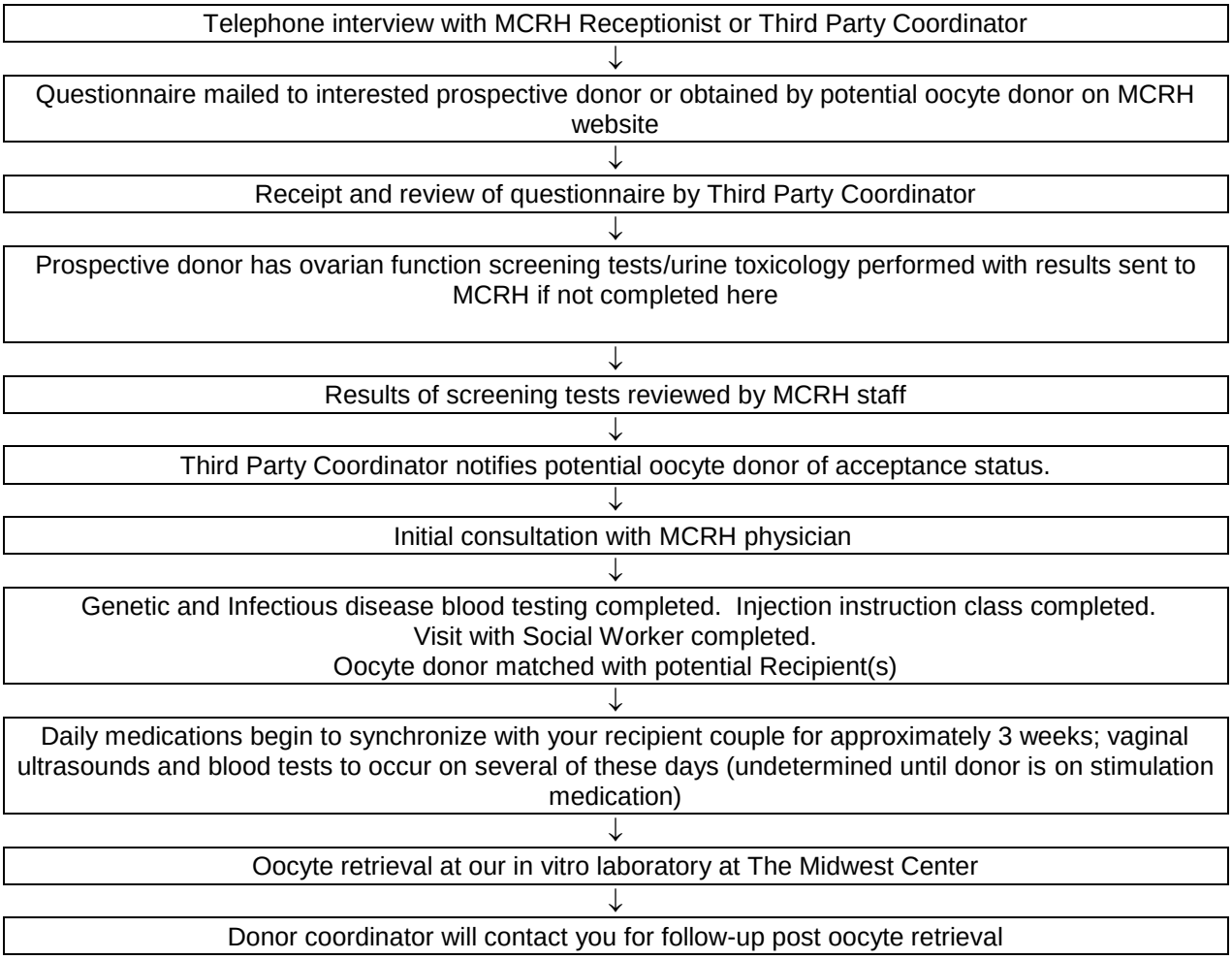
After the ovaries have been appropriately stimulated, our physician will retrieve the oocytes from your ovaries, going through the vagina, in a brief procedure using an ultrasound-guided needle. During this procedure, you will receive intravenous sedation medication to prevent discomfort. You will remain for observation for approximately one hour following the retrieval procedure. Later that same day, the oocytes will be inseminated for the benefit of the couple receiving them. The outcome of the recipient's cycle will remain anonymous.

Remember, we will explain all these steps in greater detail at your consultation appointment and we are happy to answer any questions that you may have.

## Other Issues:

- Reimbursement: $4,000.00
  ($250.00 **bonus** for any donors you refer to MCRH that **complete** the donation process)
- Limit: 6 cycles (per physician approval)
- Anonymity: Strictly enforced
- Children at the office: In order to be sensitive to our other patients, we ask that you not bring children to the office for your appointments.
- Sexual activity: Abstinence or barrier contraception is REQUIRED from the initiation of treatment with birth control pills until two weeks post retrieval.
- Transportation: You are responsible for your transportation to and from MCRH. You will need to have a ride provided for you on the day of the oocyte retrieval.
- Appointment scheduling: Appointments need to be scheduled in advance. You will be given advance notice of the next appointment. It is **imperative** that you come on the day that you are requested to.
- Communication: MCRH will provide a voicemail box for you to receive private messages. You may access it from anywhere once you begin your medications. Until then, we ask that we may leave messages for you on a home or work voicemail or answering machine.
- Complications: Will be reviewed in detail at your consultation visit.
- Injections: You can administer the majority of your medications. If you choose to have someone else assist you, you will be responsible to find a friend/relative/spouse, etc. who will be available twice daily to administer your injections. **THIS PERSON MUST ATTEND THE MEDICATION OUTLINE AND INJECTION TRAINING CLASS WITH YOU.**

***Timeline for Donors***



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**INSTRUCTIONS:** Please print **all** of the requested information. Write "NA" in blanks that are not applicable. Please be specific. Avoid expressions such as "natural" or "old age" for causes of death. List any health problems as specifically as possible. Give ages to your best approximation. Please list exact relationships, such as "first cousin through my mother's sister", and provide information on all relatives requested. You do **not** need to list names. If you have questions, please contact the clinic at 763-494-7700 or 800-508-9763.

**PERSONAL INFORMATION**

NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____

_____

PHONE NUMBER: Cell# _____

Home _____

Work# _____

Answering machine/voice mail: Yes / No

Okay to call you at work: Yes / No

Date _____

**PERSONAL INFORMATION** AD#:_____
(clinic will complete)

Nationality of Mother _____ of Father _____
(Norwegian/ Irish/ German/ African-American/ Native-American/ Hispanic/ French Italian/ Swedish/other)

Are you adopted? No Yes

Have you ever been arrested/ convicted of a crime: No Yes
If yes, for what reason _____
If yes, did you spend any time in jail/prison: Yes No Length of time _____

Hair color: Black Dark Brown Brown Light Brown Blonde Strawberry Blonde Auburn Red

Hair texture: Straight Wavy Curly Kinky

Eye color: Blue Brown Hazel Green Blue-Green Blue-Grey Black

Height: _____inches Weight: _____pounds

Bone size: Small Small-Medium Medium Medium-Large Large

Complexion: Very Fair Fair Medium Olive Dark

Current Occupation_____ (do not list your place of employment)

**Education** (check one)
___Completed high school

___Currently in college studying_____

___Completed college degree(s) in _____

___Currently pursuing advanced degree(s) in _____

Highest Degree earned: High School Vo-Tech AA Bachelors Masters Doctorate

School Subjects most enjoyed_____

**Race** Native American Black, Non-Hispanic White, Non-Hispanic Latina /Hispanic

Asian/Pacific Islander East Indian Multi Race

**Age** _____

**Religion** (if applicable) Protestant Catholic Jewish Other (Specify):_____

**Hobbies and interests** _____

**Personal status**
Married: No_____ Yes _____
Partner: No_____ Yes_____

Number of pregnancies: _____
Number of children: _____ # girls _____# boys _____ Date(s) of birth: _____
Number of miscarriages _____ # abortions ___ Date _____ # tubal pregnancies ____ Date _____

Right handed _____ Left handed _____ Both_____

**PERSONAL INFORMATION**

What level of schooling did your mother reach? (High school/ College/ Advanced Degree)
Other_____
What is her occupation? _____

What level of schooling did your father reach? (High school/ College/ Advanced Degree)
Other_____
What is his occupation? _____

How many blood brothers/sisters are in your immediate family (including yourself)?_____
How many females? ____ How many males? _____

What do you like doing in your spare time? (sports/ exercise/ reading/ traveling/ spending time with friends and family/ going to movies/ watching T.V./ hobbies)
other_____

Do you have any special talents? (musical/ artistic/ athletic ability/ creative skills)
other_____

How would you describe yourself? (out-going/ quiet/ sensitive/ humorous/ serious/ a leader/ a follower/ loving/ caring/ enjoy time with people/ enjoy time alone)
other_____

How do you solve your personal problems and make decisions? (quickly, no hesitation/ deliberately, carefully/ consult with friends and family/ consult with professionals)
other_____

What is important to you? (marriage/ family/ career/ education/ recreation/ travel/ pets/ money/ power/ happiness/ religion/ good health)
other_____

Why are you considering becoming a donor? (help others have a family/ for the compensation / both)
other_____

What concerns or fears do you have about being an oocyte donor?
_____

What do you see for your future/ what would you like to be doing?
_____

Have any of the following occurred within the last two years? When?

| | | |
|---|---|---|
| Divorce/Separation_____ | Remarriage_____ | Move_____ |
| Job change_____ | Financial worries_____ | Had a major illness_____ |
| Lost important friend or family member through death_____ | | Family member had major illness _____ |

**PERSONAL MEDICAL HISTORY**

Allergies (medicines, food, pollen, etc)? Yes No
If yes, please list substance and reaction caused: _____
List any childhood allergies that you have outgrown: _____

Do you wear glasses or contact lenses or have you had laser surgery? Yes No
If yes, are/were you: _____Nearsighted _____Farsighted
_____Other, please list: _____

Do you have normal hearing? Yes No
If no, please explain: _____

Condition of your teeth: _____Poor _____Fair _____Good

Usual weight? _____lbs. Recent weight loss or gain? Yes No
If yes _____ lbs gain/loss (circle one)

Your diet is: _____Vegetarian _____Non-vegetarian

Your diet is: _____Poor diet _____Average diet _____Excellent diet

How much exercise do you get? _____None _____Occasional
_____Regularly _____Professional Athlete

What type of exercise?_____

Have you had any serious illness or surgical procedures in the past? Yes No
If yes, please explain:_____ Year: _____

Have you had any operations: Yes No
If yes, please complete: Year Type of Operation
_____ _____
_____ _____
_____ _____

Have you had any hospitalizations other than for surgery? Yes No
If yes, please complete: Year Type of Illness
_____ _____
_____ _____
_____ _____

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

Have you ever had any serious illness? Yes No
If yes, please explain:_____

How many days in the preceding 12 months could you not work because of illness, etc. (colds, flu, accidents, surgery, etc)? _____

Are you currently under a physician's care for any reason? Yes No
If yes, please explain:_____

**PERSONAL MEDICAL HISTORY**

Do you drink alcoholic beverages: Yes No
If yes, which kinds? _____Beer _____Wine _____Liquor
Approximately how many drinks per day or week do you consume?_____
If you drink less than 3 drinks per day, was there ever a time when you drank more? Yes No
If yes, how much_____ When (give years)_____

Do you have any relatives with alcoholism? Yes No
If yes, who?_____

Do you use tobacco products? Yes No

If cigarettes, how many packs a day? _____
How long have you been smoking regularly? _____
Other tobacco products? _____
If you did smoke but quit, when did you last smoke? _____

Do you have any brothers or sisters who died in infancy or childhood? Yes No
If yes, what was the cause?_____

Are there any known genetic diseases or conditions that run in your family? Yes No
If yes, what are they?_____

**DONOR GENETIC HISTORY**

Were you born with any birth defects (heart defect, cleft lip or palate, club feet, other)? Yes No
If yes, explain:_____

Are there any known genetic conditions or birth defects in your family? Yes No
If yes, explain:_____

Are you of Jewish ancestry? Unknown Yes No
If yes, please check: _____ Ashkenazi _____ Sephardic _____ Other

Have you been tested as a carrier for any of the following diseases:

| | | |
|---|---|---|
| Tay Sachs: | Yes | No |
| Gaucher: | Yes | No |
| Canavan: | Yes | No |
| Fanconi Anemia Group C: | Yes | No |
| Niemann-Pick type A: | Yes | No |
| Mucolipidosis type IV: | Yes | No |
| Familial Dysautonomia: | Yes | No |
| Blooms Syndrome: | Yes | No |

If yes, result(s):

| | | | |
|---|---|---|---|
| Tay Sachs: | _____carrier | _____not carrier | _____unknown |
| Gaucher: | _____carrier | _____not carrier | _____unknown |
| Canavan: | _____carrier | _____not carrier | _____unknown |
| Fanconi Anemia Group C: | _____carrier | _____not carrier | _____unknown |
| Niemann-Pick type A: | _____carrier | _____not carrier | _____unknown |
| Mucolipidosis type IV: | _____carrier | _____not carrier | _____unknown |

**DONOR GENETIC HISTORY**

Familial Dysautonomia: _____carrier _____not carrier _____unknown
Blooms Syndrome: _____carrier _____not carrier _____unknown

Are you of black ancestry? Unknown Yes No
If yes, have you been tested as a carrier of sickle cell disease? Unknown Yes No
If yes, result: _____carrier _____not carrier _____unknown

Are you of Mediterranean, Chinese or Southeast Asian ancestry? Unknown Yes No
If yes, have you been tested as a carrier of Thalassemia? Yes No
If yes, result: _____carrier _____not carrier _____unknown

**FAMILY HISTORY**

A. Please list the requested information below:

| | **Eye Color** | **Hair Color** | **Height** | **Complexion *** | **Bone Size**** | **Ethnic Origin** (Irish,German,etc) |
|---|---|---|---|---|---|---|
| Mother | | | | | | |
| Father | | | | | | |
| Sibling | | | | | | |
| Sibling | | | | | | |
| Sibling | | | | | | |
| Sibling | | | | | | |
| Maternal Grandfather | | | | | | |
| Maternal Grandmother | | | | | | |
| Paternal Grandfather | | | | | | |
| Paternal Grandmother | | | | | | |

* Fair, Fair-Medium, Medium, Olive, Dark ** Small, Small-Medium, Medium, Medium-Large, Large

Please look through the following list of medical problems and indicate **(check ✓)** which ones you or one of your relatives have had. Please consider each condition carefully for each family member. Explain any conditions you check below, indicating which side of the family (maternal/paternal), the age of the family member at the onset of the condition/problem, and any other pertinent information. If neither you nor your indicated family members have a history of a specific medical condition, **please check "None."**

| **Medical Problem** | **None** | **Self** | **Mother** | **Father** | **Sibling** | **Child** | **Grand** fathers | **Grand mothers** | **Aunt/ Uncle** | **Cousin** | **Explain which side of family, age at onset, etc** |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **1. Heart** | | | | | | | | | | | |
| Stroke | | | | | | | | | | | |
| Heart Attack | | | | | | | | | | | |
| Congenital Heart Disease | | | | | | | | | | | |
| Heart Disease | | | | | | | | | | | |
| High Blood Pressure | | | | | | | | | | | |
| **2. Blood** | | | | | | | | | | | |
| Anemia | | | | | | | | | | | |
| Sickle-cell anemia | | | | | | | | | | | |
| Hemophilia or other bleeding problem | | | | | | | | | | | |
| Leukemia | | | | | | | | | | | |
| Immune deficiency | | | | | | | | | | | |
| Polyarteritis nodosa | | | | | | | | | | | |
| Other blood disorder | | | | | | | | | | | |
| **3. Respiratory (lungs)** | | | | | | | | | | | |
| Hay fever | | | | | | | | | | | |
| Asthma | | | | | | | | | | | |
| Emphysema | | | | | | | | | | | |
| Tuberculosis | | | | | | | | | | | |
| Lung Cancer | | | | | | | | | | | |
| Pneumonia | | | | | | | | | | | |
| Cystic fibrosis | | | | | | | | | | | |
| Alpha -1 antitrypsin disorder | | | | | | | | | | | |
| Other lung disease | | | | | | | | | | | |

| Medical Problem | None | Self | Mother | Father | Sibling | Child | Grand fathers | Grand mothers | Aunt/ Uncle | Cousin | Explain which side of family, age at onset, etc |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **4. Gastrointestinal** | | | | | | | | | | | |
| Ulcer of stomach/ duodenum | | | | | | | | | | | |
| Gallstones | | | | | | | | | | | |
| Hepatitis A (infectious) | | | | | | | | | | | |
| Hepatitis B (serum) | | | | | | | | | | | |
| Other liver disease | | | | | | | | | | | |
| Ulcerative colitis | | | | | | | | | | | |
| Pyloric stenosis | | | | | | | | | | | |
| Crohn's disease | | | | | | | | | | | |
| Intestinal cancer | | | | | | | | | | | |
| Inflammatory bowel disease | | | | | | | | | | | |
| Rectal disorder | | | | | | | | | | | |
| Any other cancer/ problem of the digestive system | | | | | | | | | | | |
| **5. Metabolic/ Endocrine** | | | | | | | | | | | |
| Diabetes mellitus requiring insulin therapy | | | | | | | | | | | |
| Diabetes not requiring insulin therapy | | | | | | | | | | | |
| Hypoglycemia | | | | | | | | | | | |
| Thyroid cancer | | | | | | | | | | | |
| Thyroid disease | | | | | | | | | | | |
| Goiter | | | | | | | | | | | |
| Adrenal dysfunction or Disorder | | | | | | | | | | | |
| Hyperactivity | | | | | | | | | | | |
| PKU or inherited metabolism disorder | | | | | | | | | | | |
| **6. Urinary** | | | | | | | | | | | |
| Progressive kidney disease | | | | | | | | | | | |
| Polycycstic kidney disease | | | | | | | | | | | |
| Other disease of urinary tract (urethra, bladder, ureter) | | | | | | | | | | | |

| Medical Problem | None | Self | Mother | Father | Sibling | Child | Grand fathers | Grand mothers | Aunt/ Uncle | Cousin | Explain which side of family, age at onset, etc |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **7. Genital/ Reproductive System** | | | | | | | | | | | |
| Uterine fibroids | | | | | | | | | | | |
| Ovarian cysts | | | | | | | | | | | |
| Cancer of cervix, ovaries or uterus | | | | | | | | | | | |
| Miscarriage or Stillborn | | | | | | | | | | | |
| Herpes Simplex Virus, Genital | | | | | | | | | | | |
| **8. Neurological** | | | | | | | | | | | |
| Migraines | | | | | | | | | | | |
| Mental retardation | | | | | | | | | | | |
| Senility or mental deterioration before age 50 | | | | | | | | | | | |
| Multiple sclerosis | | | | | | | | | | | |
| Cerebral palsy | | | | | | | | | | | |
| Epilepsy/seizures | | | | | | | | | | | |
| Neural tube defects (open spine or hydrocephalus/ water on the brain) | | | | | | | | | | | |
| Disorder or the spinal cord | | | | | | | | | | | |
| Gaucher's disease | | | | | | | | | | | |
| Wilson's Disease | | | | | | | | | | | |
| Creutzfeldt-Jakob disease | | | | | | | | | | | |
| Huntingon's disease | | | | | | | | | | | |
| Tuberous Sclerosis | | | | | | | | | | | |
| Neurofibromatosis | | | | | | | | | | | |
| Dementia or degenerative disorder | | | | | | | | | | | |
| Alzheimer's | | | | | | | | | | | |
| Parkinson's disease | | | | | | | | | | | |
| Brain Tumor | | | | | | | | | | | |
| Myasthenia Gravis | | | | | | | | | | | |
| Down's syndrome/ mongolism | | | | | | | | | | | |
| Transmissible Spongiform Encephalopathy | | | | | | | | | | | |
| Other disease of nervous system | | | | | | | | | | | |

| Medical Problem | None | Self | Mother | Father | Sibling | Child | Grand fathers | Grand mothers | Aunt/ Uncle | Cousin | Explain which side of family, age at onset, etc |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **9. Mental Health** | | | | | | | | | | | |
| Schizophrenia | | | | | | | | | | | |
| Manic depressive psychosis | | | | | | | | | | | |
| **10. Muscles/Bones /Joints** | | | | | | | | | | | |
| Muscular dystrophy | | | | | | | | | | | |
| Other chronic muscle disease | | | | | | | | | | | |
| Loss of muscle coordination | | | | | | | | | | | |
| Spinal muscular atrophy | | | | | | | | | | | |
| Systemic Lupus | | | | | | | | | | | |
| Deformity of spine | | | | | | | | | | | |
| Osteoporosis | | | | | | | | | | | |
| Dwarfism | | | | | | | | | | | |
| Hereditary low back disorder | | | | | | | | | | | |
| Rheumatoid Arthritis | | | | | | | | | | | |
| Reiter's disease | | | | | | | | | | | |
| Gout | | | | | | | | | | | |
| Club foot | | | | | | | | | | | |
| Metabolic bone disease | | | | | | | | | | | |
| **11. Sight/Sound/ Smell** | | | | | | | | | | | |
| Deafness before age 60 | | | | | | | | | | | |
| Deformity of the ear | | | | | | | | | | | |
| Cataracts before age 60 | | | | | | | | | | | |
| Blindness in both eyes before age 60 | | | | | | | | | | | |
| Color Blindness | | | | | | | | | | | |
| Glaucoma | | | | | | | | | | | |
| Deviated septum | | | | | | | | | | | |
| Any other sight/ Sound /smell disorder | | | | | | | | | | | |

| **Medical Problem** | **None** | **Self** | **Mother** | **Father** | **Sibling** | **Child** | **Grand** fathers | **Grand mothers** | **Aunt/ Uncle** | **Cousin** | **Explain which side of family, age at onset, etc** |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **12. Skin** | | | | | | | | | | | |
| Acne | | | | | | | | | | | |
| Eczema | | | | | | | | | | | |
| Psoriasis | | | | | | | | | | | |
| Pigmentation disorders | | | | | | | | | | | |
| Albinism | | | | | | | | | | | |
| Infectious skin disease | | | | | | | | | | | |
| More than 5 purple- or coffee- colored spots on skin (size of quarter or larger) | | | | | | | | | | | |
| Numerous lumps under the skin | | | | | | | | | | | |
| Other skin disorders | | | | | | | | | | | |
| **13. Other** | | | | | | | | | | | |
| Alcoholism | | | | | | | | | | | |
| Drug abuse, misuse, or addiction | | | | | | | | | | | |
| Breast cancer | | | | | | | | | | | |
| Any cancer not mentioned above | | | | | | | | | | | |
| Cleft palate or cleft lip | | | | | | | | | | | |
| Serious birth defects | | | | | | | | | | | |
| Inguinal hernia | | | | | | | | | | | |
| Early Death (less than age 50) | | | | | | | | | | | |
| Sarcoidosis | | | | | | | | | | | |
| Premature degeneration of any organ system | | | | | | | | | | | |
| Any other condition not mentioned above | | | | | | | | | | | |

**OOCYTE DONATION HISTORY**

Fill in the appropriate space for each of the following relatives. List all specific health problems, operations, and/or causes of death (include stillborns, infant deaths and childhood deaths) for each individual. Please use the "Specific Conditions listed on pages 10-15 to aid in the completion of this segment. Do not use "old age" or "natural causes."

**Parents**

**Your Mother**

| Current Age or Age at Death | Health Problem | Age Diagnosed | Living / Deceased |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |

**Your Father**

| Current Age or Age at Death | Health Problem | Age Diagnosed | Living / Deceased |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |

**OOCYTE DONATION HISTORY**

**Siblings**

**Your Brothers**

| Current Age or Age at Death | Health Problem | Age Diagnosed | Living / Deceased |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |

**Your Sisters**

| Current Age or Age at Death | Health Problem | Age Diagnosed | Living / Deceased |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |

**Children**

**Your Daughters**

| Current Age or Age at Death | Health Problem | Age Diagnosed | Living / Deceased |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |

**Your Sons**

| Current Age or Age at Death | Health Problem | Age Diagnosed | Living / Deceased |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |

**OOCYTE DONATION HISTORY**

**Mother's Family**

**Your Grandfather (your mother's father)**

| Current Age or Age at Death | Health Problem | Age Diagnosed | Living / Deceased |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |

**Your Grandmother (your mother's mother)**

| Current Age or Age at Death | Health Problem | Age Diagnosed | Living / Deceased |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |

**Aunts (your mother's sisters)**

| Current Age or Age at Death | Health Problem | Age Diagnosed | Living / Deceased |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |

**Uncles (your mother's brothers)**

| Current Age or Age at Death | Health Problem | Age Diagnosed | Living / Deceased |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |

**OOCYTE DONATION HISTORY**

**Father's Family**

**Your Grandfather (your father's father)**

| Current Age or Age at Death | Health Problem | Age Diagnosed | Living / Deceased |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |

**Your Grandmother (your father's mother)**

| Current Age or Age at Death | Health Problem | Age Diagnosed | Living / Deceased |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |

**Aunts (your father's sisters)**

| Current Age or Age at Death | Health Problem | Age Diagnosed | Living / Deceased |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |

**Uncles (your father's brothers)**

| Current Age or Age at Death | Health Problem | Age Diagnosed | Living / Deceased |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |

**DONOR RISK FACTOR HISTORY**

Are you willing to administer daily injections? Yes No

Have you applied or been screened to be an oocyte donor before? Yes No
If yes, list name and location of oocyte donor program(s):

_____

_____

Were you accepted as an oocyte donor? Yes No
If yes, how many times did you donate? _____

Are you currently enrolled as an oocyte donor in another program? Yes No

**DONOR FERTILITY\SOCIAL HISTORY**

Age at onset of menses _____

Are your menstrual cycles regular? _____

# of days from beginning of one cycle to the next naturally:_____ Average:_____ Range:_____

# of days from beginning of one cycle to the next if on Birth Control Pills_____

Sexual Preference: Heterosexual Homosexual Bisexual Asexual None

Number of current sexual partners:_____

Number of sexual partners during the past six months:_____

Number of total past sexual partners:_____

**Pregnancy History:**

Any pain with intercourse? Yes No

# of times you have had a confirmed pregnancy_____

# of losses_____ Spontaneous_____ Elective_____

# of living children_____

Length of time it took you to get pregnant. Shortest_____ Longest_____

**Contraceptive History:**

Currently use: _____IUD _____Diaphragm _____Condom _____Birth Control Pills

_____Rhythm _____Spermicide _____Depo-Provera

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?_____

Explain any “yes” answers: _____

**DONOR RISK FACTOR HISTORY**

Have you ever used or do you currently use any of the following drugs?

Marijuana Yes No
If yes, Frequency/Year(s)_____ How Used_____

Cocaine Yes No
If yes, Frequency/Year(s)_____ How Used_____

Barbiturates Yes No
If yes, Frequency/Year(s)_____ How Used_____

Narcotics/Opiates Yes No
If yes, Frequency/Year(s)_____ How Used_____
(Heroin, Methadone, Opium, Morphine, Codeine)

Amphetamines Yes No
If yes, Frequency/Year(s)_____ How Used_____

Hallucinogens Yes No
If yes, Frequency/Year(s)_____ How Used_____

Tranquilizers Yes No
If yes, Frequency/Year(s)_____ How Used_____

PCP Yes No
If yes, Frequency/Year(s)_____ How Used_____

Inhalants Yes No
If yes, Frequency/Year(s)_____ How Used_____

Steroids Yes No
If yes, Frequency/Year(s)_____ How Used_____

## DONOR RISK FACTOR HISTORY

Are you presently taking any **prescribed** medications? Yes No
If yes, please specify what and why: _____

Did you take any prescribed medications within the last **six weeks**? Yes No
If yes, please specify what and why: _____

List all drugs you have taken in the preceding 12 months (prescription, nonprescription, herbal & sports supplements, recreational):

| Medication | How Often | Reason |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

List all current medications (include vitamins, aspirin, antacids, laxatives, herbal & sports supplements, etc.)

| Medication | How Often | Reason |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**DONOR RISK FACTOR HISTORY**

In the preceding six months, were you exposed to any **EXCESSIVE** amounts of the following in your 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 | Yes/No | 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 | | |
| Cleaning solutions/solvents | Yes No | | |

Please list all the jobs you have had in the preceding five years and your possible exposure to chemicals, drugs and gases. Please consider carefully.

| Jobs/Duties | Dates of Employment | | Exposed to which chemicals, drugs or gases. |
|---|---|---|---|
| | Year Began | Year Ended | |
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |

**DONOR RISK FACTOR HISTORY/DONOR SCREENING QUESTIONS**

**Specific information concerning your potential risk of HIV or hepatitis infection is required. <u>Respond to each exclusion factor</u> below by circling "YES" for any category you are in or "NO" for any category you are not in.**

Have you injected drugs for non-medical reasons in the preceding five years, including intravenous, intramuscular, or subcutaneous? Yes No

Do you have hemophilia and have received human-derived clotting factors concentrates in the preceding five years? Yes No

Have you engaged in sex in exchange for money or drugs in the preceding five years? Yes No

Have you had sex in the preceding 12 months with any person who would have answered yes to any of the 3 previous items, or had sex with a male who has had sex with another male in the preceding 5 years, or with any person known or suspected to have HIV infection, including any person who has had a positive or reactive test for HIV virus hepatitis B (HBV) infection or clinically active (symptomatic) hepatitis C (HCV) infection? Yes No

Have you been exposed in the preceding 12 months to known or suspected HIV, HBV, and/or HCV-infected blood through percutaneous inoculation (e.g., needle-stick) or through contact with an open wound, non-intact skin, or mucous membrane? Yes No

Have you been in juvenile detention, lock up, jail or prison for more than 72 consecutive hours in the preceding 12 months? Yes No

Have you lived with (resided in the same dwelling) another person who has hepatitis B or clinically active (symptomatic) hepatitis C infection in the preceding 12 months? Yes No

Within the preceding 12 months, have you undergone tattooing, ear piercing, or body piercing in which sterile procedures were **not** used, e.g., contaminated instruments and/or ink were used, or **shared** instruments that had not been sterilized between procedures were used? Yes No

Have you had a past diagnosis of clinical, symptomatic viral hepatitis after your eleventh birthday, unless evidence from the time of illness documents that the hepatitis was identified as being caused by hepatitis A virus (e.g., a reactive IgM anti-HAV test), Epstein-Barr Virus (EBV), or cytomegalovirus (CMV)? Yes No

If you have had a smallpox vaccination (vaccinia virus) in the preceding 8 weeks, has your scab separated spontaneously?

____ N/A—I have not had a smallpox vaccination in the preceding eight weeks.
____ Yes---my scab has since separated spontaneously.
____ N/A—I did not acquire a scab as a result of my smallpox vaccination
____ No—my scab has not separated spontaneously

If you have had a smallpox vaccination (vaccinia virus) in the preceding 8 weeks, has it been 21 days post vaccination?

____ N/A—I have not had a smallpox vaccination (vaccinia virus) in the preceding 8 weeks.
____ Yes
____ No

If you have had a smallpox vaccination (vaccinia virus) in the preceding 8 weeks and have had complications as a result of that vaccine, have your complications been completely resolved for at least 14 days? Yes No N/A

Have you been diagnosed with clinically recognizable vaccinia virus infection and developed scabs or skin lesions acquired by close contact with someone who received the smallpox vaccine (i.e., touching the vaccination area or the scab, including the covering bandages, or touching clothing, towels, or bedding that might have come into contact with an un-bandaged vaccination area or scab) and the resulting scab has since spontaneously separated?

____N/A—I have not been diagnosed with clinically recognizable vaccinia virus infection.
____N/A—I did not have any complications, scabs, or lesions as a result of my diagnosis.
____Yes—my scab has since separated spontaneously
____No—My scab did not separated spontaneously, but it has been three or more months since the date of the vaccination of the vaccine recipient with whom I had close contact.
____No—My scab has not yet separated. No—my scab did not separate spontaneously, and it has been less than three months since the date of the vaccination of the vaccine recipient with whom I had close contact.

Have you been diagnosed with clinically recognizable vaccinia virus infection and developed **other** complications of vaccinia infection acquired by close contact with someone who received the smallpox vaccine (i.e., touching the vaccination area or the scab, including the covering bandages, or touching clothing, towels, or bedding) that might have come in contact with an un-bandaged vaccination area or scab?

____N/A—I have not been diagnosed with clinically recognizable vaccinia virus infection.
____Yes—but my complications have been resolved for at least fourteen days.
____No—I had no complications as a result of my diagnosis.
____Yes—but my complications have not been resolved for at least fourteen days.

Have you had Progressive necrosis (dying skin tissue) in the area of a smallpox vaccination, Encephalitis following smallpox vaccination, or Vaccinia keratitis (infection of the cornea of the eye) following smallpox vaccination Yes No

Have you had a medical diagnosis, onset of illness, or suspicion of WNV (**West Nile Virus**) infection (including diagnosis based on symptoms and/or laboratory results of confirmed WNV viremia in the preceding 120 days? Yes No

Have you tested **positive** or **reactive** for WNV infection using an FDA licensed or investigational WNV NAT donor screening test in the preceding 120 days? Yes No

Have you had or been treated for **Chlamydia trachomatis** or **Neisseria gonorrhea** or **Syphilis** infection in the preceding **12 months**? Yes No

Have you ever been diagnosed with vCJD or any other form of Creutzfedlt-Jakob dieases (CJD)? If yes,_____ Yes No

Have you ever been diagnosed with dementia or any degenerative or demyelinating disease of the central nervous system or other neurological disease of unknown etiology? Yes No

Have you spent 3 months or more, cumulatively, in the UK (England, Northern Ireland, Scotland, Wales, the Isle of Man, the Channel Islands, Gibraltar, or the Falkland Islands) form the beginning of 1980 through the end of 1996? Yes No

Are you a current or former US military member, civilian military employee, or dependant of a military member or civilian employee, who has resided at US military basis in northern Europe (Germany, UK, Belgium, and Netherlands) for 6 months or more cumulatively from 1980 through 1990, or elsewhere in Europe (Greece, Turkey, Spain, Portugal, or Italy) for 6 months or more cumulatively from 1980 through 1996? Yes No

Have you lived cumulatively for 5 years or more in Europe (Albania, Austria, Belgium, Bosnia-Herzegovina, Bulgaria, Croatia, Czech Republic, Denmark, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Liechtenstein, Luxembourg, Macedonia, Netherlands, Norway, Poland, Portugal, Romania, Slovak Republic, Slovenia, Spain, Sweden, Switzerland, England, Northern Ireland, Scotland, Wales, Isle and Man, Channel Island, Falkland Island, and Yugoslavia) from 1980 until present? Yes No

Have you received any transfusion of blood or blood components in the UK (England, Northern Ireland, Scotland, Wales, Isle of Man, Channel Islands, Gibraltar, Falkland Islands) or France between 1990 and the present? Yes No

Did you travel outside the United States (except Canada) in the **preceding three years**? Yes No
If yes, when and where? _____

Have you ever been exposed to "agent orange" or any other herbicides or chemicals in military action or elsewhere? (forest service, highway maintenance, etc.) Yes No
Which substance(s)? _____
If yes, when: _____ Where? _____

Have you been the recipient of a xenotransplantation product (transplantation, implantation, or infusion) of either cells, tissues or organs from a **non-human**/animal source (this includes human bodily fluids, cells, or organs that have had **ex-vivo contact** with live non-human/ animal cells, tissues, or organs)? Yes No

Has anyone you have had close contact with (e.g., intimate or living in the same household, where sharing of kitchen and bathroom facilities occur regularly) been the recipient of a xenotransplantation product (transplantation, implantation, or infusion) of either cells, tissues or organs from a nonhuman animal source (this includes human bodily fluids, cells, or organs that have had ex-vivo contact with live nonhuman animal cells, tissues, or organs)? Yes No

Does your medical history or medical records show any evidence of a diagnosis or a prior **positive or reactive** screening test result for HIV? Yes No

Have you ever had unexplained weight loss? Yes No

Have you ever had unexplained night sweats? Yes No

Have you ever had blue or purple spots on our under the skin or mucous membranes typical of Kaposi's sacroma? Yes No

Have you ever had dissemination lymphadenopathy (swollen lymph nodes) for **longer** than one month? Yes No

Have you ever had an unexplained temperature of greater than 100.5F (38.6C) for more than 10 days? Yes No

Have you ever had unexplained persistent cough or shortness of breath? Yes No

Have you ever had opportunistic infections (infections that take advantage of a weakened immune system)? Yes No

Have you ever had unexplained persistent diarrhea? Yes No

Have you ever had unexplained persistent white spots or unusual blemishes in your mouth? Yes No

Does your medical history or medical records show any evidence of a diagnosis or a prior **positive/reactive** screening test result for Hepatitis B or Hepatitis C Virus? Yes No

Have you ever had unexplained jaundice? Yes No

Have you ever had hepatomegaly (enlarged liver)? Yes No

Have you had a past diagnosis of clinical, symptomatic viral hepatitis after your 11th birthday that was not later identified as being caused by hepatitis A virus, Epstein Barr Virus, or cytomegalovirus? Yes No

Have you ever experienced unexplained fever, headache, body aches, or eye pain that may have been accompanied by skin rash on the trunk of the body or by swollen lymph glands? Yes No

Have you ever been diagnosed with a severe illness such as encephalitis, meningitis, menigoencephalitis, or acute flaccid paralysis? Yes No

Have you ever had signs and symptoms of severe illness, including headache, high fever, neck stiffness, stupor, disorientation, coma, tremors, convulsions, and muscle weakness or paralysis? Yes No

Have you, in the last 12 months, been diagnosed with sepsis (including bacteremia, septicemia, sepsis syndrome, systemic infection, systemic inflammatory response syndrome (SIRS) or septic shock)? Yes No

Have you ever had clinical evidence of infection with two or more of the following systemic responses to infection if unexplained: temperature of greater than 100.4F (38C), elevated heart rate, elevated respiratory rate or elevated white blood cell count? Yes No

Have you, in the last 12 months, experienced more severe signs of sepsis including unexplained hypoxemia, elevated lactate, oliguria (less than normal urination), altered mentation and hypotension (low blood pressure) and/or positive blood cultures? Yes No

Have you ever experienced unexplained paraparesis (weakness in the lower extremities)? Yes No

Did you exhibit any of the following conditions within the preceding 12 months?

- Dysuria (painful urination) Yes No
- Urethral Discharge Yes No
- Genital Ulcer Yes No
- NSU (non-specific urethritis) Yes No

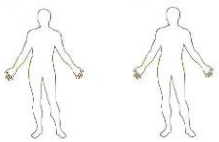
Have you ever experienced any of the following conditions:

- Genital Herpes Yes No If yes, list date _____
- Genital Warts Yes No If yes, list date _____

In the preceding 12 months, did you have sex or close contact (e.g., living in the same household, where sharing of kitchen and bathroom facilities occurred regularly) with anyone who has had:

Genital Herpes Yes No
Genital Warts Yes No
Chronic Hepatitis (carrier) Yes No

Front Back



Do you have any tattoos? Yes No
If yes, list date received: _____Location:(circle)

Have you ever had acupuncture/ear piercing/body piercing? Yes No
If yes, which body parts/ date(s) _____

Have you ever been previously excluded from blood donation? Yes No
If yes, identify the reason and date(s): _____

Have you ever been treated with human pituitary-derived growth hormone (pit-hGH)? Yes No
If yes, explain _____

Did you have a blood transfusion in the preceding **12 months**? Yes No
If yes, explain _____

Were you bitten by an animal suspected of rabies in the preceding 12 months? Yes No
If yes, when:_____ explain _____

Do you have any history of dementia or degenerative neurologic disorders of viral or unknown etiology? Yes No
If yes, explain _____

Have you injected Bovine insulin since 1980? Yes No
If yes, when _____ explain_____

Have you received a transplant of human dura mater? Yes No
If yes, explain _____

Did you have a vaccination or immunization in the preceding 12 months? Yes No
If yes, explain _____

Have you ever taken anti-malarial drugs or had malaria? Yes No
If yes, please explain: _____

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

Have you ever had any major illnesses such as amoebic dysentery, pneumonia ,mononucleosis,etc?
If yes, please explain:_____ Yes N0

Have you or any of your sexual partners had any sexually transmissible diseases other than those listed in previous questions? Yes No

Have you ever been tested for **HIV** (AIDS)? Yes No
If yes, when: _____ Reason for testing: _____

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 explain: _____

Have you had a medical diagnosis of **ZIKV** i**nfection** in the **past 6 months**? Yes No

If yes, when? (Date)_____

Have you resided in or traveled to an area with **active ZIKV transmission within the past 6 months**?

Yes No

If yes, **travel location**:_____/ Date(s)_____

Have you had sexual intercourse **within the past 6 months** with a male who is known to have had a medical diagnosis of **ZIKV infection** or has resided in or traveled to an area with **active ZIKV transmission within the past 6 months**? Yes No

If yes, travel location:_____/ Date(s)_____

**THE MIDWEST CENTER FOR REPRODUCTIVE HEALTH, P.A.**

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**Toll Free** 800.508.9763
**Fax** 763.494.7706
**Web Site** www.mcrh.com

## CONSENT FOR TESTING AND RELEASE OF INFORMATION FOR HIV AND HEPATITIS

It has been required that I receive blood testing for the presence of HIV antibody, Hepatitis C antibody and Hepatitis B antigen included in a panel of testing in order to facilitate treatment as an oocyte donor.

I have been informed about the nature of the blood tests, the expected benefits and risks involved, and have been given the opportunity to ask questions concerning infectious disease blood testing.

I understand that the blood tests for the virus which causes Acquired Immune Deficiency Syndrome ("AIDS"), Hepatitis B and Hepatitis C are not 100% accurate, and that these blood tests sometimes produce false positive or false negative test results. I/We further understand that the presence of HIV antibodies means that a person probably has been **infected** with the AIDS virus, but does not necessarily mean that a person will develop AIDS.

I understand that my primary caregiver will notify me of the results of the blood tests and that the results will be explained to me.

I understand that the results of the test(s) will become part of my medical record, but that The Midwest Center for Reproductive Health, to the best of its ability, will not disclose the results of these tests to others except to the extent required by law or pursuant to my subsequent written authorization.

On this basis, I authorize the performance of the blood test(s) referred to above.

_____ _____

DATE (DONOR)

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## RELEASE OF HIV (AIDS) BLOOD TEST RESULTS

I, _____, a participant in The Midwest Center for Reproductive Health, P.A.'s Donor Oocyte Program, acknowledge that MCRH has afforded me the opportunity for individual, face-to-face disclosure of my HIV (AIDS) blood test results and appropriate counseling; nevertheless, I hereby direct that the results of this test be disclosed to me by The Midwest Center for Reproductive Health in the manner indicated below.

_____ Registered or certified mail addressed and sent to me at the address given below.

_____ Person-to-person telephone call at the phone number given below.

_____ Registered or certified mail addressed and sent to my physician, at the address given below.

_____ Person-to-person telephone call to my physician at the phone number given below.

Name: _____

Number/Street: _____

City: _____

State/Zip: _____

Telephone: (_____)_____

I hereby authorize The Midwest Center for Reproductive Health, its agents, and employees, to disclose the results of my HIV (AIDS) blood test to me directly or to the person(s) designated by me above and in the manner specified above; I hereby elect to reject the opportunity for individual, face-to-face disclosure of the results of my HIV (AIDS) blood test and appropriate counseling by The Midwest Center for Reproductive Health.

_____ _____
Signature (donor) Date