

Dear Prospective Egg Donor:

Thank you for your inquiry about our Anonymous Egg Donor Program. We appreciate your interest in wanting to help infertile couples achieve their dreams of having children. Our goal is to help guide you through the process as comfortably as possible so that it will be rewarding not only to the couple, but also to you as the donor.

Please take some time to review this packet which includes information about egg donation and also about South Jersey Fertility Center. If you wish to proceed with the Egg Donor Process, please complete the Donor History Questionnaire, as well as the other forms requested, and mail them back to us in the enclosed envelope.

Be sure that you answer all questions as completely and as truthfully as possible. A copy of the Donor History form will be given to the recipient couple to review before they choose their donor. It will also be given to the couple who chooses you as their donor so that they have a complete medical/familial history. Even if a couple chooses not to disclose this information to their child(ren), it is still important that it be available. If the child(ren) are told that they are born through the use of donor eggs, these forms could provide them with information valuable for medical and/or psychological reasons.

All of this information will remain ANONYMOUS. Any identifying information (name, birth date, address, etc.) will be deleted from all forms and paperwork given to the recipient couple.

Once your questionnaires are received, we will review them and determine if you qualify to be a donor. Some women may not be chosen to participate due to age, family history of genetic diseases or other factors. It is important that we screen as carefully as possible so that we can make the process of egg donation a successful one for both the donor and the recipient couple.

If you are selected by a recipient the screening process will begin. This includes physical examination, testing for infectious diseases (blood work and cultures), and psychological evaluation. The next step is to synchronize the cycles of the donor and the recipient. Throughout this phase you will be expected to maintain close contact with the Egg Donor Coordinator. You will be compensated \$8000 for your time and effort on the day of the Egg Retrieval.

We thank you for your interest in our donor egg program. We will do our best to make the visits and convenient as possible according to your schedule. No matter what the outcome of the cycle, you will have the satisfaction of knowing that your participation help an infertile couple do all that was possible to achieve their dreams.

Sincerely yours,

**Tracy Krause, APN-C, MSN**

Tracy Krause, APN-C, MSN  
Egg Donor Coordinator

TK:cmd

# South Jersey Fertility Center

## Oocyte Donor Program

South Jersey Fertility Center was established by Dr. Robert Skaf in July 1989. Our IVF program was started in 1990 and since then we have performed thousands of treatment cycle. The IVF Center is next to our office in Marlton at 400 Lippincott Drive, Suite #140, Marlton, NJ. Monitoring of treatment cycles can also be performed in our Sewell and Egg Harbor Township locations, however the actual retrieval and transfer processes are performed in Marlton.

The most well known ART procedure is IVF (In Vitro Fertilization), which resulted in the first IVF birth in England in 1978. Since that time, many thousands of babies have been born worldwide. New technologies have been developed including ICSI (Intracytoplasmic Sperm Injection), Cryopreservation, Assisted Hatching and Egg Donation. We offer all of these options at South Jersey Fertility Center.

Egg Donation is one form of a "3<sup>rd</sup> Party Reproduction", whereby a third person besides the intended couple is used to donate eggs, sperm or a host uterus. Egg donation is based on the IVF process and was developed to help those women who are unable to conceive due to impending or complete ovarian failure and attempt to create a family by using eggs(oocytes) from a woman who is willing to undergo the process of egg donation.

To better understand how the Egg Donor Program works, you must first understand the IVF process, as this is the form of treatment through which eggs are obtained for donation.

### In Vitro Fertilization (IVF)

In Vitro Fertilization (IVF) is a process by which one or more eggs are removed from the ovaries and fertilized outside the body. Successfully fertilized egg cells(embryos) are then placed into the uterus (womb) for implantation and establishment of pregnancy. This process bypasses the fallopian tubes.

The indications for IVF include:

1. Absence or blockage of the fallopian tubes
2. Damaged fallopian tubes (due to scarring from endometriosis, previous surgery, pelvic infection, etc.)
3. Infertility due to male factor
4. Previously failed treatment with conventional infertility therapy
5. Unexplained infertility
6. Donor egg

The IVF/Donor Egg cycle consists of four step:

1. Ovarian stimulation (hyperstimulation, ovulation induction)
2. Collection of eggs (retrieval)
3. Fertilization of eggs in laboratory
4. Placement of embryos into the uterus (transfer)

### Ovarian Stimulation (Donor)

The purpose of ovarian stimulation is to yield multiple, healthy, fertilizable eggs. In order for us to obtain as many eggs as possible and to control the cycle, we use a combination of medications. These medications, which are given by injection, are similar to hormones the body naturally produces. The medications used are Lupron, FSH (Gonal F/Follistim/Bravelle) and hCG. The entire stimulation process takes about 2 weeks.

#### Lupron (leuprolide)

The purpose of this medication is to stop the body from producing too much LH hormone which would then trigger ovulation too early. Lupron is injected subcutaneously in the thigh with a small insulin syringe or with syringes that come with the kit. Lupron is to be taken daily (usually in the morning) until you are instructed to discontinue it just prior to your hCG injection.

Some of the side effects you may experience from this medication include hot flashes, breast tenderness, mood swings, and headache. They usually resolve in 1-2 weeks.

### Gonal F/Follistim/Bravelle (FSH)

These are injectable fertility drugs which directly stimulate the ovaries. These drugs (similar to the body's naturally occurring hormones) stimulate the ovaries to increase the number of follicles (egg sacs) produced. Because these are very potent stimulants, it is very important that we monitor very frequently during treatment in order to get the best results and prevent adverse side effects. Ultrasounds will be done to determine size and number of follicles and when to perform the retrieval. Blood work will also be done to check Estrogen levels to see the body's response to these medications. There will be one (sometimes two) shots per day for about 10 days. Office visits for ultrasounds and blood work will be every other day, sometimes every day until the day of retrieval (averages 6-7 visits). These visits can be arranged in our Marlton, Sewell and Egg Harbor Twp locations. Side effects of these drugs include ovarian enlargement, bloating and discomfort, and mood swings. Severe ovarian hyperstimulation is rare (1-2%), but if it occurs, could require hospitalization. Close monitoring will be done in order to prevent potential complications.

When it is time for retrieval, a shot of hCG (Human Chorionic Gonadotropin) (Ovidrel) is given to begin the maturation process of the eggs. Retrieval will be done prior to ovulation, about 36 hours after hCG shot is given.

### Collection of Eggs (Retrieval) – Donor

Egg retrieval is performed trans-vaginally with ultrasound guidance. This is a minor surgical procedure performed in the office under anesthesia to minimize discomfort. A needle is inserted through the upper vagina and is guided from follicle to follicle in order to aspirate the follicular fluid. The fluid is collected into test tubes and is then examined by the embryologist to determine if eggs are present. The procedure takes approximately 1 hour. You will remain in the recovery area for 1-2 hours at which time you will be discharged to home. You must have someone drive you to and from the center, and you may have someone accompany you during the preparation and recovery periods. You will be very groggy and may not drive. You may have some minor abdominal discomfort, tenderness or cramping and minor bleeding, but severe pain or heavy bleeding is rare.

You should eat a light meal and rest for the next 24 hours. You may then resume your normal activity as you feel up to it. Avoid any strenuous physical activity, heavy lifting or intercourse for about 2 weeks.

You will be scheduled for a follow-up visit 2 weeks after the procedure. You should avoid intercourse until this time or use a barrier method of contraception to prevent pregnancy, such as condoms and foam. This is critical, since we may not be able to retrieve every egg and you may end up ovulating on your own and could be pregnant!

### Fertilization of Eggs in Laboratory

A period of hours after the retrieval, the eggs obtained will be inseminated with the recipient partner's sperm, which has been previously collected and prepared. This is a laboratory procedure performed by the embryologist. The eggs and sperm are then incubated and will be checked to see how many fertilize the following days.

### Placement of Embryos into the Uterus (Transfer) – Recipient Patient

Several days later, the fertilized eggs will be transferred into the uterus of the recipient patient. She will have been treated with a combination of medications in order to prepare the lining of her uterus to be ready for implantation of the embryos. These may include Lupron injections, Estrogen (pills, patches, injections) and Progesterone (pills, injections, suppositories). The recipient cycle and the donor cycle will need to be coordinated carefully so they will be ready at the same time. The recipient patient will have been put through a trial cycle of hormone replacement prior to the actual cycle to assure that the uterine lining is adequate – Mock cycle. This is determined by ultrasound, blood testing and endometrial biopsy. Once the transfer of embryos occurs, the recipient patient will be closely followed until we can determine if pregnancy has been established. Excess embryos may be frozen for use in another transfer cycle at a later time.

### Who are Candidates for Egg Donation and Recipient Transfer

The donor egg cycle is not an easy process either for the egg donor or the recipient couple. For both, these are multiple office visits which can interfere with the normal activities of daily life. For the recipient couple, the costs can be quite high. Although donors are compensated for their time, the requirement of the program can be quite rigorous. For these reasons, we look for donors who have humanitarian reasons for wishing to donate eggs, and we look for couples who truly wish to pursue the donor cycle as their option for achieving parenthood.

Candidates for egg donation are women who:

1. Are between the ages of 21-32
2. Have two ovaries
3. Are optimal (average) weight
4. Are not adopted
5. Have good ovarian reserve as measured by FSH
6. Have passed all screening criteria

Candidates for egg donor recipients could be women who:

1. Have complete ovarian failure due to autoimmune disease, radiation therapy, chemotherapy, genetic illnesses, surgical removal of ovaries, menopause
2. Poor ovarian response/reserve due to delayed childbearing
3. Women with previously failed IVF cycles or unexplained infertility
4. Are age 50 and under
5. Have a history of familial genetic disease risk which could affect offspring

There is a rigorous screening process for all parties involved. This includes complete history and physical exam, blood work, laboratory testing for transmissible diseases, recreational drug use and genetic abnormalities and a psychological evaluation.

Once preliminary screening has been completed, donors will be notified whether they qualify to be accepted. This does not mean there is anything wrong with these donors who are not accepted – we must have a very rigorous exclusion criteria for the benefit of both donor and recipient. We must make sure no one will come to regret their participation in the program.

Donors will be reimbursed for their time and efforts. They will not be responsible for any costs of the procedure. Payment will be dependent on how much of the cycle is completed. If you complete the full cycle, compensation will be \$8000. Payment will be rendered at the time of the retrieval.

Thank you again for your interest in our Egg Donor Program. If you wish to be a participant, please review the information contained in this packet. Your next step will be to schedule a consultation with the Donor Egg Coordinator to review paperwork, history and further explain the process. Appointments for psychological evaluation, blood testing and other preliminary tests can be scheduled at this time.

Feel free to call should you have any questions. They can be directed to our Egg Donor Coordinator, Tracy Krause, APN-C, MSN.

**SJFC USE ONLY**

Donor # \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# South Jersey Fertility Center Egg Donor Program

## DONOR HISTORY QUESTIONNAIRE: Part 1

Name \_\_\_\_\_ SS# \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

\_\_\_\_\_ Work Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Cell Phone \_\_\_\_\_

### Physical Characteristics

Age \_\_\_\_\_ Height \_\_\_\_\_ Current Weight \_\_\_\_\_ Weight at age 21 \_\_\_\_\_

Blood Type \_\_\_\_\_ Eye Color \_\_\_\_\_ Body Frame (Small, Medium, Large) \_\_\_\_\_

Natural Hair Color \_\_\_\_\_ Type of Hair (check all that apply)

Curly/Wavy (naturally)  Curly/Wavy (processed)  Straight (naturally)  Straight (processed)

Average Texture  Thin Texture Premature Graying (at what age \_\_\_\_\_)

Other \_\_\_\_\_

Skin Color:

Fair  Medium  Olive  Light Brown  Dark Brown  Ebony  Freckled  Rosy

Other \_\_\_\_\_

Birthmarks: \_\_\_\_\_

### Personal Characteristics

Race: Mother \_\_\_\_\_ Father \_\_\_\_\_

Ethnic Origin: Mother \_\_\_\_\_ Father \_\_\_\_\_

Marital Status: \_\_\_\_\_ Duration of relationship with current partner \_\_\_\_\_

Sexual Orientation:  Heterosexual  Homosexual  Bisexual

Education:  Completed Grade School  Completed High School  
 Currently in college, pursuing degree in \_\_\_\_\_  
Area of Study \_\_\_\_\_  
 Completed college, degree in \_\_\_\_\_  
 Currently pursuing advanced degree in \_\_\_\_\_  
 Advanced degree in \_\_\_\_\_

Testing Scores: SAT \_\_\_\_\_ GRE \_\_\_\_\_ MAT \_\_\_\_\_ LSAT \_\_\_\_\_ MCAT \_\_\_\_\_

Occupation, Current \_\_\_\_\_

Occupation, Previous \_\_\_\_\_

Right-handed  Left-handed  Ambidextrous

**Donor Social / Medical History**

Do you drink caffeinated beverages?  Yes  No

If yes, how much \_\_\_\_\_

Do you smoke cigarettes?  Yes  No

If Yes, how many Cigarettes per day \_\_\_\_\_

Do you drink alcoholic beverages? Yes  No

If so, which kinds?  Beer  Wine  Liquor

Approximately how many drinks do you consume: per day \_\_\_\_\_ per week \_\_\_\_\_

If you now 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)

Have you ever used or do you currently use any of the following drugs?  Yes  No

	Frequency/When (years)	How used?
Marijuana		
Cocaine		
Barbituates		
Narcotics (heroin, methadone, opium, morphine, codeine)		
Amphetamines		
Hallucinogens		
Tranquilizers		
Anti-depressants		
PCP		
Inhalants (amyl or butyl nitrate, aerosol propellants)		
Over the counter Drug (if so, which ones?)		

Have you ever used IV (intravenous) Drugs?  Yes  No

If yes, explain \_\_\_\_\_

Have you ever been admitted to a hospital or institution for substance or alcohol abuse?  Yes  No

If yes, please explain \_\_\_\_\_

Diet (check all applicable):

- Vegetarian  Non-Vegetarian  
 Poor Eating Habits  Average Eating Habits  Good Eating Habits

Exercise: What Type? \_\_\_\_\_ How Often? \_\_\_\_\_

Teeth:  Poor Condition  Fair Condition  Good Condition  Excellent Condition

Any Orthodontic work? \_\_\_\_\_

Do you have any speech impairment?  Yes  No

If yes, please explain \_\_\_\_\_

Hearing:  Poor  Fair  Good  Excellent

Do you wear hearing aids?  Yes  No

For what type of problem? \_\_\_\_\_

Vision:  Poor  Fair  Good  Excellent

Do you wear glasses or contact lens?  Yes  No

Are you  Nearsighted  Farsighted  Other \_\_\_\_\_

Age when first wore glasses? \_\_\_\_\_

Allergies:  Yes  No

Allergen/Medication	Reaction(s)	Age of Onset

Have you outgrown any allergies?  Yes  No

If yes, explain \_\_\_\_\_

Do you exercise?  Never  Sometimes  Routinely

What type of exercise? \_\_\_\_\_

Please list any surgical procedures you may have had in the past

Type of Surgery	Reason For Surgery	Year

Please list any hospitalizations not included above

Reason for Hospitalization	Year

Have you had a blood transfusion?  Yes  No What Year \_\_\_\_\_

Have you had any major radiation or X-ray exposure?  Yes  No

If yes, explain \_\_\_\_\_

Do you have any medical/major medical insurance?  Yes  No

Please list any medications you are currently taking, including over the counter.

Name of Medication/Dose	Reason for Taking	How Long have you been taking

Are you currently sexually active?  Yes  No

Number of sexual partners within the last six months: \_\_\_\_\_

If applicable, my sex partner has had other sex partners in the last six months  Yes  No

Have you ever been involved with somebody who is bisexual?  Yes  No

Method of contraception (Birth Control) \_\_\_\_\_ How Long \_\_\_\_\_

Include condoms, spermicide, rhythm, birth control pills, Depo Provera, Norplant, etc.

Previous methods of Contraceptives used in the past (please indicate) \_\_\_\_\_

\_\_\_\_\_

Have you or your partner ever had:

	Self	Partner	When	Number of Occurrences
Syphillis				
Gonorrhea				
Chlamydia				
Venereal Warts				
Herpes				
Hepatitis A, B, or C (specify)				
Non-specific Urethritis				
Pelvic Infection, Pelvic Inflammatory Disease				
Other Sexually Transmitted Diseases (specify)				

Do you have a history of pelvic adhesions/scar tissue?     Yes    No

Do you have a history of pelvic infection or pelvic inflammatory disease?     Yes     No

**Reproductive History**

Age at onset of menses \_\_\_\_\_ Frequency (how often, i.e. 28 days) \_\_\_\_\_

If you are currently using hormonal contraception (i.e. pill, patch, ring) please indicate the frequency of your menstrual cycles while **not** on the hormonal contraception: \_\_\_\_\_

Are they regular?     Yes    No                      # of days you bleed \_\_\_\_\_

Type of Flow (i.e. heavy, light, clots etc) \_\_\_\_\_

Have you ever had trouble conceiving?                       Yes             No             Never Tried

When was your last pap smear? \_\_\_\_\_

Have you ever had an abnormal pap smear?                       Yes             No

    If yes, explain \_\_\_\_\_

Have you ever had a breast mass (lump)?                       Yes             No

    If yes, explain \_\_\_\_\_

When was your last breast exam? \_\_\_\_\_

Do you have any gynecologic problems? \_\_\_\_\_

Total Number of Times Pregnant \_\_\_\_\_

Year	Vaginal or C-Section	Weight	Sex	Healthy Baby	Miscarriage	Ectopic	Termination	Complications (Specify)

**Children**

Age	Sex	Natural	Stepchild	Adopted	Living with You

Are any children deceased?  Yes  No

If so, explain \_\_\_\_\_

**Toxic Exposure**

Exposure	Year	How Often	Type of Toxin
Toxic Chemical			
Sprays			
Fumes/Exhaust			
Radiation			
Insecticides			
Lead/Lead Products			
Asbestos/Asbestos Products			
Cleaning Solutions			
Recreational Drugs			
Agent Orange			
Other herbicides or Chemicals			

**Family Medical History**

Characteristics – Please describe the physical characteristics of the following members of your family. Please use their natural eye and hair color. Also note if they wear corrective glasses or contact lenses.

	Age	Eye Color	Hair Color	Complexion	Weight/Height	Body Type	Vision
<b>Mother</b>							
<b>Father</b>							
<b>MGM</b>							
<b>MGF</b>							
<b>PGM</b>							
<b>PGF</b>							
<b>Brothers</b>							
<b>Sisters</b>							

Note - MGM = Maternal Grandmother  
PGM = Paternal Grandmother

MGF = Maternal Grandfather  
PGF = Paternal Grandfather

How many blood siblings in your immediate family (include yourself)? \_\_\_\_\_

Number of Females \_\_\_\_\_ Number of Males \_\_\_\_\_

Are you adopted?  Yes  No

How many adopted siblings in your immediate family (including yourself)? \_\_\_\_\_

Number of Females \_\_\_\_\_ Number of Males \_\_\_\_\_

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

If yes, what relation are they to you? \_\_\_\_\_

Any family history of infertility?  Yes  No

If yes, explain \_\_\_\_\_

Please list below any member of your family that have died. Note if the sibling(s) are adopted.

	Age at time of Death	Cause of Death
Mother		
Father		
Brother (s)		
Sister (s)		
MGM		
MGF		
PGM		
PGF		
Aunt (s)		
Uncle (s)		

Do you have any current health/medical problems or conditions?      Yes      No

Please explain \_\_\_\_\_

Have you ever been tested for the following:

	Carrier	Non-Carrier	Unknown
Canavan's Disease (Ashkenazi Jewish)			
Tay-Sach's Disease (Ashkenazi Jewish/French Canadian)			
Sickle Cell Disease (African American)			
Cystic Fibrosis			
Thalassemia (Hispanic, Asian, Mediterranean)			

Please review the following medical problems and identify any members of your family affected. Please consider each condition carefully for each natural family member and include maternal and paternal grandparents, parents, siblings, aunts, uncles and cousins.

	None Affected	Self	Relative/ Relationship	Comments (be specific - indicate age of onset)
<b>HEART</b>				
Stroke				
Heart Attack				
Heart Disease from Birth				
Heart Disease - Other				
Hardening of the Arteries				
High Blood Pressure				
High Cholesterol Level				
Heart Malformation				
Mitral Valve Prolapse				
<b>BLOOD</b>				
Anemia				
Sickle-Cell Anemia				
Hemophilia or other bleeding Disorder				
Leukemia				
HIV Virus				
Lymphoma				
Immune Deficiency				
Other Blood Disorder (specify)				
<b>RESPIRATORY</b>				
Hay Fever/Environmental Allergy				
Asthma				
Emphysema				
Tuberculosis				
Lung Cancer				
Pneumonia				
Other Lung Disease (specify)				

	None Affected	Self	Relative/ Relationship	Comments (be specific - indicate age of onset)
<b>GASTRO-INTESTINAL</b>				
Ulcer of stomach or duodenum				
Gall Stones				
Hepatitis A (infectious)				
Hepatitis B (serum)				
Hepatitis C				
Cirrhosis				
Other Liver Disease (specify)				
Colon Cancer				
Ulcerative Colitis				
Crohn's Disease				
Cystic Fibrosis				
Intestinal Cancer				
Developmental disorder of the stomach and intestine				
Pyloric Stenosis				
Rectal Disorder				
Any othe cancer/problem of the digestive system (specify)				
<b>ENDOCRINE</b>				
Diabetes Mellitus				
Hypoglycemia				
Thyroid Cancer				
Thyroid Disease				
Goiter				
Adrenal Dysfunction or disorder				
Hyperactivity				
Hormonal Dysfunction or disorder				
<b>URINARY</b>				
Polycystic Kidney Disease				
Other Kidney Disease				
Other Disease of the urinary tract (urethra, bladder, ureter) specify				
<b>REPRODUCTIVE</b>				
Undescended Testicle				
Hermaphroditism/Ambiguous genitals				
Hypospadias				
Prostate Cancer				
Testicular Cancer				
Endometriosis				
Uterine Fibroid				
Chronic Vaginitis				
Ovarian Cysts				
Polycystic Ovaries				
Cancer of the Cervix, Ovaries or Uterus (specify)				
2 or more miscarriages				
Stillborn				
Death of newborn infant				
Neonatal jaundice				

	None Affected	Self	Relative/ Relationship	Comments (be specific - indicate age of onset)
<b>NEUROLOGY</b>				
Migraines				
Mental Retardation				
Down's Syndrome				
Senility before age 50				
Multiple Sclerosis				
Cerebral Palsy				
Epilepsy				
Seizure/Convulsive Disorders				
Hydrocephalus (water on the brain)				
Spina Bifida/Neural Tubal Defect (specify)				
Disorder of the spinal cord (specify)				
Huntingdon's Disease				
Gaucher's Disease				
Wilson's Disease				
Parkinson's Disease				
Alzheimer's Disease				
Paraplegia				
Tourette's Syndrome				
Other Diseases of the nervous system (specify)				
<b>MENTAL</b>				
Schizophrenia				
Manic Depressive or bipolar disease				
Obsessive/Compulsive				
Suicide				
Other mental health disorder requiring hospitalization (specify)				
<b>MUSCULAR/SKELETAL</b>				
Muscular Dystrophy				
Other chronic muscle disease (specify)				
Scoliosis				
Loss of muscle coordination				
Deformity of the spine (specify)				
Lupus				
Osteoporosis				
Dwarfism				
Arthritis				
Gout				
Myasthenia Gravis				
<b>VISION/HEARING/SMELL</b>				
Deafness before age 50				
Deformity of the ear				
Cataracts before age 50				
Blindness				
Glaucoma				
Retinoblastoma				
Any other sight, sound, smell disorder (specify)				

	None Affected	Self	Relative/ Relationship	Comments (be specific - indicate age of onset)
<b>SKIN</b>				
Acne				
Eczema				
Skin Cancer				
Pigmentation Disorders				
Neurofibromatosis				
Infectious skin disorders				
Other disorders of the skin (specify)				
<b>CONGENITAL ANOMALIES</b>				
Cleft Lip/palate				
Congenital hip problems				
Club Feet				
Other Congenital anomalies (specify)				
Turner's Syndrome				
Klinefelter's Syndrome				
Cri du chat Syndrome				
Trisomy 18				
Trisomy 13				
Fragile X Syndrome				
<b>OTHER</b>				
Alcoholism				
Drug abuse, misuse or addiction				
Learning disabilities				
Breast Cancer				
Allergies				
Any other cancer not mentioned (specify)				
Any other condition not mentioned (specify)				

### Personal Information

1. Write a brief description of your personality and character.

2. Describe your philosophy of life.

3. What message would you like passed on to the recipient of your eggs?

4. What is your reason for wanting to donate eggs?

5. What characteristics are important to you that the recipient parents possess?

**Your Family**

	Education	Occupation	Intellectual/ Academic Accomplishments	Artistic Accomplishments
Mother				
Father				
Siblings				
Sister 1				
Sister 2				
Sister 3				
Sister 4				
Brother 1				
Brother 2				
Brother 3				
Brother 4				

**Your Children**

	Personality	Artistic Ability	Intelligence	Special Characteristics
Child 1				
Child 2				
Child 3				
Child 4				

**Childhood**

1. Describe yourself as a child.

2. What was your family life like?

3. What is your earliest childhood memory?

4. What problems did you have as a child (e.g. health, learning, social etc.)?

5. When I was a child:

My favorite thing to do was: \_\_\_\_\_  
At home I was expected to: \_\_\_\_\_  
My parents were strict about: \_\_\_\_\_  
My parents taught me to value: \_\_\_\_\_  
What I loved most about my father was: \_\_\_\_\_  
My favorite relatives were: \_\_\_\_\_  
I loved to visit: \_\_\_\_\_  
In comparison to others I was: \_\_\_\_\_

**Teenage Years:**

Describe yourself as a teenager:

Describe your achievements:

What problems did you have? (e.g. health, social, educational, etc).

**When I was a teenager:**

My favorite subject(s) was: \_\_\_\_\_  
My worst subject(s) was: \_\_\_\_\_  
The activities I was involved in were: \_\_\_\_\_  
My most important influence(s) was: \_\_\_\_\_  
In comparison to others I was: \_\_\_\_\_  
I liked to go: \_\_\_\_\_  
I traveled to: \_\_\_\_\_  
I was talented as: \_\_\_\_\_  
My ambition was to: \_\_\_\_\_

**Religion**

Religion born into: \_\_\_\_\_

Religion practiced: \_\_\_\_\_

Are you an Atheist?    Yes    No                      Agnostic?    Yes    No

How religious are you "now"? \_\_\_\_\_

**Activities**

How athletic are you?

What types of exercise or physical activities do you enjoy?

Do you have any musical talents?

What skills, interests, or talents do you have? Please describe.

What physical, artistic, or social abilities are you most proud of?

What have you achieved as an adult?

I hereby certify that the above information is true and complete, to the best of my knowledge, and that I have not knowingly or intentionally excluded or withheld any information requested in this questionnaire. I also agree that I have asked the meaning/explanation of any terms or questions I was unsure of.

\_\_\_\_\_  
Signature of Donor

\_\_\_\_\_  
Date

Date Reviewed: \_\_\_\_\_

Signature \_\_\_\_\_

**General Information**

Who will be giving you the injections?     Self     Another Person

If another person will be giving you the injections, will they be able to come to the office for instruction?    Yes     No

Will you be able to come into the office for monitoring and laboratory work in the mornings between:

7-8 AM	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
8-9 AM	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
9-10 AM	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

Is there someone who can bring you to South Jersey Fertility Center and take you home the day of the retrieval?  
 Yes     No

Is it okay to leave a detailed message on your home phone?     Yes     No

If no, would you like us to leave a message stating from :

- Your doctor's office
- South Jersey Fertility Center
- Egg Donor Program
- Other, explain \_\_\_\_\_

Please list the best times to contact you \_\_\_\_\_

*Please attach a recent good quality , color photograph of yourself (For SJFC use only)*



I hereby certify that the above information is true and complete, to the best of my knowledge, and that I have not knowingly or intentionally excluded or withheld any information requested in this questionnaire. I also agree that I have asked the meaning/explanation of any terms or questions I was unsure of.

\_\_\_\_\_  
Signature of Donor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date