



**Prospective Oocyte Donor Questionnaire  
(V2.09.2)  
(Completed by Prospective Donor, Page 2)**

**Sexual Preference**

Heterosexual\_\_\_\_\_ Homosexual\_\_\_\_\_ Bisexual\_\_\_\_\_

**Menstrual History**

Age of your first menstrual cycle: \_\_\_\_\_

How often do you get your menstrual cycle: \_\_\_\_\_

How long does your cycle last: \_\_\_\_\_

**Sexual/Contraceptive History**

Number of sexual partners in the past year: \_\_\_\_\_

Have you had any sexual partners that have used drugs: \_\_\_\_\_

Have you had any sexual partners with a Sexually Transmitted Disease: \_\_\_\_\_

If so, which: \_\_\_\_\_

Have you had a sexual partner that is homosexual or bisexual: \_\_\_\_\_

Do you have or have you been treated for any of the following? (Check all that apply):

\_\_\_Chlamydia \_\_\_Gonorrhea \_\_\_Syphillis \_\_\_HIV/AIDS

\_\_\_Herpes \_\_\_HPV/Warts \_\_\_PID \_\_\_Trich

\_\_\_Endometriosis \_\_\_Ovarian Cysts \_\_\_Abnormal Pap Smear

Type of Birth Control presently used: \_\_\_\_\_

**Pregnancy History**

Indicate all pregnancies and outcomes below:

PREGNANCY DATE	PREGNANCY OUTCOME	BOY/GIRL BIRTHDATE	MEDICAL ISSUES	TIME TO CONCEIVE

Are you Adopted: \_\_\_\_\_

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**Medical History**

Describe any current medical problems: \_\_\_\_\_  
\_\_\_\_\_

What routine medications do you take? \_\_\_\_\_

Do you wear glasses or contact? \_\_\_\_\_

Do you have any allergies or medication allergies? \_\_\_\_\_  
\_\_\_\_\_

What surgeries have you had? \_\_\_\_\_  
\_\_\_\_\_

How much caffeine do you consume daily? \_\_\_\_\_

Do you or have you ever smoked? \_\_\_\_\_

How often do you exercise? \_\_\_\_\_

Are you right or left handed? \_\_\_\_\_

**Family History**

<b>RELATIVE</b>	<b>CAUSE OF DEATH</b>	<b>HEIGHT</b>	<b>WEIGHT</b>	<b>HAIR COLOR</b>	<b>EYE COLOR</b>	<b>HEALTH PROBLEMS</b>
<b>MOTHER</b>						
GRANDFATHER						
GRANDMOTHER						
<b>FATHER</b>						
GRANDFATHER						
GRANDMOTHER						
<b>BROTHER/SISTER</b>						
<b>BROTHER/SISTER</b>						
<b>BROTHER/SISTER</b>						

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Has any member of your family been diagnosed with a birth defect or genetic disorder? \_\_\_\_\_

Did you have any siblings that have deceased from health related problems?  
\_\_\_\_\_

Have you or any member of your family been treated for psychological issues, Depression, Schizophrenia or Bipolar Disorder? (Please indicate): \_\_\_\_\_  
\_\_\_\_\_

**Physical/ Ethnic Information**

Ethnicity:

- |          |         |
|----------|---------|
| 1. _____ | _____ % |
| 2. _____ | _____ % |
| 3. _____ | _____ % |
| 4. _____ | _____ % |

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

Skin Color: \_\_\_\_\_ Light/Fair    \_\_\_\_\_ Medium/Olive    \_\_\_\_\_ Dark

Natural Hair Color: \_\_\_\_\_    Hair Texture: \_\_\_\_\_

Eye Color: \_\_\_\_\_    Complexion: \_\_\_\_\_

Height: \_\_\_\_\_    Weight: \_\_\_\_\_

Frame: \_\_\_\_\_ Slight/Small    \_\_\_\_\_ Medium/Average    \_\_\_\_\_ Large

Hobbies/Sports/Interests: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Tell something about yourself you would like to share with a recipient couple: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PLEASE ATTACH A 4X6 OR LARGER COLOR PHOTO WITH YOUR PROFILE!**