



Advanced Reproductive Health Center, Ltd. Oocyte Donation Program

Prospective Oocyte Donor Questionnaire

(Completed by Prospective Donor, following telephone intake)

Personal Information

Name: _____ Age _____ Date of Birth ___ / ___ / ___

Address: _____

Phone: (Home) _____ (Work) _____

I heard about the donor egg program at Advanced Reproductive Health Center, Ltd.
from:

___ A Friend

___ An ARHC patient

___ Another Donor

___ A newspaper/magazine add

___ Website

___ At ARHC

Education

___ High School Date of completion ___ / ___ / ___

___ College Date of completion ___ / ___ / ___

Current Major _____

Degree Obtained _____

___ Other

Employment

___ I am currently employed

___ Part-time employee

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Employment (continued)

___ Full-time employee

Occupation _____

___ I work in the home

___ I am unemployed

Marital Status

___ Married

___ Single with one partner

___ Engaged

___ Single and dating

___ Living together

___ Separated or Divorced

Sexual Preference

___ Heterosexual

___ Homosexual

___ Bisexual

Menstrual Cycles

Age when you had your first period? _____

I have a period every _____ days and it lasts for _____ # of days.

___ There are times that I have bleeding between my periods.

___ I have had bleeding after intercourse.

Sexual/Contraceptive History

I have had _____ sexual partners in the past year.

I currently have or have had in the past a sexual partner that has used drugs _____

I currently have or have had in the past a sexual partner that has a sexually transmitted disease _____

I currently have or have had in the past a sexual partner who is/was a homosexual or bisexual _____

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Sexual/Contraceptive History (continued)

For contraceptive use, presently I use:

____ Oral Contraceptives ____ Condom ____ IUD ____ Diaphragm
____ Depo-Provera ____ Norplant (If Norplant, date of last shot ___/___/___)

I have been treated in the past or have been told that I have been exposed to the following:

____ A sexually transmitted disease (Check all that apply)

____ Chlamydia ____ AIDS/HIV ____ Herpes

____ Venereal Warts ____ Syphilis ____ Gonorrhea

____ Endometriosis

____ PID

____ Ovarian Cysts

____ Tuberculosis

____ Abnormal Pap Smear

Pregnancy History

Please list all confirmed pregnancies with outcomes below:

Pregnancy	Did you deliver a baby?	If Yes, Boy or Girl and DOB	Does the child have any medical problems?	If No, Miscarry or Abortion?

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Psychological History

_____ I have been seen or treated by a psychologist.

_____ I have been diagnosed with one of the following currently or in the past:

_____ Depression _____ Obsessive-Compulsive Disorder

_____ Schizophrenia _____ Manic Depressive Disorder

_____ To my knowledge, no one in my family has ever been treated for the above problems.

_____ I have had family members treated with the above disorders

Please explain _____

Family History

Age (or Age at Time of Death)	Cause of Death	Height	Weight	Hair Color	Eye color	Medical Problems
Mother						
Grandfather						
Grandmother						
Father						
Grandfather						
Grandmother						
Brother/Sister						
Brother/Sister						
Brother/Sister						

I AM INTERESTED IN BECOMING AN EGG DONOR BECAUSE:

_____ I think it would be a rewarding experience for me.

_____ I always wanted to help someone with infertility difficulties.

_____ I think the process is exciting.

_____ I need the money.

_____ Other

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I WOULD BE AVAILABLE TO START TREATMENT BEGINNING ___/___/___

Certification

I hereby certify my answers were voluntarily given in this questionnaire. I have answered these questions to the best of my ability. I am not aware of any problems in myself, my family or previous sexual partners that have not been addressed in this questionnaire.

Signature

Date

Director Approval _____

Date _____

Physician Approval _____

Date _____



Advanced Reproductive Health Center, Ltd. Oocyte Donation Program

Oocyte Donor Profile Information for Recipient

Age: _____ Race: _____ #Times Pregnant _____

Ethnic Background (Your family's Country (ies) of origin:

- 1. _____ % *Example 1. Polish 50%*
- 2. _____ % *2. German 25%*
- 3. _____ % *3. Irish 25%*

Religion: _____ Occupation: _____

Education: _____ Eye color: _____

Skin Color: _____ Light _____ Dark _____ Medium Hair color: _____

Height: _____ Ft _____ In Weight: _____ Pounds

Frame: _____ Small _____ Medium _____ Large

Complexion: _____

Hobbies/Sports: _____

Tell something about yourself that you would like the perspective recipient of your eggs to know:

Don't forget to attach a current picture of yourself



**ADVANCED REPRODUCTIVE HEALTH CENTERS, LTD
CHICAGO IVF**

PROSPECTIVE EGG DONOR:

Please return your profile to Cheryl Tropsic at:

**Advanced Reproductive Health Center/Chicago IVF
Attention: Cheryl Tropsic
5225 Old Orchard Road
Suite 10
Skokie, Illinois 60077**

Thank you.

**www.Chicago-IVF.com
1-866-IVF-CHGO**

Our Mission Statement: “...Exceeding patient expectations...”