

COOPER INSTITUTE FOR REPRODUCTIVE HORMONAL DISORDERS **10/07**
DONOR OOCYTE PROGRAM
8001F GREENTREE COMMONS
MARLTON, NJ 08053
856-810-7853

APPLICATION # _____

DONOR APPLICATION FORM

Today's date: _____/_____/_____

NAME: _____ PARTNER NAME: _____
last first mi last first mi

Date of Birth: _____/_____/_____ Age: _____ SS#: _____/_____/_____

ADDRESS: _____

city state zip code

PHONE # _____ - _____ - _____ WORK # _____ - _____ - _____

Partner's SS#: _____/_____/_____ Partner's Date of Birth: _____/_____/_____

Current Ob/Gyn: _____
full name address

Duration of infertility: _____ years Days from beginning of one menstrual period to the next _____ to _____

Paid Donor: _____ Shared Egg Program: _____ Drug Plan: _____

Infertility Type : Tubal factor Endometriosis Malefactor Unexplained Non-Ovulation N/A

(circle)
 Other: _____

Have you ever had a hysterosalpingogram (HSG) performed? yes no If "yes", please give dates and results

Date	Performed by	Results

Have you had previous fertility treatment? yes no Excluding IVF, please list and describe

PREGNANCY DATA

Please list any pregnancies and detailed information below

Date	Outcome	Infertility Treatment (Indicate type)	# of Months Needed to Conceive	Type of Delivery	Sex	With Current Partner?
		Y N			M F	
		Y N			M F	
		Y N			M F	
		Y N			M F	

IVF HISTORY

Indicate the number of previous IVF and/or GIFT/ZIFT cycles: _____ Record detailed information regarding prior cycles

Date	Clinic	Medications	# Eggs	# Fertilized	ICSI?	# Transfer	Pregnancy Outcome

Do you take medications of any kind? Please include any over-the-counter medications taken on a regular basis, vitamins, etc. Include dosage if known.

CHARACTERISTICS

Height: _____ Weight: at 21? _____ Current Weight: _____

Body Frame: Small Medium Large
(circle)

Natural Hair Color: Black Lt Brown Brown Dk Brown Auburn Red Lt Blonde Blonde Dk Blonde
(circle)

Hair (All that Apply) Wavy Straight Curly Thin texture Premature Gray (at what age _____)
(circle)

Eye Color: Blue Gray Green Hazel Brown Black
(circle)

Skin Tone: Fair Light Medium Dark Light Brown Dark Brown Ebony Freckled Rosy
(circle)
Olive Lt Olive Dk Olive Birthmarks

Race: _____ Mother: _____ Father: _____

Ethnicity: _____

Blood Type: A Pos A Neg B Pos B Neg AB Pos AB Neg O Pos O Neg Unsure
(circle)

Right Handed: _____ Left Handed: _____ Ambidextrous: _____

Marital Status: Single Married Separated Divorced Widowed
(circle)

Duration of relationship with current partner: _____

If you or anyone in your family has had any of the following conditions, check yes and describe below:

YES	NO		YES	NO	
___	___	1. Down's Syndrome or Known Chromosomal Disorder	___	___	21. Skin Disease: Eczema/Psoriasis
___	___	2. Mental Retardation	___	___	22. Coffee-colored spots on the Skin
___	___	3. Seizure Disorder	___	___	23. Early Death (less than age 50)
___	___	4. Muscular Dystrophy or Multiple Sclerosis	___	___	24. Cystic Fibrosis
___	___	5. Premature Senility (Before age 50)	___	___	25. Arthritis before age 50
___	___	6. Deafness before age 50	___	___	26. Drug Addiction
___	___	7. Blindness	___	___	27. Hemophilia
___	___	8. Cataracts (before age 40)	___	___	28. Chronic Anemia
___	___	9. Schizophrenia or Manic Depression	___	___	29. Sickle Cell Anemia
___	___	10. Serious Birth Defects	___	___	30. Elevated Cholesterol Levels
___	___	11. Minor Birth Defects	___	___	31. Early Heart Attack or Stroke (before age 50)
___	___	12. Cleft Lip and/or Cleft Palate	___	___	32. Alcoholism
___	___	13. Club Foot	___	___	33. Allergies
___	___	14. Open Spine or Water on the Brain	___	___	34. Asthma
___	___	15. Congenital Heart Defects	___	___	35. Heart Disease
___	___	16. Congenital Hip Problems	___	___	36. High Blood Pressure
___	___	17. Two or More Miscarriages or Stillborns	___	___	37. Cancer: type and location
___	___	18. Diabetes Mellitus	___	___	38. Tay Sachs
___	___	19. Thyroid Disease	___	___	39. Sickle Cell Trait
___	___	20. Polycystic Kidney Disease	___	___	40. Thalassemia
					41. Depression / Mental Health

If you answered YES to any of the above, please answer the following:

Question #	Specific Relation or Family Member	Condition	Age of Onset
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

42. Do you or have you ever used recreational drugs/Alcohol?

(circle)			Yes	No
If YES, specify:	Cigarettes /Cigars	Alcohol	Marijuana	Cocaine
(circle)	Heroin	Crack	Amphetamines	IV Drugs
	LSD			

Indicate frequency: _____

If you or anyone in your family had any of the following conditions, check yes and describe below.

YES	NO		YES	NO	
___	___	43. Liver Disease	___	___	57. Gout
___	___	44. Lung Disease	___	___	58. Cerebral Palsy
___	___	45. Appendicitis	___	___	59. Dwarfism
___	___	46. Crohn's Disease	___	___	60. Migraines
___	___	47. Color Blindness	___	___	61. Wilson's Disease
___	___	48. Huntington's Chorea	___	___	62. Glaucoma
___	___	49. Sarcoidosis	___	___	63. Goiter
___	___	50. Lupus	___	___	64. Leukemia
___	___	51. Tuberculosis	___	___	65. Emphysema
___	___	52. Hepatitis A,B,or C	___	___	66. Dyslexia
___	___	53. Ulcers	___	___	67. Skin Cancer: Melanoma
___	___	54. Colitis	___	___	68. Kidney/Gall Stones
___	___	55. Alzheimer's	___	___	69. Hodgkin's Disease
___	___	56. Osteoporosis	___	___	

If you answered YES to any of the previous, please answer the following:

Question #	Specific Relation or Family Member	Condition	Age of Onset
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you had any surgery(ies):

List any surgery(ies) you have had and dates of surgery

1. _____
2. _____
3. _____

Have you had any hospitalization(s) not mentioned above:

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

(circle)

If yes, explain: _____

Please indicate date of testing and results of the following, also list any treatment

Test	Date Performed	Results (circle one)	Treatments
Rubella Immunity		immune non-immune	Vaccinated?
Chlamydia Culture		positive negative	
Mycoplasma Culture		positive negative	
Pap Smear		normal abnormal	
Mammogram		normal abnormal	

PSYCHO-SOCIAL QUESTIONNAIRE

What do you hope to achieve by volunteering in the egg donor program (e.g., emotionally, financially) _____

What message would you like passed on to the recipient of your eggs/their offspring? _____

YOUR CHILDREN:

Describe the following:

PERSONALITY	ARTISTIC ABILITY	INTELLIGENCE	DISTINGUISHING CHARACTERISTIC(S)
1.			
2.			
3.			
4.			

YOUR CHILDHOOD:

Describe yourself as a child (e.g., personality, health, happiness, etc.)

What was it like growing up in your family?

What religion did you belong to as a child?

What was your earliest memory as a child?

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

WHEN I WAS A CHILD:

My favorite thing to do was: _____

At home I was expected to do: _____

My parents were strict about: _____

My parents taught me to value: _____

What I loved most about my father was: _____

What I loved most about my mother was: _____

My favorite relatives were: _____

I loved to visit: _____

In comparison to others I was: _____

YOUR TEENAGE YEARS:

Describe yourself as a teenager: _____

Describe your achievements: _____

Did you do poorly in anything: _____

Did you have any problems as a teenager (e.g., health, acne, 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: _____

The most important influence on me was: _____

In comparison to others I was: _____

I liked to go: _____

I traveled to: _____

I was talented as: _____

My ambition was to: _____

ADULTHOOD:

RELIGION: How religious are you now? Very Moderately Not at all
(circle)
Are you an: Atheist Agnostic
(circle)

ACTIVITIES: How athletic are you? Very Average Not Athletic
(Circle)
Do you exercise: Regularly Occasionally Not at all
(circle)

What types of exercise or physical activity do you enjoy?

Do you have musical ability? _____

What other skills or talents do you have (e.g., painting, writing, reading, ability at games, crossword puzzles, handicraft, etc.)? Please describe in detail.

Describe any special interests you have (e.g., Girl Scout leader, fund raiser, pet owner, volunteer activities, etc.)

What physical, artistic, intellectual or social abilities do you feel best about?

What have been your achievements as an adult?

Tell us everything you know in detail regarding the egg donation process:

- Self-injections
- Frequent blood testing
- Vaginal ultrasounds
- Early morning availability
- Use of condoms
- Visits to center: 1st visit for screening (may be done on the phone) 8-10 visits not including day of egg retrieval (local donors only)
- Visit for egg-retrieval (if long distance, anticipate 5 or more day stay – shared donors longer to include embryo transfer)
- Committed time frame once in cycle

PLEASE INCLUDE A RECENT PHOTOGRAPH OF YOURSELF. MOST OFTEN, THIS IS FOR PROGRAM USE ONLY. OCCASIONALLY A RECIPIENT WILL REQUEST TO VIEW A PICTURE OF YOU. THIS PHOTO IS ONLY VIEWED IF YOU GIVE PERMISSION.

DO YOU GIVE PERMISSION FOR YOUR PHOTOGRAPH TO BE VIEWED **YES** **NO**
(Circle)

I, _____, have completed the physical profile, genetic/medical history, and psycho-social history forms. I have answered the above questions honestly and to the best of my knowledge and ability. I understand that this information will be used and relied on by the IVF Program and by the Program recipients. I have not knowingly nor intentionally given false or misleading information. I understand that knowingly or intentionally providing false information will not only be a cause for my disqualification as an egg donor, but will also allow the IVF program or a program recipient to bring lawsuit to recover any damages they might incur because of false or misleading information.

DATE: ____/____/____ SIGNATURE: _____