



GEORGIA REPRODUCTIVE SPECIALISTS

Donor Confidential Information

Last Name: _____ First Name: _____ Middle Initial: _____

Donor # : _____ (To be completed by GRS Staff)

D.O.B: ____/____/____ AGE: _____ SSN: _____

Address: _____

Phone Numbers: Daytime:(____) _____ Can we leave a message? _____

Evening:(____) _____ Can we leave a message? _____

Occupation: _____

Height: ____ Weight: ____ Eye Color: ____ Hair Color: ____ Hair Texture: ____

Race: _____ Ethnic Origin: _____

Emergency Contact: _____ Relationship: _____

Phone #: (____) _____

Significant Other (SO) Last Name: _____ SO First Name: _____

SO Middle Initial: ____ SO SSN: _____ SO Birthdate ____/____/____

How did you hear about the egg donation program at GRS? _____

Have you ever participated in an egg donor program in the past? _____

If so, when and with what facility? _____

Tape a recent photograph of yourself here

Physical Characteristics**Donor ID:**

Age: _____ Year of Birth: _____

Height: _____ Weight: _____

Race: _____ Ethnic Origin: _____

Place of Birth: _____ Religion Born Into: _____

If born in a sub-Saharan country, date moved to this country: _____

Please circle appropriate response**BODY TYPE/****BONE STRUCTURE:** Small medium large**HANDS:** Right-handed left-handed ambidextrous**EYES:**

• Color	brown	hazel	green	blue
• Set	narrow	average	wide	
• Size	small	average	large	
• Shape	round	oval	almond	
• Shade	light	medium	dark	

HAIR:

• Natural color	blond	brown	black	red	Other: _____
• Color as a young child	blond	brown	black	red	Other: _____
• Shade	light	medium	dark		
• Type	straight	wavy	curly		
• Fullness	thin	medium	thick		
• Texture	fine	medium	coarse		

NOSE:

• Size	small	medium	large
• Width	narrow	average	wide
• Length	short	average	long
• Nostril flare	small	average	wide

CHEEKBONES:

• Set	low	average	high
• Prominence	slight	medium	strong

MOUTH:

• Size	small	average	large
• Lips	thin	average	full

Physical Characteristics (cont'd.)

Donor ID: _____

CHIN:

- **Shape** square oval round
- **Prominence** slight average strong
- **Cleft** none slight medium strong

SKIN:

- **Tone** light med-light medium med-dark dark
- **Tan ability** none slight medium easy
- **Condition** oily medium dry combination
- **Acne** none slight medium severe

At what age: _____

OTHER FACIAL FEATURES:

- **Moles** none one several numerous
- **Freckles** none several moderate numerous
- **Dimples** none slight medium deep

EYESIGHT:

- **Vision** normal far-sighted near-sighted
- **Glasses** none single bifocal trifocal
- **Astigmatism** yes no

Age diagnosed: _____

DENTAL:

- **Device** none braces retainer other: _____
- **Reason** cosmetic accident disease other: _____

Age during use _____ to _____ years of age

OTHER:

List: _____

Reason/cause _____

Describe your family by the following physical characteristics:

	Eye Color	Hair Color	Complexion	Height	Body Type/Wt.
Father					
Mother					
Brother					
Sister					
PGF					
PGM					

Physical Characteristics (cont'd.)

Donor ID: _____

MGF					
MGM					

Personal Characteristics

LEVEL OF EDUCATION:

Completed high school: (Y / N) High School GPA: _____

_____ Currently in college, pursuing a degree in: _____ GPA: _____

_____ Completed college, degree in: _____ GPA: _____

_____ Currently pursuing an advanced degree in: _____

_____ Completed an advanced degree in: _____

LANGUAGES:

Speak: _____

Read: _____

Write: _____

ATHLETIC ACTIVITY (circle appropriate choice): athletic active average inactive

What physical activities do you engage in? _____

Have you excelled in any physical activities? _____

MANUAL DEXTERITY: dexterous average clumsy

What manual skills do you have? _____

TEMPERAMENT / PERSONALITY:

How would you describe yourself? Please include a description of your personality and temperament:

Personal Characteristics (cont'd.)

Donor ID: _____

MUSICAL ABILITY: musical average tone deaf

Voice: soprano alto tenor baritone bass

Instrument: _____ _____ years experience

Other: _____ _____ years experience

Reproductive History

Age at first period _____

Are your cycles regular? _____

Interval between periods? (How many days are there from the start of one period to the start of the next period?)

PREGNANCY HISTORY

Year	Outcome	Any Complications?

Did your mother take DES while she was pregnant with you? _____

Have you ever been diagnosed with infertility? _____ Explain: _____

Medical History

Donor ID:

Allergies (food, pollen, bee stings, medications, etc.) _____

Describe childhood allergies you have outgrown: _____

Medical Characteristics (cont'd.)

Do you have any medical illnesses (asthma, diabetes, seizure disorders, etc.?) _____

Do you have abnormal hair growth that requires regular removal? _____

What are your bleeding tendencies: Do you have frequent nosebleeds, bleeding gums when you brush your teeth, and/or menstrual periods with blood clots? _____

List the drugs (prescription and non-prescription) that you take regularly: _____

Any other medicines taken in the last 5 years: _____

Do you smoke cigarettes? _____ How much? _____

What types of alcoholic beverages do you drink? _____

How many alcoholic drinks do you consume per day? _____ Week? _____ Month? _____

Have you ever used any kind of mind-altering drugs such as marijuana, LSD, heroin, cocaine or meth? If yes, please give details and last date used: _____

Have you ever used neuroleptic agents (tranquilizers, valium, thorazine, etc.) or anti-depressants? If yes, give details date last used: _____

Medical Characteristics (cont'd.)

Donor ID: _____

Have you been incarcerated for 72 consecutive hours or longer within the past year? _____

Have you ever used an injected drug or had a sexual partner who did? _____

Have you engaged in prostitution at any time since 1977? _____

Have you been involved sexually with anyone during the past 12 months who has engaged in prostitution at any time after 1977? _____

Have you been sexually involved with an HIV-positive person within the last 5 years? _____

Have you been sexually active during the past 6 months? _____

Are you currently sexually active? _____

Are you in a monogamous relationship? _____ If no, then the number of partners you have been sexually active with over the past six months: _____

Have you or a partner of yours ever had a sexually transmitted disease (gonorrhea, syphilis, hepatitis, Chlamydia, herpes, condyloma or trichomoniasis)? _____

Describe your diagnosis, year and treatment: _____

Have you had multiple sexual partners (more than 10)? _____

Have you acquired a tattoo or other non-sterile skin piercing procedure within the last 12 months? _____

Have you ever been refused as a blood donor? _____ Why? _____

Have you received blood transfusion within the last 12 months? _____

Have you ever received factor VIII or factor IX concentrates (blood transfusion) that were not heat treated or otherwise vial inactivated? _____ Within the past year? _____

Have you been exposed to radiation or toxic chemicals in your work or personal life? _____

Have you received a bite from an animal suspect for rabies within the last six months? _____

Have you ever had surgery? _____ If so, describe: _____

Medical Characteristics (cont'd.)

Donor ID: _____

(cont'd surgery) _____

Have you been told of any gynecological problems (endometriosis, fibroids, ovarian cysts, abnormal Pap smears, etc.)? _____

Have you ever received treatment by pituitary-derived human growth hormone? _____

Family Health History

	Age, if alive	Age at death	Medical problems or cause of death
Mother			
Father			
Brother 1			
Brother 2			
Brother 3			
Sister 1			
Sister 2			
Sister 3			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Child 1			
Child 2			
Child 3			

Please read the following list of medical problems carefully and indicate which ones you or one of your relatives have had. Please consider each condition carefully for each family member:

Medical Problem	Yourself	Mother	Father	Siblings	Grandparents	Other family	Describe
HEART							
A. Stroke							
B. Heart Attack							
C. Heart Disease							
1. From birth							
2. Other							
D. Hardening of arteries							
E. High blood pressure							
BLOOD							
A. Anemia							
B. Sickle-cell anemia							
C. Hemophilia or other bleeding problems							
D. Leukemia							
E. Immune deficiency							
F. Other blood disorder							
RESPIRATORY (lungs)							
A. Hay fever							
B. Asthma							
C. Emphysema							
D. Tuberculosis							
E. Lung cancer							
F. Pneumonia							

Medical Problem	Yourself	Mother	Father	Siblings	Grandparents	Other family	Describe
G. Other lung disease							
GASTRO-INTESTINAL							
A. Ulcer of stomach or duodenum							
B. Gall stones							
C. Hepatitis A (infectious)							
D. Hepatitis B (serum)							
E. Other liver disease							
F. Colon cancer							
G. Ulcerative colitis							
H. Crohn's disease							
I. Cystic fibrosis							
J. Intestinal cancer							
K. Any other cancer/problem of digestive system							
METABOLIC/ENDORCRINE							
A. Diabetes mellitus							
B. Hypoglycemia							
C. Thyroid cancer							
D. Thyroid disease							
E. Goiter							
F. Adrenal dysfunction or disorder							
G. Hyperactivity							
A. Kidney disease							
B. Other disease of urinary tract (urethra, bladder, ureter)							

Medical Problem	Yourself	Mother	Father	Siblings	Grandparents	Other family	Describe
C. Rectal disorder							
GENITAL/REPROCUCTIVE							
A. Undescended testicle							
B. Hypospodiasis							
C. Prostate cancer							
D. Uterine fibroids							
E. Ovarian cysts							
F. Cancer of cervix, ovaries or uterus							
NEUROLOGICAL							
A. Migraines							
B. Mental retardation							
C. Senility before age 50							
D. Multiple sclerosis							
E. Cerebral palsy							
F. Epilepsy							
G. Hydrocephalus							
H. Disorder of the spinal cord							
I. Huntington's chorea							
J. Gaucher's disease							
K. Wilson's disease							
L. Creutzfeldt-Jacob disease							
M. Alzheimer's disease							
N. Other diseases of the nervous system							

Medical Problem	Yourself	Mother	Father	Siblings	Grandparents	Other family	Describe
MENTAL HEALTH							
A. Schizophrenia							
B. Manic depressive							
C. Other mental health disorders requiring hospitalization							
MUSCULAR/BONES/JOINTS							
A. Muscular dystrophy							
B. Other chronic muscle disease							
C. Lupus							
D. Deformity of the spine							
E. Osteoporosis							
F. Dwarfism							
G. Hereditary low back disease							
H. Arthritis							
I. Gout							
SIGHT/SOUND/SMELL							
A. Deafness before age 60							
B. Deformity of the ear							
C. Cataracts before age 50							
D. Blindness							
E. Color blindness							
F. Glaucoma							
G. Deviated septum							
H. Any other sight/sound/smell disorder							

Medical Problem	Yourself	Mother	Father	Siblings	Grandparents	Other family	Describe
SKIN							
A. Acne							
B. Eczema							
C. Skin cancer							
D. Pigmentation disorders							
E. Other disorders of the skin							
OTHER							
A. Alcoholism							
B. Drug abuse, misuse or addiction							
C. Breast cancer							
D. Any other cancer not mentioned above							
E. Any other condition not mentioned above							

Has any member of your family, including yourself, had a problem or defect at birth of any of the following body systems? (Circle one)

1. Bones, muscles, joints, limbs No / Yes
2. Gastrointestinal system No / Yes
3. Nervous system, brain, spinal cord No / Yes
4. Blood circulation No / Yes
5. Respiratory system No / Yes
6. Organ (heart, lung, kidney, etc.) No / Yes
7. Genital/urinary No / Yes
8. Metabolic (hormones, enzymes, etc.) No / Yes

Family History (cont'd.)

Donor ID: _____

If you answered yes to any of the above questions please list below the specific defect in each case.

Birth Defect	Who	When did this happen?	Relevant Circumstances

Do you have any brothers or sisters who died in infancy or childhood? _____

If "yes", what was the cause? _____

Are there any known genetic diseases or conditions that run in your family? _____

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 _____

Please explain: _____

For Office Use Only

Code # _____ Signature _____