DIAMOND INSTITUTE FOR INFERTILITY
89 MILLBURN AVENUE
MILLBURN, NEW JERSEY 07041
EGG DONATION PROGRAM

FEMALE DONOR HISTORY

I. IDENTIFYING INFORMATION

Date_____

Name_____ City_____

Address_____State_____ Zip_____

Telephone Number - Day: ( )_____ Evening: ( ) _____

Date of Birth_____ Social Security Number _____

Insurance Company_____ Insurance I.D. #_____

Nature of present employment (title, brief description) _____

_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Cohabitating

GENETIC TRAITS – PLEASE CIRCLE ONE

RACE:	CAUCASIAN	ASIAN	BLACK	ORIENTAL	HISPANIC
	OTHER (PLEASE INDICATE) _____				
ETHNIC ORIGIN:	MOTHER_____ FATHER _____				
RELIGION:	_____				
SKIN TONE:	FAIR	MEDIUM	DARK		
HAIR COLOR:	BLACK	BROWN	RED	BLONDE	
HAIR TEXTURE:	STRAIGHT	CURLY	WAVY		
EYE COLOR:	BROWN	GREEN	BLUE	HAZEL	
HEIGHT:	_____				
WEIGHT:	_____				
BLOOD TYPE:	A	B	AB	O	
RH FACTOR:	POSITIVE	NEGATIVE			
PREDOMINANTLY:	☐ RIGHT HANDED	☐ LEFT HANDED	☐ AMBIDEXTROUS		
FRAME SIZE:	SMALL	MEDIUM	LARGE		
EDUCATION:	NO. OF YEARS COMPLETED_____				

Write a brief description of your personality and please include your interests and hobbies: _____

_____

_____

_____

FAMILY CHARACTERISTICS

RELATION	EYE COLOR	HAIR COLOR	COMPLEXION	HEIGHT	WEIGHT
Mother:	_____	_____	_____	_____	_____
Father:	_____	_____	_____	_____	_____
Siblings (Same Parents)					
Brother/Sister	_____	_____	_____	_____	_____
Brother/Sister	_____	_____	_____	_____	_____

II. MEDICAL HISTORY

YES NO

Have you ever had pelvic surgery? ☐ ☐

If yes, specify date and type: _____

Do you have or have you ever had (check all that apply):

☐ Anemia
☐ Appendicitis
☐ Breast Milky Discharge
☐ Chlamydia
☐ Chronic Headaches
☐ Endometriosis
☐ Gonorrhea
☐ Herpes
☐ Hirsutism (Excess Hair Growth)
☐ Kidney Infection
☐ Ovarian Cysts
☐ Pelvic Infection
☐ Rheumatic Fever
☐ Syphilis
☐ Tuberculosis
☐ Back Problems (Surgery)
☐ Vaginitis (Trichomoniasis, yeast)
# of episodes_____
☐ Hospitalizations (Explain)_____
_____
_____
☐ Surgeries (Explain)_____
☐ Have you ever been injured in an accident (if yes, explain)_____
_____
☐ Venereal Warts
☐ Visual Disturbances
☐ Eyeglasses/Lenses from Age ____
☐ Any Allergies: List:_____
_____
_____

YES NO

Have you ever received X-Rays to the pelvic area for therapy or diagnosis? ☐ ☐

If yes, specify _____

Within the last year, have you taken any prescription medication? (Including Birth Control Pills) ☐ ☐

If yes, list all prescriptions and problems for which you were taking them: _____

_____

Are you taking any over-the-counter medications on a regular basis? ☐ ☐

If yes, list all medications and diagnoses: _____

_____

_____

Do you use or have you ever used (check all that apply):

☐ Alcohol - How many glasses per week do you usually drink? Wine____ Beer____ Cocktails____

☐ Cigarettes - Number of packs per day_____

☐ Illicit or Recreational Drugs (Marijuana, Cocaine, Barbiturates, Narcotics, Heroin, Methadone, Hallucinogens, Tranquilizers, Anti-Depressants) _____

III. MENSTRUAL AND PREGNANCY HISTORY

Age at first period?_____ When was our last period? _____

Are your periods regular? ☐ ☐

If yes, what is the usual number of days between periods? _____

If no, how many times per year do you menstruate? _____

What is the usual duration of your period? _____

Do you bleed or spot between periods? ☐ ☐

How many pregnancies (including abortions) have you had? _____

	When? (Year)	End in Abortion?	End in Miscarriage?	Ectopic Pregnancy?	Infertility Therapy Required to Conceive?	How Long to Conceive?	Baby Born Alive	Is Current Partner the Father?
1st Pregnancy								
2nd Pregnancy								
3rd Pregnancy								
4th Pregnancy								
5th Pregnancy								

YES NO

Were there any complications during or after your pregnancies or abortions? ..... ☐ ☐

If yes, explain _____

IV. CONTRACEPTIVE/SEXUAL HISTORY

What form of contraception do you use now or have you used in the past? Check all that apply:

☐ Pills Name:_____ ☐ IUD Name_____ ☐ Diaphragm ☐ Withdrawal ☐ Foams/Jellies

☐ Condom ☐ Rhythm ☐ Tubal Ligation ☐ None ☐ Other: _____

How many sexual partners have you had in the past year? _____

Current form of contraceptive _____

Have you or any of your sexual partners ever had:

			MYSELF/PARTNER	WHEN & WERE YOU TREATED
SYPHILIS	☐ YES	☐ NO	_____	_____
GONORRHEA	☐ YES	☐ NO	_____	_____
CHLAMYDIA	☐ YES	☐ NO	_____	_____
VENEREAL WARTS	☐ YES	☐ NO	_____	_____
HERPES	☐ YES	☐ NO	_____	_____
OTHER SEXUALLY TRANSMITTED DISEASES	☐ YES	☐ NO	_____	_____
BLOOD TRANSFUSIONS	☐ YES	☐ NO	_____	_____
HEPATITIS	☐ YES	☐ NO	_____	_____
AIDS/HIV POSITIVE	☐ YES	☐ NO	_____	_____

V. FERTILITY HISTORY

YES NO

Is there a family history of infertility? ..... ☐ ☐

If yes, who (List all members and relationship to you): _____

_____

Is there a history of hormonal disorders in your family? ..... ☐ ☐

If yes, who and what type: _____

_____

Have you been treated for infertility before? ..... ☐ ☐

If yes, who was your physician? _____

	YES	NO
What cause of infertility was diagnosed? _____		
Have you ever taken any drugs for infertility?	☐	☐
If yes, list _____		
Have you ever donated eggs before?	☐	☐
If yes, when and where? _____		
How many times? _____		
Was it as a known donor? _____		
Anonymous donor? _____		
Have you ever had surgery for tubal reversal?	☐	☐
If yes, specific dates: _____		
Have you ever had surgery for lysis of adhesions?	☐	☐
Have you ever had cervical conization or cautery?	☐	☐
Have you ever had any other surgery (D&C, ovarian, appendectomy, thyroid)?	☐	☐
If yes, please specify: _____		
Have you ever undergone artificial insemination or in-vitro fertilization?	☐	☐
If yes, using partner or donor sperm? _____		

_____

Why do you want to be an Egg Donor? _____

_____

_____

_____

_____

_____

_____

If we could pass on a message to the recipient, what would it be? _____

_____

_____

_____

_____

_____

_____

I, the undersigned, acknowledge that the following answers were accurate and truthful to the best of my knowledge and including all relevant information.

Signed _____ Date _____

Please enclose a photograph along with this questionnaire.

All information is kept strictly confidential.