Please answer the following questions about your educational, reproductive, and medical history. If it is determined that you qualify as a potential donor based on the information, you will be asked to complete additional forms that will give more details about physical and personal characteristics, family health history and personal medical history.

Education:

Did you complete grade school? ☐ YES ☐ NO High school? ☐ YES ☐ NO

Are you currently in college? ☐ YES ☐ NO Have you completed college? ☐ YES ☐ NO

Reproductive History:

Age of first period: ☐ Are your cycles regular? ☐ YES ☐ NO

Intervals between periods: ☐

Pregnancy History (please list all details):

Have you used anything for contraception either currently or in the past? (birth control pills, IUD, Depo-Provera, etc) ☐ YES ☐ NO

If yes, when and what methods were used?

Did your mother take DES while she was pregnant with you? ☐ YES ☐ NO

Have you ever been diagnosed with infertility? ☐ YES ☐ NO
If yes, please explain:

www.kyfertility.com
T: 859-277-5736
F:859-276-2236

Lexington Fertility Center

CONFIDENTIAL DONOR INFORMATION

Name:

DOB: Age: SSN:

Address:

Phone Number (home/cell): Can we leave a message? ☐ YES ☐ NO

Emergency Contact: Relationship:

Phone Number:

Occupation:

Height: Weight: Eye Color: Hair Color:

Religious Preference: Ethnic Origin:

How did you hear about the egg donation program?

Have you participated in an egg donor program in the past? ☐ YES ☐ NO

If yes, when and which facility?

Do you currently have health insurance coverage? ☐ YES ☐ NO

If yes, through

Medical History:

Allergies (food, pollen, bee stings, medications, etc):

Do you have any medical illnesses (asthma, diabetes, seizure disorders, migraines, hypertension, hypercholesterolemia, herpes, gonorrhea, *Chlamydia*, hepatitis, syphilis, condyloma, trichomoniasis, etc)?

☐ YES ☐ NO Other:

List the drugs, prescriptions and over-the-counter, you take regularly:

Any other medications taken in the last 5 years:

Medical History continued:

Do you smoke cigarettes? ☐ YES ☐ NO If yes, packs per day:

Is there any history of medical problems in your family? ☐ YES ☐ NO

If so, please describe:

Does your schedule allow you to have frequent doctor appointments between 8:00 am and 10:30 am?
☐ YE ☐ NO

Do you have a fear of getting your blood drawn or having injections? ☐ YES ☐ NO

Have you ever used any kind of mind-altering drugs such as marijuana, LSD, heroin or cocain?
☐ YES ☐ NO

If yes, please give details and last date used:

Have you ever used neuroleptic agents (tranquilizers, valium, thorazine, etc) or antidepressants?
☐ YES ☐ NO

If yes, please give details and last date used:

Medical History continued:

Have you been incarcerated for 72 consecutive hours or longer within the past year? ☐ YES ☐ N

Have you ever used an injected drug or had a sexual partner who did so? ☐ YES ☐ NO

Have you engaged in prostitution at any time since 1977? ☐ YE ☐ NO

Have you been sexually involved with an HIV-infected person in the past 5 years? ☐ YES ☐ NO

Have you been sexually active during the past 6 months? ☐ YES ☐ NO

Are you in a monogamous relationship? ☐ YES ☐ NO

What is your sexual orientation?

Have you ever had a sexual partner who was gay or bisexual? ☐ YES ☐ NO

Have you acquired a tattoo or non-sterile piercing within the past 12 months? ☐ YES ☐ NO

Have you ever been refused as a blood donor? ☐ YES ☐ NO

If yes, why?