

# Southeastern Fertility Center

## Infertility ■ Reproductive Endocrinology

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Welcome to Southeastern Fertility Center,

We appreciate your interest in our Donor program. We are a regional fertility center located in Mount Pleasant, South Carolina and we treat various forms of infertility.

We started our in-vitro fertilization (IVF) program in 1984 and the first pregnancy achieved in South Carolina was reported that year. Donor eggs offer the possibility of childbearing to women whose ovaries are absent or who have ovarian failure and do not produce eggs that can be fertilized. By using IVF techniques, eggs are retrieved from a donor and fertilized by the sperm of the recipient's partner. Two to three embryos are placed into the recipient's uterus, any remaining embryos are frozen for that recipient's future use.

All egg donors must meet the following requirements before participating in our program:

- ▶ Age 20 to 31 years.
- ▶ Non-Smoker.
- ▶ Be in good health and physically fit.
- ▶ Have one menstrual cycle without birth control.
- ▶ Obtain previous medical records for SEFC chart.

The actual cycle for undergoing egg donation will require a commitment of approximately six (6) weeks (although you will be seen in our office only a few times during this period); we offer flexible times for monitoring to accommodate most schedules (monitoring appointments usually require 20 to 30 minutes). One week before retrieval you will need to be monitored daily. **YOUR ABSOLUTE COMMITMENT IS VERY IMPORTANT TO THE PROGRAM.**

The retrieval procedure takes approximately one hour and after the procedure you should plan to rest at home for the afternoon. This is the only time that you would not be able to work or participate in your normal activities.

In addition to the tremendous gratification in assisting a couple to reach their dream of parenthood, you will be compensated, \$3,500.00, for your participation.

Please fill out the enclosed questionnaire and return it as soon as possible **WITH A CURRENT PHOTOGRAPH** (the photograph is for our office use **only**). After reviewing your information, we will contact you to come in and meet with us.

Thank you for your interest in our program. We look forward to meeting you soon.



Cari Maness, RN  
SEFC Donor Program Coordinator

**EGG DONOR QUESTIONNAIRE**

Profile: \_\_\_\_\_

Name: (First/MI/Last)		
Street Address:		
City:	State:	Zip:
Home Phone:	May we leave messages at this number? Y / N	
Cell Phone:	Work Phone:	
Email:		
Date of Birth: (mm/dd/yy)	Age:	SSN:
Have you ever donated for another program? Y / N      If so, where?		
Do you have your own transportation <input type="checkbox"/> YES <input type="checkbox"/> NO		Race:
How or where did you hear about our Program? (Check all that apply)		
<input type="checkbox"/> Previous Donor <input type="checkbox"/> Friend <input type="checkbox"/> Word of Mouth <input type="checkbox"/> Internet Search Engine <input type="checkbox"/> City Paper <input type="checkbox"/> Free Times <input type="checkbox"/> Ladies Room <input type="checkbox"/> Facebook <input type="checkbox"/> SEFC Website <input type="checkbox"/> Flyer <input type="checkbox"/> Print Ad <input type="checkbox"/> Other: _____		
In case of Emergency Contact: _____		
Name	Telephone Number	Relationship



**PLEASE ATTACH A CURRENT,  
COLOR PHOTO OF YOURSELF HERE**



**FOR OFFICE USE ONLY**

DATE: _____	DAY 3 LABS	RECOMMENDATION
Ovarian Volume	E2 _____	<input type="checkbox"/> SINGLE <input type="checkbox"/> SPLIT
RT _____ Follicle # _____	LH _____	
LT _____ Follicle # _____	FSH _____	STIMULATION
Genetics _____ Psychological _____		<input type="checkbox"/> GP _____ <input type="checkbox"/> Meld <input type="checkbox"/> LL

PERSONAL INFORMATION	
Marital Status:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated
Religion:	<input type="checkbox"/> Protestant <input type="checkbox"/> Catholic <input type="checkbox"/> Jewish <input type="checkbox"/> Baptist <input type="checkbox"/> Episcopal <input type="checkbox"/> Methodist <input type="checkbox"/> Other _____
Nationality (ie. German, Italian, etc. NOT American or Caucasian)	
Mother:	_____
Father:	_____
Current Occupation:	

Educational Background (Check the highest level achieved)	
High School	<input type="checkbox"/> Technical <input type="checkbox"/> Some College: 1 / 2 / 3 years <input type="checkbox"/> University
Associate's Degree:	_____
Bachelor's Degree:	_____
Post-Graduate Degree:	_____
SAT Score:	_____
ACT Score:	_____
Post Graduate Score:	_____
If currently a student, Major is: _____	
Highest Level of Education Achieved for Family Members (Check all that apply)	
Mother:	<input type="checkbox"/> HS Diploma <input type="checkbox"/> Associates Degree <input type="checkbox"/> Bachelors Degree <input type="checkbox"/> Post Graduate Degree <input type="checkbox"/> Doctorate
Father:	<input type="checkbox"/> HS Diploma <input type="checkbox"/> Associates Degree <input type="checkbox"/> Bachelors Degree <input type="checkbox"/> Post Graduate Degree <input type="checkbox"/> Doctorate
Brothers:	<input type="checkbox"/> HS Diploma <input type="checkbox"/> Associates Degree <input type="checkbox"/> Bachelors Degree <input type="checkbox"/> Post Graduate Degree <input type="checkbox"/> Doctorate
Sisters:	<input type="checkbox"/> HS Diploma <input type="checkbox"/> Associates Degree <input type="checkbox"/> Bachelors Degree <input type="checkbox"/> Post Graduate Degree <input type="checkbox"/> Doctorate

PHYSICAL PROFILE	
Are you adopted? Y / N	Is either of your parents adopted? Mother / Father / Neither
Hair color:	<input type="checkbox"/> Black <input type="checkbox"/> Dark Brown <input type="checkbox"/> Brown <input type="checkbox"/> Light Brown <input type="checkbox"/> Blonde <input type="checkbox"/> Auburn <input type="checkbox"/> Red
Hair Texture (circle all that apply):	<input type="checkbox"/> Straight <input type="checkbox"/> Wavy <input type="checkbox"/> Curly <input type="checkbox"/> Kinky <input type="checkbox"/> Thin <input type="checkbox"/> Thick <input type="checkbox"/> Average
Eye Color:	<input type="checkbox"/> Blue <input type="checkbox"/> Brown <input type="checkbox"/> Hazel <input type="checkbox"/> Green <input type="checkbox"/> Blue/Green <input type="checkbox"/> Blue/Grey <input type="checkbox"/> Black
Height: _____	Weight: _____
Blood Type (if known): _____	
Skin Color:	<input type="checkbox"/> Fair <input type="checkbox"/> Medium <input type="checkbox"/> Olive <input type="checkbox"/> Ebony <input type="checkbox"/> Light Brown <input type="checkbox"/> Dark Brown <input type="checkbox"/> Rosy <input type="checkbox"/> Freckled
Bone Size:	<input type="checkbox"/> Small <input type="checkbox"/> Small-Medium <input type="checkbox"/> Medium <input type="checkbox"/> Medium-Large <input type="checkbox"/> Large

Do you have any ongoing medical problems?       YES       NO  
 If yes, explain: \_\_\_\_\_

Do you take any medications routinely?       YES       NO  
 If yes, which medications: \_\_\_\_\_

Profile # \_\_\_\_\_

DOB \_\_\_\_\_

GENERAL HEALTH AND MEDICAL HISTORY

Allergies:  Medications  Food  Environmental  Other: \_\_\_\_\_

If yes, please specify: \_\_\_\_\_

Vision:  N/A  Nearsighted  Farsighted  Other \_\_\_\_\_

Do you wear glasses or contact lenses? YES / No

Have you ever had corrective eye surgery? YES / No

Hearing:  Poor  Fair  Good  Excellent

What is the condition of your teeth? (Please circle one)

Poor Fair Good Excellent

If fair or poor, please explain: \_\_\_\_\_

Have you ever worn braces?  YES  NO

Have you EVER smoked?  YES  NO Tobacco Usage:  YES  NO

If yes, how much?  >2-4/week  1 pack/week  1 pack/day  <1 pack/day

I have been a smoker for \_\_\_\_\_ years.

What is your usual weight in lbs.? \_\_\_\_\_ lbs.

Have you had any recent weight loss or gain? YES / NO

If yes, explain \_\_\_\_\_

Your diet is: \_\_\_\_\_ Vegetarian \_\_\_\_\_ Non-Vegetarian

How much exercise do you get?  None  Occasional  Regular  Athlete

Caffeine Usage: What is your daily caffeine consumption?

Coffee, how much \_\_\_\_\_  Soft Drinks, how much \_\_\_\_\_

Alcohol Consumption: (please circle one)

None Occasional Regular Excessive 1-2/week 1-2/day Other \_\_\_\_\_

Are you:  LEFT HANDED  RIGHT HANDED

Have you ever been turned down for blood donation?  YES  NO

If so, why? \_\_\_\_\_

\_\_\_\_\_

Profile # \_\_\_\_\_

DOB \_\_\_\_\_

**MEDICAL HISTORY**

Have you had any serious illness or surgical procedures in the past? YES / NO

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Have you had any operations? YES / NO

If yes, please complete:	YEAR	TYPE OF OPERATION
	_____	_____
	_____	_____
	_____	_____

Have you had any hospitalizations other than for surgery? YES / NO

If yes, please complete:	YEAR	TYPE OF HOSPITALIZATION
	_____	_____
	_____	_____
	_____	_____

Have you ever had any broken bones? YES / NO

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Have you ever had any serious illness? YES / NO

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Please indicate with a check if you have had any of the following:

- |                                            |                                        |                                        |                                         |
|--------------------------------------------|----------------------------------------|----------------------------------------|-----------------------------------------|
| <input type="checkbox"/> GONORRHEA         | <input type="checkbox"/> SYPHILIS      | <input type="checkbox"/> HERPES        | <input type="checkbox"/> HEPATITIS      |
| <input type="checkbox"/> BLOOD TRANSFUSION | <input type="checkbox"/> LIVER DISEASE | <input type="checkbox"/> RENAL DISEASE | <input type="checkbox"/> KIDNEY DISEASE |

List all drugs you've taken in the past 12 months (prescription, non-prescription, herbal, and sports supplements)

MEDICATION	HOW OFTEN	REASON
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all current medications (include vitamins, aspirin, antacids, laxatives, herbal supplements and sports supplements)

MEDICATION	HOW OFTEN	REASON
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Profile # \_\_\_\_\_

DOB \_\_\_\_\_

Have you ever taken anti-malarial drugs or had malaria? YES / NO  
If yes, please explain: \_\_\_\_\_

Have you had any major radiation exposure or X-Ray exposure? YES / NO  
If yes, please explain: \_\_\_\_\_

Have you ever had or been treated for syphilis? YES / NO  
If yes, when: \_\_\_\_\_ How many times: \_\_\_\_\_ When was the last time: \_\_\_\_\_

Have you ever had or been treated for gonorrhea? YES / NO  
If yes, when: \_\_\_\_\_ How many times: \_\_\_\_\_ When was the last time: \_\_\_\_\_

Have you ever been tested for HIV (AIDS)? YES / NO  
If yes, when: \_\_\_\_\_ How many times: \_\_\_\_\_ When was the last time: \_\_\_\_\_

Have you or any of your sexual partners ever had:

NSU (Non Specific Urethritis) Myself: YES NO If yes, when: \_\_\_\_\_  
Partner: YES NO If yes, when: \_\_\_\_\_

Chlamydia Myself: YES NO If yes, when: \_\_\_\_\_  
Partner: YES NO If yes, when: \_\_\_\_\_

Venereal Warts Myself: YES NO If yes, when: \_\_\_\_\_  
Partner: YES NO If yes, when: \_\_\_\_\_

Herpes Myself: YES NO If yes, when: \_\_\_\_\_  
Partner: YES NO If yes, when: \_\_\_\_\_

Other Sexually Transmissible Disease \_\_\_\_\_  
Myself: YES NO If yes, when: \_\_\_\_\_  
Partner: YES NO If yes, when: \_\_\_\_\_

Did you travel outside the United States (except Canada) in the past three years? YES / NO  
If yes, when and where? \_\_\_\_\_

Have you ever used or do you currently use any of the following drugs?

Marijuana	YES	NO	If yes, Frequency/Year(s)_____	How Used_____
Cocaine	YES	NO	If yes, Frequency/Year(s)_____	How Used_____
Barbiturates	YES	NO	If yes, Frequency/Year(s)_____	How Used_____
Narcotics/Opiates	YES	NO	If yes, Frequency/Year(s)_____	How Used_____
Amphetamines	YES	NO	If yes, Frequency/Year(s)_____	How Used_____
Hallucinogens	YES	NO	If yes, Frequency/Year(s)_____	How Used_____
Tranquilizers	YES	NO	If yes, Frequency/Year(s)_____	How Used_____
PCP	YES	NO	If yes, Frequency/Year(s)_____	How Used_____
Inhalants	YES	NO	If yes, Frequency/Year(s)_____	How Used_____
Steroids	YES	NO	If yes, Frequency/Year(s)_____	How Used_____

In the past six months, were you exposed to any EXCESSIVE amounts of the following in your living environment or while involved in hobbies? If yes to any of these, give dates and how often you have been exposed. Please consider carefully.

EXPOSED TO	YES / NO		WHEN	HOW OFTEN
Toxic/Chemicals or Substances	YES	NO		
Sprays	YES	NO		
Fumes/Exhaust	YES	NO		
Radiation	YES	NO		
Flea powder/sprays	YES	NO		
Lead/Lead products	YES	NO		
Asbestos/Asbestos products	YES	NO		
Cleaning solutions/solvents	YES	NO		

DONOR GENETIC HISTORY
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Do you have any brothers or sisters who died in infancy or childhood? YES / NO

If yes, what was the cause? \_\_\_\_\_

Are there any known genetic diseases or conditions that run in your family? YES / NO

If yes, what are they? \_\_\_\_\_

Family Fertility History: Please list below any family members who experienced miscarriages:

Family Member (Sister, Aunt, Grandmother, etc.)	Paternal or Maternal	Age	Number of Miscarriages
1.			
2.			
3.			
4.			

Were you born with any birth defects (heart defect, cleft lip or palate, club feet, other)? Y / N

If yes, explain: \_\_\_\_\_

Are there any birth defects that run in your family? Y / N

If yes, explain: \_\_\_\_\_

Are you of Jewish ancestry? YES NO UNKNOWN

If yes, please check: \_\_\_\_\_ Ashkenazi \_\_\_\_\_ Sephardic \_\_\_\_\_ Other

Have you been tested as a carrier for any of the following diseases?

Tay Sachs YES NO

Gaucher YES NO

Canavan YES NO

If yes, what were results? (carrier, not carrier, unknown) \_\_\_\_\_

Are you African ancestry? YES NO UNKNOWN

If yes, have you been tested as a carrier for sickle cell disease? \_\_\_\_\_

If yes, what were results? (carrier, not carrier, unknown) \_\_\_\_\_

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Are you of Mediterranean, Chinese or Southeast Asian Ancestry?      YES                  NO                  UNKNOWN

If yes, have you been tested as a carrier of Thalassemia? \_\_\_\_\_

If yes, what were results? (carrier, not carrier, unknown) \_\_\_\_\_

Were you vaccinated for any reason in the past 12 months?                                  YES      /      NO

If yes, why, when and what for what? \_\_\_\_\_

Were you exposed to known or suspected HIV, Hepatitis B or Hepatitis C infected blood through percutaneous inoculation or through contact with an open wound, non-intact skin or mucous membrane in the preceding 12 months?    YES    /    NO

If yes, please explain: \_\_\_\_\_

	YES	NO
Do you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever seen a counselor?	<input type="checkbox"/>	<input type="checkbox"/>	Dates: _____
			If yes, explain: _____
			_____
			_____

Were you born with any birth defects?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, explain: _____
			_____
			_____

Have you ever used other recreational drugs?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, what, when and how long: _____
			_____
			_____
			_____

## DONOR FERTILITY/SOCIAL HISTORY

Age at onset of menses \_\_\_\_\_

# of days from beginning of one cycle to the next **NATURALLY**: \_\_\_\_\_ Average: \_\_\_\_\_ Range (days): \_\_\_\_\_

# of days from beginning of one cycle to the next if on Birth Control Pills: \_\_\_\_\_

Number of current sexual partners: \_\_\_\_\_

Number of sexual partners during last six months: \_\_\_\_\_

Number of TOTAL past sexual partners: \_\_\_\_\_

## PREGNANCY HISTORY

# of times you have had a confirmed pregnancy: \_\_\_\_\_

# Miscarriages \_\_\_\_\_, at how many weeks? \_\_\_\_\_ # of Elective Terminations \_\_\_\_\_

# of living children \_\_\_\_\_

What is the length of time it took you to get pregnant? Shortest: \_\_\_\_\_ Longest: \_\_\_\_\_

## CONTRACEPTIVE HISTORY

Currently use: \_\_\_\_\_ IUD \_\_\_\_\_ Diaphragm \_\_\_\_\_ Condom \_\_\_\_\_ Rhythm

\_\_\_\_\_ Birth Control Pills \_\_\_\_\_ Spermicide \_\_\_\_\_ Depo-Provera

If currently on Birth Control Pills, \_\_\_\_\_ (NAME)

When did you start taking Birth Control Pills? \_\_\_\_\_

How long have you been on Birth Control Pills? \_\_\_\_\_

If you are on Depo-Provera, when was your last injection? \_\_\_\_\_

## REPRODUCTIVE DONATION HISTORY

Have you applied or been screened to be a reproductive donor before? YES NO

If yes, list the name and location of Reproductive donor program(s) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Were you accepted as a Reproductive donor? YES NO

If yes, how many times did you cycle? \_\_\_\_\_

Are you currently enrolled as a Reproductive donor in another program? YES NO

Profile # \_\_\_\_\_

DOB \_\_\_\_\_

Please fill out the requested information below. **Anything left blank could disqualify your application.**

RELATIVE	AGE	EYE COLOR	NATURAL HAIR COLOR	COMPLEXION*	HEIGHT	BONE SIZE**	WEIGHT
Mother							
Father							
Brother(s)							
2.							
3.							
Sister(s)							
2.							
3.							
Maternal Grandfather							
Maternal Grandmother							
Paternal Grandfather							
Paternal Grandmother							

\* Fair, Fair/Medium, Medium, Olive or Dark

\*\* Small, Small/Medium, Medium, Medium/Large or Large

Fill in the appropriate space for each of the following relatives. List all specific health problems and causes of death for each individual. Please do not use "old age" or "natural causes" for causes of death.

Family Member	Health Problem (s)	Current Age/ Age at Death	Living / Dead (check one)
Mother	_____		_____
Father	_____		_____
Brother	_____		_____
Sister	_____		_____
Maternal Grandfather	_____		_____
Maternal Grandmother	_____		_____
Paternal Grandfather	_____		_____
Paternal Grandmother	_____		_____









Profile # \_\_\_\_\_

DOB \_\_\_\_\_

Medical Problem	None	Self	Mother	Father	Sibling	Grandparent	Aunt/ Uncle	Explain which side of family, age of onset, etc.
Albinism								
Infectious Skin Disease								
More than 5 purple or coffee colored spots on skin (size of quarter or larger)								
Other skin disorder								
<b>13. Other</b>								
Alcoholism								
Drug Abuse, Misuse or Addiction								
Breast Cancer								
Any cancer not listed above								
Cleft Palate of Lip								
Serious Birth Defect								
Inguinal Hernia								
Early Death (less than age 50)								
Sarcoidosis								
Premature degeneration of any other organ system								
Any other condition not listed above								

**SOCIAL AND PERSONALITY**

Briefly describe your personality: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

What are your special interest and hobbies? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Why do you want to donate? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

