ADVANCED REPRODUCTIVE CENTER OF HAWAII
1319 Punahou Street, Suite 510 Honolulu, HI 96826
Phone: (808) 949-6611 Fax: (808) 949-6610

Egg Donor Application

DATE APPLIED: _____

Please take your time and write legibly. We will remove your identifying information and provide this to our patients that are looking for an egg donor. You can mail or fax your completed application to us (attention: Kim). Our address and fax number are listed above.

Name:_____ Age:_____ Date of Birth:_____

Address:_____ City:_____ State:_____

Zip Code:_____ Home Phone:_____ Work Phone:_____

Cell Phone:_____ Email Address:_____ Marital Status:_____

Social Security Number: _____

Are you a U.S. Citizen? ☐ Yes ☐ No Country of Origin?_____

Are you a Resident Alien? ☐ Yes ☐ No If yes, provide your alien number: A_____

Please include a copy of your social security card or TIN & green card along with the application

Are you a non-resident Alien? ☐ Yes ☐ No If yes, what type of VISA?_____

Please include a copy of your visa & work permit information with the application

Would you be willing to provide photos of yourself, (between age 2- current) for prospective recipients to view?

☐ Yes ☐ No If yes, please email them to archawaii1@yahoo.com

Why are you interested in becoming an egg donor?_____

_____

_____

Ethnic Origin

Self: _____ Mother: _____

Father: _____ Were you adopted? _____

Physical Characteristics

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Natural hair color:_____ Hair texture: _____ Eye color: _____

Skin Tone: _____ Freckles:_____

Education

Did you complete high school? _____ Have you or are you currently attending college? _____

If yes, which college do/did you attend? _____

What is or was your major? _____ Degree(s) earned? _____

Personal Preferences/Abilities:

Are you skilled mechanically or technically? _____

How are your abilities in mathematics? _____

How would you rate your literary skills? _____

How would you rate your athletic abilities? _____

How would you rate your musical ability? _____

Artistic Talents? _____ What languages do you speak? _____

Religion: _____

Do you have any special talents or hobbies? _____

How would you describe your personality? _____

_____

What is your ultimate ambition in life?

_____

_____

Reproductive History

Have you ever donated eggs before? _____ If yes, when? _____ Where?_____

Have you ever been diagnosed with infertility? _____

If yes, explain: _____

Are you currently sexually active? _____ What type of contraception do you use?_____

Have you had more than 10 past sexual partners? _____

Have you ever been treated for the following sexually transmitted diseases?

HIV (AIDS), Syphilis, Gonorrhea, Chlamydia, Genital Warts, Other: _____

_____

Have you ever been pregnant? _____ If yes, how many times? _____

How many children do you have? _____

Have you ever had an abortion? _____ If yes, how many? Year(s): _____

Have you ever had a miscarriage? _____ If yes, how many? Year(s): _____

Have you been told of any gynecological problems (endometriosis, fibroids, ovarian cysts, abnormal pap smear, etc?)

_____

_____

Is there a history of fertility problems in your family (difficulty conceiving or miscarriages)? _____

If yes, explain:_____

Medical History

Allergies (food, pollen, bee stings, medication, etc)

_____

_____ _

Describe childhood allergies you have outgrown: _____

_____

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

_____

Do you have any 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?

_____

Do you wear corrective lenses or have you had laser surgery? _____

Are you currently under a physicians care for any reason? _____

Have you ever had an eating disorder? _____ If yes, please explain: _____

Vision: _____ Hearing: _____

Have you ever had any type of surgery?_____ If yes, please explain: _____

_____

List any drugs, prescription and non prescription, vitamins, or herbal supplements that you take regularly:

_____

_____

Any other medications taken in the last 5 years:

_____

Do you smoke cigarettes? _____ If yes, how many? _____

Do you drink alcoholic beverages?_____ What types? _____

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

Have you ever used any kind of mind altering drugs such as marijuana, LSD, heroin, or cocaine? _____. If yes, state what drugs, how often, and last date used? _____

_____

Have you ever used narcotics (tranquilizers, valium, thorazine, oxycontin, etc)? _____

If yes, state which drug, how often and last date used? _____

_____

Have you ever used anti-depressants (Prozac, Xanax, Zoloft, Buspar, Wellbutrin, etc.)? _____

If yes, state which drug, how often, and last date used: _____

_____

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

_____

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

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

_____

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

Are you in a monogamous relationship? _____ If no, what is the number of partners you have been sexually active with over the last 6 months? _____

Have you ever had a sexual partner that was gay or bisexual? _____

Have you or a partner of yours ever had a sexually transmitted disease (gonorrhea, chlamydia, syphilis, hepatitis, herpes, condyloma, or trichomoniasis)? _____ Describe your diagnosis and treatment: _____

_____

Have you had multiple sexual partners?

_____

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

Have you ever received a blood transfusion outside the US? _____

Have you ever received clotting factor concentrates for a bleeding problem such as hemophilia? _____

Have you been exposed to radiation or toxic chemicals in your workplace or personal life_____ If yes, explain:

_____

Have you ever had a surgery? _____ If yes, describe: _____

_____

In the past 12 months have you been under a doctor's care or had a major illness or surgery? _____

_____

Have you ever received treatment of human growth hormone? _____

Have you ever had an organ or tissue transplant, including dura matter or cornea? _____

Have you ever been diagnosed with or had possible exposure to SARS (severe acute respiratory syndrome)?

_____

Have you ever been diagnosed with West Nile virus? _____

Have you ever been arrested or convicted of a crime? _____ If yes, please explain: _____

_____

Please list and describe all of your tattoos or body piercing(s):

Date Received:_____ Description Location _____ Sterile Needle(s) Used?_____

Family Health History

	Age (if alive)	Or Age at Death	Medical Problems or Cause of Death
Mother			
Father			
Brother(s): 1			
2			
3			
4			
Sister(s): 1			
2			
3			
4			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Children (if any):			

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

Medical Problems	Yourself	Mother	Father	Siblings	Grandparents	Other Family	Describe
Heart							
A. Stroke							
B. Heart attack							
C. Heart disease							
A) From birth							
B) Other							
D. Hardening of the arteries							
E. High cholesterol							
F. High blood pressure							
Blood							
A. Anemia							
B. Sickle-cell anemia							
C. Hemophilia or other bleeding problem							
D. Leukemia							
E. Immune deficiency							
G. Other Blood disorder							
Respiratory							
A. Hay fever							
B. Asthma							
C. Emphysema							
D. Leukemia							
E. Lung cancer							
F. Pneumonia							
G. Cystic Fibrosis							
H. Other lung disease							
Gastro-intestinal							
A. Ulcer of the stomach or duodenum							
B. Gall stones							
C. Emphysema							
D. Hepatitis A (infectious)							
E. Hepatitis B (blood)							
F. Colon cancer							
G. Ulcerative colitis							
H. Crohn's disease							
I. Intestinal cancer							
J. Any other cancer/problem of the digestive system							
Metabolic/Endocrine							
A. Diabetes							
B. Hypoglycemia							
C. Thyroid cancer							

Medical Problems	Yourself	Mother	Father	Siblings	Grandparents	Other Family	Describe
D. Thyroid disease							
E. Goiter							
F. Adrenal dysfunction or disorder							
G. Hyperactivity							
Urinary							
A. Kidney disease							
B. Other disease of urinary tract							
C. Rectal disorder							
Genital/Reproductive							
A. Undescended testicle							
B. Hypospadias							
C. Prostate cancer							
D. Uterine fibroid							
E. Ovarian cysts							
Cancer of the cervix							
Neurological							
A. Migraines							
B. Mental Retardation							
C. Senility before age 50							
D. Multiple sclerosis							
E. Epilepsy							
F. Cerebral Palsy							
G. Hydrocephalus							
H. Disorder of the spinal cord							
I. Huntington's chorea							
J. Gaucher disease							
K. Wilson's disease							
L. Creutzfeldt-Jakob disease							
M. Alzheimer's disease							
N. Spina bifida							
O. Nuerofibromatosis							
P. Parkinson's disease							
Q. Tuberous sclerosis							
R. Other diseases of the nervous system							
Mental Health							
A. Schizophrenia							
B. Manic depression							
C. Bipolar illness							
D. Eating disorders							
E. Depression							
F. Other mental heath disorders requiring hospitalization							
Muscular/ Bones/Joints							
A. Muscular dystrophy							

Medical Problems	Yourself	Mother	Father	Siblings	Grandparents	Other Family	Describe
B. Other chronic muscle disease							
C. Lupus							
D. Deformity of the spine							
E. Dwarfism							
F. Hereditary lower back disease							
G. Osteoporosis							
H. Arthritis							
I. Rheumatoid arthritis							
J. 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. Retinoblastoma							
G. Glaucoma							
H. Deviated septum							
I. Any other sight, sound, smell disorder							
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. Learning disability							
F. Autism							
G. Cleft lip or palate							
H. Club foot							
I. Albinism							
J. Marfan syndrome							
K. Any other birth defects							
L. Any other condition not mentioned above							

Has any member of your family, including yourself, had a problem of defect at birth of any of the following systems?

1. Bones, muscles, joints, limbs
2. Gastrointestinal system
3. Nervous system, brain, spinal cord
4. Blood circulation
5. Respiratory system
6. Organ (heart, lung, kidney, etc)
7. Genital. Urinary
8. Metabolic (hormones, enzymes, etc)

No _____ Yes _____

If yes, please list below the specific defect in each case:

Birth Defect	Who	When Did it Happen	Relevant Circumstances

Release of Photo and Donor Profile

I authorize Advanced Reproductive Center of Hawaii to share my photos and Egg Donor Application with their patients. I understand that my photos and Egg Donor Application are only available to Advanced Reproductive Center of Hawaii and only distributed to prospective parents.

_____ _____ _____

Donor's Printed Full Name Donor's Signature Date

Egg Donor Application Acknowledgment

I acknowledge that the answers on this application are accurate and truthful to the best of my knowledge. These responses, and any other information I provide during the egg donation process, will remain completely confidential. Information from this questionnaire will be made available to the recipient/recipient couple anonymously. I understand that knowingly falsifying or omitting any information may result in cancellation of the cycle.

_____ _____ _____

Donor's Printed Full Name Donor's Signature Date