Date Received:__________

FAMILY FERTILITY CENTER
CONFIDENTIAL

OVUM DONOR PROGRAM APPLICATION FORM

Please fill out as truthfully as possible and use an extra sheet of paper if necessary. Include pictures with your completed application. These applications are often saved by the families for the children conceived from ovum donation. Please type or print as legibly as possible with dark ink. You may not have all of the information you need to complete this application today. Please keep a copy so that you may update the application as you obtain the information from memory, family members or records; then please send us the completed form for our records. No identifying information will be made available to recipients without your permission.

PLEASE COMPLETE WITH A BLACK INK PEN

Date of Application: _____________

PERSONAL INFORMATION

______________________ ________________ _________________
Last name First name Middle name
Address:____
City: ___________________________ State:______________Zip:______
Phone: Home (____) ______-_________ Leave Message Yes___ No____
Cell (____) ______-_________ Leave Message Yes___ No____
Work (____) ______-________ Leave Message Yes___ No____
E-mail Address: ____________________________
Age:______ Date of birth____________
Marital Status: Married Single Separated Divorced Widowed
Spouse Name: ____

Medical Insurance: _________________________ ____________________
Name I.D. number
S.S. Number: _____________ Driver's License No:____________ State:_____
Do you have a car? _______________
Occupation:____
Employer:____
Employer's Address:_______________________________________
(Street) (City, State) (Zip)
Person to be notified in case of emergency:_______________________________
Address: _____________________________________Phone:______________________
Are you registered as a Donor anywhere else? ____Yes _____No
If so, what is the name of the Center? ________________________________

***Please only sign up with one agency!!! We will work hard to try and find a match for you.**

Date:_____________ Applicants First Name:__________________
Applicant's Age:________

FERTILITY HISTORY

Number of pregnancies: ______ Dates of pregnancies: ____________
Number of miscarriages: ______ Dates of miscarriages: ____________
Number of abortions: ______ Dates of abortions: ____________
Number of stillbirths: ______ Dates of each stillbirth: ____________

Number of children:________

First name	Age	Sex	Birth date	Health/Problems

Are your menstrual periods regular: Yes No
How long is your monthly cycle:_____________days
Interval between periods_________________
Age of onset of menses ________________
Have you ever donated eggs before: Yes No
If yes; when:_________ Where:____

Birth control method used:
____

Is there any history of fertility problems in your family?
(difficulty conceiving or miscarriages): Yes No
If yes explain:
____
____

Did your parents have difficulty conceiving: ___ Yes ___No
Do any of your siblings have fertility problems: ___ Yes ___No
Does anyone in your family have fertility problems: ___ Yes ___No

Did your mother take diethylstilbestrol (DES) or any prescription drug while she was pregnant with you or any of your siblings: Yes No

If yes explain:
____
____
____

PERSONAL CHARACTERISTICS

Height:______ Dress Size:______ Eye color:_____ Hair color:_____

(If recently pregnant: pre-pregnancy dress size: _______)

Hair: Curly Wavy Straight

Complexion: Fair Medium Dark

Body type/bone structure: Small Medium Large

Ethnic origin/ ancestry: Mother_________________________Father________________
Religion born into:___________________Race:______________________
Sexual Orientation: Heterosexual______ Homosexual_______ Bisexual______
Education: **(check one & list year you are currently completing)**
___ completed grade school
___ completed high school
___ Currently in college pursuing degree in ____________________________
Where?____

___Completed college degree in____________________________________
Where?____

___Currently pursuing advance degree in______________________________
Where?____

___Advance degree in____
Where?____

Please list your Test Scores:
SAT Verbal____ Math____ Total____
GRE Verbal____ Quantitative____ Analytical____ Total(V+Q)_____
LSAT______ MCAT______ ACT______
Other____________________

Marriages: ____________ ____
Date _______________City, County, State___________________________

Date _______________City, County, State___________________________

PERSONAL AND MOTIVATIONAL

In your own words, describe your personality and character:
____
____
____
____

ACADEMIC HISTORY

Please describe academic strengths and weaknesses during school years:
Elementary School:

High School:

College:

Special talents, skills, hobbies, etc.
(Examples: music, art, athletics, medicine, law, cabinet maker, handcrafts, writing, reading, ability to do games, crossword puzzles etc)

Yourself

MUSICAL ABILITY

ARTISTIC ABILITY

FOREIGN LANGUAGE ABILITY____

____

FAVORITE BOOKS____

____

RECENTLY READ BOOKS____

____

Do you like pets? If so, what type of pets is you favorite? ________________________

Please describe any special talents, skills, hobbies, careers, etc. in your family. (Examples: music, art, athletics, medicine, law, cabinet maker, handcrafts, writing, reading, ability to do games, crossword puzzles etc)

Mother (Please include highest level of education)______________________________

____

____

____

Father (Please include highest level of education)________________________________

____

____

____

Siblings____

____

____

Grandparents____

____

____

____

____

____

Please describe your childhood:

What is your ultimate ambition or goal in life?

Imagine yourself five years from today watching from a distance the child born with your egg donation, playing in a playground. What do you imagine yourself feeling and thinking?

PERSONAL HEALTH HISTORY

Have you ever had surgery: Yes_____ No_____
If yes, please explain:____

Have you ever had hospitalization not already mentioned: Yes_____ No_____
If yes, please explain:____

Have you ever had major radiation or X-ray exposure: Yes_____ No_____
If yes, please explain:____

Do you currently have any allergies: Yes_____ No_____
If yes, are they to: Food Drugs Environment Other
Please list below specific substances and reaction(s) produced:

Substance	Reaction
______________________________	____________________________
______________________________	____________________________
______________________________	____________________________

As per above, please describe any childhood allergies you have outgrown:
____
____

How is your vision (without glasses): Poor Fair Good Excellent

Do you wear glasses or contacts: Yes No If yes, since what age?_____
Your vision is about: 20/______
Are you: Nearsighted Farsighted Other______________________________

Do you have normal hearing: Yes No

What is the condition of your teeth: Poor Fair Good

Blood type: __________________________

Have you ever had any cosmetic surgery? ____
If yes, please explain____

PERSONAL HEALTH : WORK HISTORY/EXPOSURE

What is your current or most recent occupation:___________________________________
____
____

In the past six months have you been exposed to any of the following in your living environment, or while involved in hobbies or extra curriculum activities. If yes, please check the appropriate item below and give dates and how often you have been exposed. Please, consider each carefully.

Exposed to:	WHEN	HOW OFTEN
Toxic chemicals	__________________	______________________
Sprays	__________________	______________________
Fumes/Exhaust	__________________	______________________
Radiation	__________________	______________________
Flea powers/sprays	__________________	______________________
Lead/lead products	__________________	______________________
Asbestos/asbestos products	__________________	______________________

Please list all jobs you have had in the past five years and your possible exposure to chemicals, drugs, and gases. Please consider carefully.

Jobs/Duties	Year Began	Year Ended	Exposed to which (drugs, chemicals, gases)

FAMILY HEALTH HISTORY

Please describe your family members by the following physical characteristics:

	Eye color	Hair color	Complexion	Height	Body type	Vision
Mother	________	_______	________	_______	________	_______
Father	________	_______	________	_______	________	_______
Grandfather (Paternal)	________	_______	________	_______	________	_______
Grandmother (Paternal)	_______	_______	________	_______	________	_______
Grandmother (Maternal)	_______	_______	________	_______	________	_______
Grandfather (Maternal)	_______	_______	________	_______	________	_______
Genetic Siblings	_______	________	_______	_______	_______	_______
	_______	________	_______	______	_______	_______
	_______	________	_______	_______	_______	_______

How many genetic siblings are in your immediate family (including yourself): ___
Have twins or multiple births occurred in your family: Yes No
If yes, what relation to you:____________________________________

Please list below at what age members of your family died and what the cause of their death. Please be as specific as possible.

	Age(if living)	Age at time	Cause of death
Grandfather(paternal)	________	________	________
Grandmother(paternal)	________	________	________
Grandfather(maternal)	________	________	________
Grandmother(maternal)	________	________	________
Father	________	________	________
Mother	________	________	________
Brothers	________	________	________
1.	________	________	________
2.	________	________	________
3.	________	________	________
Sisters	________	________	________
1.	________	________	________
2.	________	________	________
3.	________	________	________

ALCOHOL USE

Please indicate current alcohol use by each family member:

DRINKS PER WEEK

	None	1-2	3-5	6-10	over 10	
Self						
Grandfather (paternal)						
Grandmother (paternal						
Grandfather (maternal)						
Grandmother (maternal)						
Father						
Mother						
Brothers						
1						
2						
3						
Sisters						
1						
2						
3						

Has any member of your family, including yourself and your children, had a problem or defect at birth of any of the following body systems:

Bones, muscles, joints, limbs	Yes	No
Gastrointestinal system	Yes	No
Nervous system, brain, spinal cord	Yes	No
Ears, eyes	Yes	No
Blood circulation	Yes	No
Respiratory system	Yes	No
Organ (heart, lungs, kidney, etc.)	Yes	No
Genital/urinary	Yes	No
Metabolic (hormones, enzymes,etc)	Yes	No
Other Birth Defect	Yes	No

If yes to any of the above, please explain the specific defect in each case.

Birth defect	Who	How did it happen	Circumstances

Do you have any brothers or sisters who died in infancy or childhood? Yes No

If yes, please explain what was the cause:

____
____
____

Are there any known genetic diseases or conditions that run in your family?
Yes No

If yes, please explain what they
are:____
____
____

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
If yes, please explain them:

____
____
____

Look through the following list of medical problems and indicate which ones you or one of your relatives have had. Please consider each condition carefully for each family member. Check (√) all that apply.

CONDITION:

HEART	Self	Mother	Father	Siblings	Maternal Grandparents	Paternal Grandparents	Child	Aunts/Uncles Cousins
Stroke								
Heart Attack								
Heart disease								
from birth								
other								
Hardening of arteries								
High blood pressure								

If you answered yes to any of the above conditions, please explain:
Please describe any circumstances, (i.e., diet, smoking) and indicate the date of onset of condition.

____
____

BLOOD	Self	Mother	Father	Siblings	Maternal Grand Parent	Paternal Grandparents	Child	Aunts/Uncles Cousins
Anemia								
Sickle cell								
Hemophilia								
Leukemia								
Immune Deficiency								
Other Blood Disorders								

If you answered yes to any of the above conditions, please explain:
Please describe any circumstances, (i.e., diet, smoking) and indicate the date of onset of condition.

____
____
____
____

RESPIRTORY	Self	Mother	Father	Siblings	Maternal Grand Parents	Paternal Grandparents	Child	Aunts/Uncles Cousins
Hay fever								
Asthma								
Emphysema								
Tuberculosis								
Lung Cancer								
Pneumonia								
Other								

If you answered yes to any of the above conditions, please explain:
Please describe any circumstances, (i.e., diet, smoking) and indicate the date of onset of condition.

____
____
____
____

GASTRO	Self	Mother	Father	Siblings	Maternal Grandparents	Paternal Grandparents	Child	Aunts/Uncles Cousins
Gastro Intestinal								
Ulcer								
Gall stones								
Hepatitis A								
Hepatitis B								
Liver disease								
Colon cancer								
Ulcerative colitis								
Crohn's Disease								
Cystic Fibrosis								
Intestinal cancer								
Other:								

If you answered yes to any of the above conditions, please explain:
Please describe any circumstances, (i.e., diet, smoking) and indicate the date of onset of condition.

____
____
____
____

URINARY	Self	Mother	Father	Siblings	Maternal Grandparents	Paternal Grandparents	Child	Aunts/Uncles Cousins
Kidney Disease								
Rectal Disorder								
Other								

If you answered yes to any of the above conditions, please explain:
Please describe any circumstances, (i.e., diet, smoking) and indicate the date of onset of condition.

____
____
____
____

GENITAL/ REPRODUCTIVE	Self	Mother	Father	Siblings	Maternal Grandparents	Paternal Grandparents	Child	Aunts/Uncles Cousins
Un-descended Testicle								
Hypospadiasis								
Prostate Cancer								
Uterine Fibroids								
Ovarian Cysts								
Cervical Cancer								
Ovarian Cancer								
Other								

If you answered yes to any of the above conditions, please explain:
Please describe any circumstances, (i.e., diet, smoking) and indicate the date of onset of condition.

___

___

___

___

MENTAL	Self	Mother	Father	Siblings	Maternal Grandparents	Paternal Grandparents	Child	Aunts/Uncles Cousins
Mental Health								
Schizophrenia								
Manic Depressive								
Clinical Depression								
Anxiety								
Learning disabilities								
Mental Retardation								
Other mental illness								

If you answered yes to any of the above conditions, please explain:
Please describe any circumstances, (i.e., diet, smoking) and indicate the date of onset of condition.

___

___

___

MUSCLES/ BONES/ JOINTS	Self	Mother	Father	Siblings	Maternal Grandparents	Paternal Grandparents	Child	Aunts/Uncles Cousins
Muscular Dystrophy								
Chronic Muscle Disease								
Lupus								
Deformity of Spine								
Dwarfism								
Low back pain								
Gout								
Osteoporosis								
Other:								

If you answered yes to any of the above conditions, please explain:
Please describe any circumstances, (i.e., diet, smoking) and indicate the date of onset of condition.

____

____

____

____

SIGHT/ SOUND/ SMELL	Self	Mother	Father	Siblings	Maternal Grandparents	Paternal Grandparents	Child	Aunts/Uncles Cousins
Deafness before Age 60								
Deformity of the ear								
Cataracts before age 50								
Blindness								
Color blindness								
Glaucoma								
Deviated Septum								
Other								

If you answered yes to any of the above conditions, please explain:
Please describe any circumstances, (i.e., diet, smoking) and indicate the date of onset of condition.

____

____

____

SKIN	Self	Mother	Father	Siblings	Maternal Grandparents	Paternal Grandparents	Child	Aunts/Uncles Cousins
Acne								
Eczema								
Skin cancer								
Pigmentation Disorders								
Other								

If you answered yes to any of the above conditions, please explain:
Please describe any circumstances, (i.e., diet, smoking) and indicate the date of onset of condition.

____
____
____

OTHER	Self	Mother	Father	Siblings	Maternal Grand Parent	Paternal Grandparents	Child	Aunts/Uncles Cousins
Alcoholism								
Drug/substance abuse								
Breast cancer								
Any other Cancer								
Nervous System Disorders								
Seizure Disorder								
Diabetes								
Elevated Cholesterol								
Other								

If you answered yes to any of the above conditions, please explain:
Please describe any circumstances, (i.e., diet, smoking) and indicate the date of onset of condition.

____
____
____
____

Do you or anyone in your family have a history of any of the following disorders?

		Yes	No
1.	Cleft Lip	_____	_____
2.	Cleft Palate	_____	_____
3.	Congenital Hip Dislocation	_____	_____
4.	Clubfoot	_____	_____
5.	Albinism	_____	_____
6.	Hemoglobin Disorder	_____	_____
7.	Hereditary Hypercholesterolemia	_____	_____
8.	Neurofibromatosis	_____	_____
9.	Juvenile Diabetes Mellitus	_____	_____
10.	Epileptic Disorder	_____	_____
11.	Rheumatoid Arthritis	_____	_____
12.	Glucose -6-Phosphate Dehydrogenase	_____	_____
	Deficiency	_____	_____
13.	thalassemia	_____	_____
14.	Sickle Cell Disease	_____	_____
15.	Tay Sachs Disease	_____	_____
16.	Huntington's Disease	_____	_____
17.	Retinitis Pigmentosa	_____	_____
18.	Marfan Syndrome	_____	_____
19.	Retinoblastoma	_____	_____
20.	Alport Disease	_____	_____

Comments If Yes	Self Or Family Member	Comments:
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

If you could pass on a message to the recipient(s) of your eggs, what would that message be?

____
____
____
____
____
____
____

Why do you want to be a donor?

____
____
____
____
____

Are you willing to be an anonymous donor? Yes No

Are you willing to be a semi anonymous donor? Yes No
(meet but no exchange of last name or phone #)

Would you be open to meeting the child if his/her parents
wanted this when the child was eighteen. Yes No

Are you interested in our surrogate mother/gestational carrier program: Yes No

If the recipient(s) of your eggs choose to be anonymous, please list non-identifying questions that you may want to have answered by the recipient couple:

____
____
____
____
____
____
____

I, the undersigned, do hereby swear and affirm that the above statements are true and correct to the best of my knowledge.

Signature:___________________________ **Date**:________________________

AUTHORIZATION FOR RELEASE OF INFORMATION
(Civil Code section 56.10)

TO: ANY PHYSICIAN, MEDICAL FACILITY, PSYCHIATRIST, PSYCHOLOGIST, OR OTHER HEALTH CARE OR MENTAL HEALTH PROFESSIONAL:

YOU ARE HEREBY AUTHORIZED to release to **FAMILY FERTILITY CENTER** any and all medical, psychological, psychiatric, or health information pertaining to me, which is now or in the future may be in your possession or under your control.

FAMILY FERTILITY CENTER is expressly authorized hereby to copy, or receive copies of, any records or documents pertaining to me or the information specified above, and to distribute said copies to
____
(Prospective Parents) or to any other Prospective Parents and to any other interested physician, psychiatrist, psychologist or health care or mental health professional who requires the information for purposes of medical or psychological assessment or treatment.

The information may be used in, or in connection with, the ovum donor program agreement I entered into with the Prospective Parents identified above or with other Prospective Parents.

This authorization shall remain valid for two years from the date hereof.

I have been advised of my right to receive a copy of this Authorization.

Dated:________________________ __________________________________
OVUM DONOR

msw/ovdauth

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Family Fertility Center to disclose the information contained in this Ovum Donor Application to anyone interested in using my ovum/ova in order to conceive a child, and for review by appropriate medical and psychological professionals and their staffs. I understand, and expressly condition this authorization upon such understanding, that my last name will only be disclosed to the appropriate health care professionals involved in my ovum donor process. I give my consent to the release of my photo(s) on the FFC website to Intended Parents who have authorization from FFC staff.

DATED: ____________________ ___________________________________

SIGNATURE

HUSBAND/PARTNER INFORMATION FORM

I am ____, the husband/partner of ____. I cannot attend the intake interview that you have scheduled for my wife/partner on ______________________________.

_ I am supportive of my wife's/partner's decision to donate her ovum (a) to help an infertile couple have a child.

_ I am not supportive of my wife's/partner's decision to donate her ovum (a) to help an infertile couple have a child.

The reasons for my decision are as follows (in no order of importance):

1.

2.

3.

4.

5.

(continue on back if necessary)

_________________________ Date

________________________________ Signature

APPLICANT REFERENCES

When calling references we simply state that you are applying for a voluntary position working with the public. We do not mention anything related to Ovum Donation or the Family Fertility Center.

Please provide the names of 3 (three) acquaintances, friends, or co-workers, that have known you for more than 5 years; DO NOT include relatives or in-laws. If you have an employment history, please include one person who was your supervisor.

Applicant's Name__________________ Date:________________

Name:______________________ Relationship:______________________

Phone No: (__ __ __) __ __ __ - __ __ __ __

Name:______________________ Relationship:______________________

Phone No: (__ __ __) __ __ __ - __ __ __ __

Name:______________________ Relationship:______________________

Phone No: (__ __ __) __ __ __ - __ __ __ __

**** PLEASE ATTACH A RECENT PHOTOGRAPH OF YOURSELF AND **** **** YOUR CHILDREN ****

How did you become aware of the **Family Fertility Center?**

Newspaper advertisement – Name of publication_________________
Newspaper/magazine article – Name of publication________________
Friend/acquaintance
Other ________________

PERSONAL HEALTH HISTORY FOR IVF PHYSICIAN AND FFC

Do you drink alcohol: Yes_____ No_____ If yes, how many:________
Have you ever abused alcohol: Yes_____ No _____
If yes, when & how much:____
Do you smoke cigarettes Yes______ No__________
Are you using marijuana now: Yes_____ No_____ If yes, how often__________
Have you ever used illegal or unprescribed drugs: Yes_____ No_____
If yes, what drugs and how often:_______________________________________
Are you using illegal or unprescribed drugs now: Yes_____ No_____
If yes, what drugs and how often:_______________________________________

Have you had any therapy with a psychiatrist or any other mental health professional:
Yes_____ No_____
If yes, when and why: ____
____

Have you ever had any psychiatric hospitalization: Yes_____ No_____
If yes, please be as specific as possible:__________________________________

Have you ever been treated for Syphilis: Yes_____ No____ If yes, when:_____

How many times:_______________ When was the last time:______________

Have you ever been treated for Chlamydia: Yes_____ No____ If yes, when:_____

How many times:_______________ When was the last time:______________

Have you ever been treated for Gonorrhea: Yes___ No___ If yes, when:______

How many times:_______________ When was the last time:______________

Have you or any of your sexual partners had:

			Myself	Partner	When
NSU(non-specific urethritis)	Yes	No	___	____	____
Chlamydia	Yes	No	___	____	____
Venereal warts	Yes	No	___	____	____
Herpes	Yes	No	___	____	____
Other sexually transmissible diseases	Yes	No	___	____	____

Have you ever tested positive for Hepatitis B, Hepatitis C, or HIV: Yes____ No____

Have you ever had any problems with the law: Yes_____ No_____
Please list any arrests, convictions, sentences, etc:
____
____

RISK FACTOR QUESTIONNAIRE

FDA regulations require that an eligibility determination be performed for ovum and sperm donors, based on testing and screening for relevant communicable diseases. This is for the protection of possible recipients of the tissue, and as well as those people who may handle or come in contact with the tissue. Please read and answer the following questions truthfully and to the best of your knowledge. We recognize that some of the questions are of a sensitive nature, and thank you for providing the most accurate information. Please describe any YES answers on the bottom of this form.

Group 1	YES	NO
1. Have you or a family member had Creutsfeldt-Jakob ("Mad Cow") disease or Variant Creutzfeldt-Jakob disease or risk for it?		
2. Were you a member of the US military, a civilian military employee, or a dependant of a member of the US military who spent a total of 6 months on or associated with a military base stationed in Belgium, Netherlands, or Germany between 1980-1990, and/or Spain, Portugal, Turkey, Italy, or Greece between 1980-1996?		
3. Have you visited or lived in the United Kingdom (UK) for three (3) or more months between 1980-1996? (UK includes: England, Scotland, Wales, Northern Ireland, Isle of Man, Channel Islands, Gibraltar, Falkland Islands)		
4. Have you had a blood transfusion in the United Kingdom (UK), or France between 1980 to present?		
5. Have you traveled or lived a cumulative time of 5 years or more since 1980 to present in any combination of countries in Europe?		
6. Have you received Human Pituitary Growth Hormone (used until 1985) or dura matter (brain covering) graft?		
7. Have you injected Bovine (beef) insulin (used to treat diabetes) since 1980?		
8. Do you have biologic relative who has been diagnosed with CJD? Biologic relative in this setting means a mother, father, sibling, grandparent, aunt, uncle, or children		
9. Have you been diagnosed with dementia or any degenerative or demyelinating disease of the central nervous system?		
Group 2		
10. Have you ever had prior reactive (positive) screening for HIV?		
11. Have you had sex with someone who has been diagnose with HIV?		
12. Have you used needles to take injectible drugs for non-medical use, including steroids, or anything not prescribed by a doctor (including intravenous, intramuscular, and subcutaneous injections) within the past five (5) years?		
13. Have you engaged in sex in exchange for money or drugs in previous 5 years?		
14. Have you received human-derived clotting factor concentrates for a bleeding disorder such as hemophilia or related blood clotting disorder within the past 12 months?		
15. Have you ever had sexual contact or participated in sexual activity with someone of the same sex in previous 5 years?		
16. Have you had sexual contact in the past 12 months with anyone described in questions 12-15?		
17. Were you or sexual partner born or have you or your sexual partner lived in certain countries in Africa after 1977? (Cameroon, Central African republic, Chad, Congo, Equatorial Guinea, Gabon, Niger or Nigeria)		
18. Have you received a blood transfusion or any medical treatment that involved blood in the countries listed above in question 17 after 1977?		

Group 3		
19. Do you have unexplained weight loss (10 pounds or more in less than 2 months), night sweats, or swollen lymph nodes (lumps in your neck, arm pits, or groin) for longer than one month?		
20. Have you had an unexplained temperature of more than 100.5 F for 10 or more days?		
21. Have you had unexplained white spots or unusual blemishes in mouth?		
22. Do you have blue/purple spots under skin or mucous membranes?		
23. Do you have unexplained cough, shortness of breath, persistent diarrhea or other infection?		
Group 4		
24. Have you ever had prior reactive (positive) screening for HTLV?		
25. Have you ever tested positive for Adult T-Cell Leukemia?		
26. Have you ever experienced weakness in your lower extremities (Paraparesis)?		
Group 5		
27. Have you ever had prior reactive (positive) screening for Hepatitis B or C virus?		
28. Have you had unexplained jaundice (yellow skin) or enlarged liver?		
29. Have you been diagnosed with clinical, symptomatic viral Hepatitis after age 11? If yes, at the time of illness, was it documented as Hepatitis A?		
30. Have you ever received a tattoo or body piercing with in the past 12 months under sterile conditions? If so, when was the last tattoo or body piercing_______________?		
31. Have you received a blood transfusion in the last 12 months (excluding your own "autologous" blood)?		
32. Have you been exposed in the preceding 12 months to known or suspected HIV, HBV, or HCV-infected blood through needle stick or through contact with an open wound, non-intact skin, or mucous membrane?		
33. Have you had close contact within 12 months with another person having clinically active hepatitis B or hepatitis C infection (i.e. living in the same household, where sharing of kitchen and bathroom facilities occurs regularly)?		
34. Have you ever been incarcerated (jailed) for more than 72 hours during the past 12 months?		
Group 6 Within past 12 months:		
35. Have you had sex with any person known or suspected to have clinically active Hepatitis B infections, or Hepatitis C infection?		
Group 7 (only to be used when person-to person transmission of SARS-CoV occurring in the world (Check CDC site)		
36. Do you currently have/or within past 7 days had a moderate respiratory illness, fever, cough, and shortness of breath or difficulty breathing?		
37. Do you have a recent X-ray showing evidence of pneumonia within past 12 months?		
38. Have you recently been diagnosed with respiratory Distress Syndrom?		
39. Have you had recent contact (within 14 days) with any person suspected with SARS?		
40. Have you recently traveled to or resided in an area (within 14 days) affected by SARS?		
41. In the past 28 days have you been exposed to, treated for, or do you have SARS?		
Group 8		
42. Have you had an unexplained fever, fast heart rate and fast respiratory rate within past 7 days?		
43. Have you been diagnosed with or treated for Sepsis or have elevated white blood cell count or positive blood cultures associated with the condition described above within the last 7 days?		
44. Do you currently have severe signs and symptoms of Sepsis; unexplained low oxygen in the blood, very low urine output, altered mental functioning, low blood pressure?		

Group 9		
45. Have you been treated for Syphilis in the past 12 months?		
46. Have you been treated for Gonorrhea in the past 12 months?		
47. Have you contracted Chlamydia, venereal warts (HPV), or genital herpes in the past 12 months?		
Group 10		
48. Have you had a Smallpox vaccination in the past 21 days? If yes, did the scab separate spontaneously?		
49. If yes, did you develop any complications (i.e: skin rashes/sores beyond the vaccination site, infection of the cornea, or general illness related to the vaccination)?		
50. Have you developed skin rashes/sores since close contact with someone who received a Small Pox vaccination?		
	YES	NO
Group 11		
51. Have you had a medical diagnosis of WNV (including diagnosis based on symptoms and laboratory results, or confirmed WNV viremia)?		
WITH IN PAST 7 DAYS:		
52. Have you had fever or headache, body aches, or eye pain?		
53. Have you had swollen Lymph nodes?		
54. Have you had a skin rash on the trunk of your body?		
55. Have you had a severe illness; encephalitis, meningitis, paralysis?		
56. Have you had severe illness with headache, high fever, neck stiffness, disorientation, coma or tremors?		
57. Have you experienced convulsions, muscle weakness, or paralysis?		
Group 12		
58. Are you a recipient or have you had intimate contact of a xenotransplantation product recipient? (Surgical transfer of cells, tissues, or especially whole organs from on species to another) If yes or this person is in your household, have you been exposed to blood, saliva, or other body fluids from this person?		

By signing this form I represent and warrant that I have read the above questions and have answered them truthfully and to the best of my knowledge.

If I was uncertain about a question, I was given the opportunity to ask the physician and/or nurse for clarification and then answered the question truthfully and to the best of my knowledge.

I understand that I am being asked **<u>not</u>** to participate in any of the above high-risk activities described in the questions contained in this questionnaire (including but not limited to tattooing, body piercing, multiple partners, unprotected sex, recreational drug use, etc.) during the donation cycle (IVF) and will inform the nursing staff if I do.

I agree to practice safe sex during this time period to prevent communicable disease exposure and prevent any unwanted pregnancy.

I understand that if I do participate in any of the above high-risk activities that I report this to the physicians or nursing staff at the IVF center and that I may be asked to postpone the donation or possibly be excluded from the donor program, IVF gestational carrier cycle or may disqualify Cryopreserved embryos from being donated in the future.

By participating in any high-risk activities such as those described herein, I understand that legal recourse by the recipient couple or individual receiving the donation is possible should my actions cause any adverse affect.

I agree to indemnify, defend and hold harmless FFC, its associated IFV centers, their doctors and employees from any and all claims, losses, liabilities and demands suffered by any of them as a result of my participation in any high-risk activities or behavior and/or any untruthfulness or inaccuracy by me concerning the same.

Name: ___________________________________
(Please Print)

Signature:___________________________________

Date:________________________

Please describe any “Yes” answers below:

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