

The Egg Donation Center of Dallas, Inc.

EDCD OVUM DONOR APPLICATION

Before you begin filling out this application to be an egg donor, please take the time to read over the following donor requirements to ensure that you meet ALL of them. Please do not apply until you DO meet all. Thank you.

REQUIREMENTS FOR DONORS

EDCD is an equal opportunity agency. We accept applications from persons of any racial and ethnic background, marital status, religious affiliation and geographical location.

You must not have had a tattoo or Chlamydia infection within the previous 12 months of undergoing a donation cycle. If you ALREADY HAVE a tattoo, that is fine. You just need to make sure that it will be at least 12 months from the time you got your tattoo, or from being treated and cleared from a Chlamydia infection until your actual donation cycle. (It does **not need to be 12 months until you **apply** to be a donor.)**

1. You must be willing and able to travel to a major city in Texas, Oklahoma, Arkansas, Kansas, Missouri, or New Mexico. (This would most likely be Dallas, Houston, San Antonio, Austin, Tulsa, Oklahoma City, Kansas City, St. Louis or Little Rock.) The first time would be for 1 day, for medical and psychological evaluation. The second time would be for 1 day, for a repeat medical exam just before retrieval, and the third time would be for approximately **4-5 days**, for egg retrieval. The rest of the time, you could be monitored locally, right where you live, by a reproductive endocrinologist. All travel expenses are paid for by the recipient couple that selects you.
2. You must be between 19-29 years old.
3. You must NOT be adopted. (If you are adopted, and have full medical records of both your biological parents, your application will be reviewed for acceptance.)
4. You must NOT be a smoker. (Your nicotine levels will be tested.)
You must NEVER smoke ANYTHING: cigarettes, cigars or anything else. Even with one puff, the eggs will be severely hurt for over 60 days. A donor, who would otherwise make 20 good eggs, will make only 6, and they will be of such poor quality that they won't fertilize. This "bad" medical record will follow you and **no one will ever pick you as a donor again!! It is just unbelievable, but nicotine really does that much damage!! If you can't quit, don't waste someone else's time and money, don't apply.**
5. You must not be more than 30 lbs. over your ideal weight. **Please do not apply if your BMI (body mass index) is 27 or higher.** A BMI chart is on the next page for your convenience and reference.
6. You must be in good health.
7. Your **SAT score must be 1100 or higher** or your **ACT score must be 24 or higher BEFORE MARCH 2005. AFTER MARCH 2005**, your scores of **Math** and **Critical Reading** (previously called Verbal) will **need to total 1100 or higher.** We do not need the total of all 3 sections in the new test. We only need the total of math and critical reading. (Very important, **must provide OFFICIAL DOCUMENTATION.** If you did not take the SAT or ACT, we need your **college G.P.A., grade point average.**) **OFFICIAL, written documentation of your scores from your school registrar is required.** (You can also easily get a copy of your scores from this address: <http://www.collegeboard.com/sat/html/students/oldsrbl.html>.) If you did not take either test, you must enclose an **OFFICIAL** copy of your college transcript, with a GPA (grade point average) of at least **3.0 on a 4.0 scale.** If you are **on a 5.0 scale, you must have at least a 3.75.**
8. You must be willing to avoid alcohol and caffeine during stimulation.
9. You must not use recreational drugs such as marijuana, cocaine, amphetamines or "downers". (You will be drug tested.) **If you use recreational drugs, don't waste someone else's time and money, don't apply.**
10. You must not use intravenous drugs now, or at any time in the past.
11. You must be willing to undergo medical and psychological screening. (This includes an HIV test and perhaps an I.Q. test.)
12. You must be willing to take daily injections (using tiny insulin needles), have frequent blood tests, sonograms and be available to go to a designated office for morning appointments at designated times.
13. If you have a fear of needles or of having blood drawn, egg donation is **NOT** for you!
14. You must be willing to give "Informed Consent" for the oocyte procedure, IV sedation and medication (such as antibiotics), and perhaps a Foley catheter.
15. You must not have a sexually transmitted disease including but not limited to gonorrhea, syphilis, genital herpes, vaginal warts, Chlamydia or HIV. FDA regulations require that it must be at least **12 months from the time you were treated and cleared from a Chlamydia infection until your actual donation cycle. (It does not need to be 12 months until you apply to be a donor.)**
16. You must not have had any sexual contact with homosexual or bisexual men at this time, or at any time in the past.
17. You must be willing to abstain from sexual intercourse for a period of approximately 2-3 weeks during treatment.
18. You must be willing to refrain from exercise for 2-4 weeks, perhaps up to 8 weeks, depending on your physician's directions.
19. You must be willing to take birth control pills for approximately 4-6-8 weeks **before** the stimulation begins.
20. It is acceptable to be on birth control pills at this time; however, you may **NOT** use birth control pills **during the actual stimulation period**, and must be willing to prevent pregnancy with another method (i.e. condoms, sponge, vaginal creams) on the cycle **PRIOR** to stimulation.
21. You must not currently have a Norplant birth control device. You must not have had a Norplant device removed within the last twelve months.
22. You must not have taken Depo birth control injections within the last nine months.
23. You must have your own transportation.
24. You must have early mornings available for doctor appointments for about two weeks.
25. You **MUST** be responsible and very dependable. You **MUST** be able to make all of your doctor appointments. This is critical
26. International donors need not apply unless you can pay for your own transportation to and from the United States.
27. **Per the FDA**, you must not have been born in or lived in any of these African countries since 1977: Cameroon, Central African Republic, Chad, Congo, Equatorial Guinea, Gabon, Niger or Nigeria. If you have, please do not apply.
28. **Per the FDA**, you must not have lived in Europe **five years or more cumulatively** from 1980 until the present. Europe includes: Albania, Austria, Belgium, Bosnia-Herzegovina, Bulgaria, Croatia, Czech Republic, Denmark, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Liechtenstein, Luxembourg, Macedonia, Netherlands, Norway, Poland, Portugal, Romania, Slovak Republic, Slovenia, Spain, Sweden, Switzerland, United Kingdom, and Yugoslavia. If you have, please do not apply.
29. It serves you well to be ***extremely polite to the nursing staff and to be on-time for your appointments.*** If the nurses are disappointed in your behavior (if they perceive you as being demanding, irresponsible or irritable), this bad report will be in your medical record. ***It will follow you wherever you go and future professionals will refuse to work with you!***

Determining Your Body Mass Index (BMI)

The chart below will help you determine your BMI. To use the table, find the appropriate height in the left-hand column. Move across the row to the given weight. **The number at the top of the column is the BMI for that height and weight. To apply, your BMI must not be above 27. Thank you.**

BMI (kg/m ²)	19	20	21	22	23	24	25	26	27 Upper Limit	28	29	30	35	40
Height (in.)	Weight (lb.)													
58 (4'10")	91	96	100	105	110	115	119	124	129	134	138	143	167	191
59 (4'11")	94	99	104	109	114	119	124	128	133	138	143	148	173	198
60 (5'0")	97	102	107	112	118	123	128	133	138	143	148	153	179	204
61 (5'1")	100	106	111	116	122	127	132	137	143	148	153	158	185	211
62 (5'2")	104	109	115	120	126	131	136	142	147	153	158	164	191	218
63 (5'3")	107	113	118	124	130	135	141	146	152	158	163	169	197	225
64 (5'4")	110	116	122	128	134	140	145	151	157	163	169	174	204	232
65 (5'5")	114	120	126	132	138	144	150	156	162	168	174	180	210	240
66 (5'6")	118	124	130	136	142	148	155	161	167	173	179	186	216	247
67 (5'7")	121	127	134	140	146	153	159	166	172	178	185	191	223	255
68 (5'8")	125	131	138	144	151	158	164	171	177	184	190	197	230	262
69 (5'9")	128	135	142	149	155	162	169	176	182	189	196	203	236	270
70 (5'10")	132	139	146	153	160	167	174	181	188	195	202	207	243	278
71 (5'11")	136	143	150	157	165	172	179	186	193	200	208	215	250	286
72 (6'0")	140	147	154	162	169	177	184	191	199	206	213	221	258	294
73 (6'1")	144	151	159	166	174	182	189	197	204	212	219	227	265	302
74 (6'2")	148	155	163	171	179	186	194	202	210	218	225	233	272	311
75 (6'3")	152	160	168	176	184	192	200	208	216	224	232	240	279	319
76 (6'4")	156	164	172	180	189	197	205	213	221	230	238	246	287	328

Body weight in pounds according to height and body mass index.

Please do not apply if your BMI (body mass index) is 27 or higher.

EDCD OVUM DONOR APPLICATION

All questions below must be answered. **Please print out this application and fill in BY HAND, NOT TYPING, USING BLACK INK ONLY.** Do not use blue or red ink or pencil. **DO NOT LEAVE ANY SPACES BLANK!** If the answer is none, or not applicable, state "N/A". Return it with **3 photos**, a copy of your driver's license and medical insurance card, if you have one. **Falsifying any part of this application constitutes a material breach of the Agreement you sign with EDCD and is grounds for termination of the Agreement.**

Date of application ____/____/____

GENERAL INFORMATION

1. Last name _____ First name _____ Middle name _____

Maiden name _____

2. Marital Status : () Married () Single () Divorced () Separated () Living Together () Widowed

3. Address: street address _____

City/State/Zip Code _____
City State Zip Code

4. Email address _____ is this email address private? Yes _____ No _____

Second email address _____ Is this email address private? Yes _____ No _____

5. Home Phone: (____) _____ May we call you at home? Yes _____ No _____

Is it ok to leave a message? Yes _____ No _____

6. Cell Phone :(____) _____ 7. Pager (____) _____

8. Age: _____ 9. Date of birth: ____/____/____

10. Social Security Number _____ - _____ - _____ 11. Occupation: _____

12. Work phone :(____) _____ 13. May we call you at work? Yes _____ No _____

14. Employer: _____

15. Employer Address: _____
Street address City State Zip Code

16. Husband's Name (if applicable): Last _____ First _____ Middle _____

17. Husband's Occupation: _____ 18. Husband's Work Phone :(____) _____

19. Employer: _____

20. Employer's Address: _____

21. Date(s) of all marriage(s): _____

22. Date(s) of all divorce(s): _____

23. City, County, State of all divorce(s): _____

24. Have you been an egg donor before? Yes _____ No _____

If yes, when, with which physician, how many times and did a pregnancy result? _____

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25. How did you hear about us? _____ School paper? _____ Which one? _____ Where? _____

26. Do you have your own transportation? Yes _____ No _____

27. Do you have a credit card? ____ If not, please get a credit card (for traveling), not a debit card.

28. Do you have early mornings available for 2-3 weeks for doctor appointments? **Yes** _____ **No** _____

29. If not, are you willing/able to use your vacation time for these appointments and/or egg retrieval? **Yes** _____ **No** _____

30. Are you willing to travel? _____ Travel (if necessary) would be for 2-3 trips, and within the states of Texas, Oklahoma, Missouri, Arkansas or New Mexico. The first time would be for 1 day, for medical and psychological evaluation. The second time would be for 1 day, for a repeat medical exam just before retrieval, and the third time would be for approximately **4-5 days**, for egg retrieval. You must have a traveling companion go with you to egg retrieval. The couple that selects you will pay for all travel costs.

To be a traveling donor, you must be monitored with early morning (8:00-9:00am) doctor appointments. Would you like these appointments near your home or place of work? **MUST CHOOSE ONE:** Home _____ Work _____

31. Some applicants move several times. We find it helpful to know a PERMANENT address (such as that of your parents) to help locate you in the event you are lost and are chosen by a recipient couple. Be assured that EDCD is very discreet and will protect your privacy.

32. **Do your parents know that you want to be an egg donor?** Yes _____ No _____

33. **Do you intend to tell them?** Yes _____ No _____

34. Ms Donor c/o Mr. & Mrs. Parents

Street address

City state zip code

(_____) _____
Parent's phone number

PERSONAL INFORMATION

Date of application ____/____/____

Please circle or write in the correct answer.

35. Religion: Christian, Jewish, Buddhist, Islamic, Hindu, Other _____

36. Race: Caucasian, Native American (American Indian), Hispanic/Latino, African or African American, Asian/Oriental, Eastern Indian-Pakistani, Other _____

37. Primary Language _____ 38. Secondary Language _____

39. Height: _____ 40. Weight: _____ BMI as calculated in chart above _____ 41. Age: _____
(Must be 27 or below)

42. Eye Color: Blue, Green, Hazel, Brown

43. Natural Hair Color: Blonde, Brown, Brunette/Black, Red

44. Natural Hair Texture: Straight, Wavy, Curly

45. Complexion: Light, Medium, Dark

46. I believe my blood type is:
A _____ B _____ O _____ AB _____
Rh- (Negative) _____ Rh+ (Positive) _____

47. Maternal Ethnic Ancestry: _____ / _____ / _____
(NOTE: GIVE SPECIFIC COUNTRY, NOT JUST "CAUCASIAN" OR "WHITE")

Each parent may have multiple countries, if it applies to them.

CHOICES: English, French, German, Italian, Irish, Scottish, Welsh, European Spanish, Swedish, Finnish, Norwegian, Danish, Dutch, Polish, Native American (American Indian), Hispanic-Latin American, African or African American, Chinese, Japanese, Korean, Philippine, Vietnamese, Taiwanese, East Indian-Pakistani, Middle Eastern, Austrian, Canadian, Russian, OTHER _____

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48. Paternal Ethnic Ancestry: _____ / _____ / _____
(NOTE: GIVE SPECIFIC COUNTRY, NOT JUST "CAUCASIAN" OR "WHITE")

Each parent may have multiple countries, if it applies to them.

CHOICES: English, French, German, Italian, Irish, Scottish, Welsh, European Spanish, Swedish, Finnish, Norwegian, Danish, Dutch, Polish, Native American (American Indian), Hispanic-Latin American, African (or African American), Chinese, Japanese, Korean, Philippine, Vietnamese, Taiwanese, East Indian-Pakistani, Middle Eastern, Austrian, Canadian, Russian, OTHER _____

49. Location: You are closest to which major city:

Albuquerque, N. Mex.	Miami, FL
Austin	Midland/Odessa
Baton Rouge	New Orleans
Birmingham, Alabama	New York, NY
College Station	Oklahoma City
Corpus Christi	Orlando, FL
Dallas	San Antonio
Fort Worth	San Diego, CA
El Paso	Shreveport
Houston	St Louis, MO
Kansas City, MO	Tampa, Florida
Little Rock	Temple, Texas
Lubbock	Tulsa

OTHER _____

50. Approximately how many miles is it from where you live to this city?
 0-20 miles (for those who live in the cities above)
 21-50 miles
 51-75 miles
 76-100 miles
 OTHER _____ miles

EDUCATIONAL HISTORY

51. Did you graduate from high school? _____ If so, what was your high school GPA? _____ If not, did you get a GED? _____

52. What is your college GPA? 2.5-4.0 _____
(Very important, must provide official documentation)

53. What is your college major? _____
 (Very important)

54. What is your SAT Score?

Before March 2005 :(800-1600) _____ (Two sections only: Math and Verbal.)

After March 2005:(800-2400): **Math**=____; **Critical Reading** (previously Verbal.)=____; **Total of these two**=_____

We do not need the total of all 3 sections, just the total of math and critical reading. **(Very important, must provide official documentation. If you did not take the SAT, we at least need your college G.P.A., grade point average.)**

55. What is your ACT Score? 20-35 _____
(Very important, must provide official documentation. If you did not take the ACT, we at least need your college G.P.A., grade point average.)

56. Please complete the following chart

FAMILY EDUCATIONAL/CAREER HISTORY:

	Highest Level of Education/Degree	Career/Talents
Yourself		
Mother		
Father		
Sibling M/F		
Sibling M/F		
Sibling M/F		
MGM Maternal Grandmother		
MGF Maternal Grandfather		
PGM Paternal Grandmother		
PGF Paternal Grandfather		

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Due to the nature of egg donation, where human products are taken from one person and placed in another, the FDA (Food and Drug Administration) requires us to ask some very personal questions. We apologize for this necessary intrusion into your privacy.

75. Do you or have you ever injected any illegal drugs? Yes _____ No _____

If yes, please describe _____

76. Have you ever had a blood transfusion? Yes _____ No _____

If yes, please explain. _____

77. Do you have a clotting disorder for which you have received human-derived clotting factor concentrate?

Yes _____ No _____

If yes, please explain. _____

78. Have you ever been the recipient of a human organ, human tissue transplant or human extract, or organs or cells from non-human sources? Yes _____ No _____

If yes, please explain. _____

79. Have you ever received growth hormone made from human pituitary glands? Yes _____ No _____

If yes, please explain. _____

80. Have you ever received a dura mater (brain covering) graft? Yes _____ No _____

If yes, please explain. _____

81. Have you ever had intimate contact (exchanged body fluids including sharing toothbrush, razors) with someone who has been the recipient of a human organ, human tissue transplant, human extract, or organs or cells from non-human sources?

Yes _____ No _____

If yes, please explain. _____

82. In the past 12 months, have you been in jail for more than 3 days in a row? Yes _____ No _____

If yes, please describe _____

83. Have you had a sexually transmitted disease within the preceding 12 months, such as gonorrhea, syphilis, PID (pelvic inflammatory disease), HPV (human papilloma virus), HSV (herpes simplex virus), genital warts, Hepatitis B, Hepatitis C or chlamydia? Yes _____ No _____

If yes, please explain _____

84. After the age of 11 have you ever had viral hepatitis [except for Hepatitis A, Epstein-Barr (EBV), or cytomegalovirus (CMV)]?

Yes _____ No _____ If yes, please explain _____

85. Are you or your partner at risk for having HIV? Yes _____ No _____ Unsure _____

If yes or unsure, please explain _____

86. Have you had sex for drugs or money or have you given anyone drugs or money to have sex with you in the past 5 years?

Yes _____ No _____

If yes, please explain. _____

87. In the past 12 months, have you had sex with anyone who would answer "yes" to the above questions 75-86?

Yes _____ No _____ If yes, please explain. _____

88. In the past 12 months, have you had sex with a man who has had sex with another man in the past 5 years?

Yes _____ No _____ If yes please explain _____

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89. In the past 12 months, have you lived with or had sex with a person known or suspected to have HIV, or active hepatitis B or hepatic C? Yes _____ No _____ If yes, please explain. _____

90. Have you ever had an accidental needle stick, sharp instrument injury or contact with human blood serum or plasma in any of these areas of your body: in the eye, mucus membranes (lips, interior of nose, mouth) or sores? Yes _____ No _____
If yes, please explain. _____

91. In the past 12 months, have you been exposed to known or suspected HIV, hepatitis B, and/or hepatitis C infected blood through percutaneous inoculation, contact with an open wound, non-intact skin, or mucus membrane? Yes _____ No _____
If yes, please explain. _____

92. In the past 12 months, have you been in close contact (i.e. sharing kitchen and bathroom) with a person having active viral hepatitis? Yes _____ No _____
If yes, please explain. _____

93. In the past 3 years (or since 2002) have you been outside the United States or Canada? Yes _____ No _____
If yes, where and **what were the approximate arrival and departure dates?** _____

94. Since 1980, have you ever lived in or traveled to Europe? (*Europe includes: United Kingdom, England, Ireland, Scotland, Wales, the Isle of Man, the Channel Islands, Gibraltar, the Falkland Islands, Albania, Austria, Belgium, Bosnia-Herzegovina, Bulgaria, Croatia, Czech Republic, Denmark, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Liechtenstein, Luxembourg, Macedonia, Netherlands, Norway, Poland, Portugal, Romania, Slovak Republic, Slovenia, Spain, Sweden, Switzerland and Yugoslavia.*) Yes _____ No _____
If yes, where and **what were the approximate arrival and departure dates?** _____

95. Between 1980 and 1996 did you spend time that adds up to 3 months or longer in the UK? (The United Kingdom includes England, Scotland, Wales and Ireland.) Yes _____ No _____

96. Since 1980 until now, have you received a transfusion of blood, platelets, plasma, cryoprecipitate, or granulocytes in the UK or France? Yes _____ No _____

97. Since 1980 until now, have you spent time that adds up to **5 years or more in Europe** (including time spent in the UK between 1980 and 1996)? (*Europe includes: United Kingdom, England, Ireland, Scotland, Wales, the Isle of Man, the Channel Islands, Gibraltar, the Falkland Islands, Albania, Austria, Belgium, Bosnia-Herzegovina, Bulgaria, Croatia, Czech Republic, Denmark, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Liechtenstein, Luxembourg, Macedonia, Netherlands, Norway, Poland, Portugal, Romania, Slovak Republic, Slovenia, Spain, Sweden, Switzerland and Yugoslavia.*) Yes _____ No _____

98. From **1980** through **1990**, were you a member of the US military, a civilian military employee or a dependent of a member of the US military? Yes _____ No _____
If yes, Did you spend a total time of 6 months or more associated with a military base in any of the following countries: **Belgium, The Netherlands or Germany?** Yes _____ No _____ N/A _____

99. From 1980 through **1996**, were you a member of the US military, a civilian military employee or a dependent of a member of the US military? Yes _____ No _____
If yes, Did you spend a total time of 6 months or more associated with a military base in any of the following countries: **Belgium, The Netherlands, Germany, Spain, Portugal, Turkey, Italy or Greece?** Yes _____ No _____ N/A _____

100. Have you been in a place affected by SARS (Severe Acute Respiratory Syndrome)? SARS is an illness first reported in China, Hong Kong and Vietnam and Singapore. Yes _____ No _____
If yes, when and where? _____ N/A _____

101. Were you born in or have you lived in any of the following African countries since 1977: Cameroon, Central African Republic, Chad, Congo, Equatorial Guinea, Gabon, Niger or Nigeria? Yes _____ No _____ If yes, which country? _____ N/A _____

102. Have you traveled to any African country since 1977? Yes _____ No _____
If yes, which country? _____ N/A _____
If yes, when you traveled to this African country, did you receive a blood transfusion or any other medical treatment with a product made from blood? Yes _____ No _____ N/A _____

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103. Have you had sexual contact with anyone who was born in or lived in any of the following African countries since 1977: Cameroon, Central African Republic, Chad, Congo, Equatorial Guinea, Gabon, Niger or Nigeria? Yes _____ No _____
 If yes, which country? _____ N/A _____

104. Have any of your blood relatives ever had Creutzfeldt-Jacob disease (CJD)? Yes _____ No _____
 If yes, have you had the genetic test for CDJ? Yes _____ No _____ N/A _____
 If yes, what was the result? N/A _____

105. Have you had a recent small pox vaccination? Yes _____ No _____
 If yes, did the scab fall off by itself? Yes _____ No _____ N/A _____

106. If you have had a recent small pox vaccination, have you had any illness or complication from it?
 Yes _____ No _____ N/A _____
 If yes, please explain. _____

107. Have you had close contact with the **small pox vaccination SITE** of anyone else? (*Example of close contact: touching the site, touching the bandages covering the site, handling bedding or clothing that has been in contact with an unbandaged vaccination site.*) Yes _____ No _____
 If yes, have you had any new rash, sore, illness or complication since this contact? Yes _____ No _____ N/A _____
 If yes, please explain. N/A _____

108. Age when periods began _____ 109. Number of days in cycle _____

109. Are your periods always regular? Yes _____ No _____ 110. How many days does your period last? _____

111. Have you ever been on birth control pills? Yes _____ No _____ If yes, which one? _____
 If yes, how long were you/have you been on these birth control pills? _____

112. What form of birth control do you use? _____ Would you be willing to change or temporarily stop? Yes _____ No _____

113. Have you ever used Depo for birth control? Yes _____ No _____ If so, when was your last shot? _____

114. What was the date of your past menstrual period? _____

115. Number of pregnancies _____ 116. Dates of pregnancies _____

117. Number of abortions _____ 118. Dates of abortions _____

119. Number of miscarriages _____ 120. Dates of miscarriages _____

121. Please complete the following chart for any children you have had:

Child	Age	Sex	Health Problem	Treatment(s) for Problem	Treatment Effective?

122. Did any of your pregnancies take longer than 6 months to achieve? Yes _____ No _____
 If yes, please explain. _____

123. Did your mother take diethylstilbestrol (DES) or any prescription drug while she was pregnant with you?
 Yes _____ No _____ If yes, please explain _____

124. Were you adopted? Yes _____ No _____ 125. Were either of your parents adopted? Yes _____ No _____
 If yes, complete the following chart:

Adopted Parent	Age	Health Problem(s)	Treatment for Problem(s)	Treatment Effective?

126. Were you or anyone in your family born with any birth defects (cleft palate, or cleft lip, heart defect or club foot)?
 Yes _____ No _____ If yes, please explain. _____

127. Please list any other illnesses, surgeries, medical conditions, problems or hospitalizations you have had, but not already mentioned. Please include the dates of any treatment. _____

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For questions 128-141, if there are any conditions checked or marked in the charts, we need 3 bits of information for each check:

1. the **age** of onset of symptom or **age** of diagnosis
2. the **treatment given** (surgery, name of drug, etc.)
3. did the treatment cure the problem? How well **did the treatment work? (results of treatment)**

128. Carefully read the following chart and **check** the appropriate box if you or any family member has ever had any of the following conditions:

NEUROLOGICAL

	You	Mother	Father	Sibling(s)	MGM maternal grandmother	MGF maternal grandfather	PGM paternal grandmother	PGF paternal grandfather
Stroke								
Epilepsy								
Seizure Disorder								
Cerebral Palsy								
Multiple Sclerosis								
Alzheimer's disease								
Premature Senility (<i>before 60</i>)								
Parkinson's disease								
Migraines								
Mental Retardation								
Hydrocephalus (water on brain)								
Change in cognition (awareness), speech or gait (walk)								
Transmissible Spongiform Encephalopathy (TSE)								
Creutzfeldt-Jacob Disease (CJD) (spongiform encephalopathy)								
Huntington's Chorea								
Spina Bifida								
Myotonic Dystrophy								
Tuberous Sclerosis								
Acute Intermittent Phorphyria								
Wilson's Disease								
Charcot-Marie Tooth Disease								
Periodic Paralysis								
Friedreich's Ataxia								
Canavan Disease								
Riley-Day Syndrome (Familial Dysautonomia)								
Angelman's Syndrome								
Brain Aneurysm								

If you checked **any** boxes in the above NEUROLOGICAL conditions, please explain EACH BOX CHECKED with three bits of information: the **age** of onset of symptom or **age** of diagnosis, the **treatment given** (surgery, name of drug, etc.), AND **if the treatment cured the problem-how well did the treatment work?**

129. Carefully read the following chart and **check** the appropriate box if you or any family member has ever had any of the following conditions:

CARDIOVASCULAR

	You	Mother	Father	Sibling(s)	MGM	MGF	PGM	PGF
Heart Defects								
Heart Surgery								
Ventricular Septal Defect								
Atrial Septal Defect								
Noonan's Syndrome								
Idiopathic Hypertrophic Subaortic Stenosis (IHSS)								
Holt-Oram Syndrome								
Myocardial Infarction (heart attack)								
Coronary Artery Disease (heart disease)								
High Blood Pressure								
Heart Failure								
Heart Block								

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If you checked **any** boxes in the above CARDIOVASCULAR conditions, please explain EACH BOX CHECKED with three bits of information: the **age of onset of symptom or age of diagnosis**, the **treatment given** (surgery, name of drug, etc.), AND **if the treatment cured the problem-how well did the treatment work?**

130. Carefully read the following chart and **check** the appropriate box if you or any family member has ever had any of the following conditions:

REPRODUCTIVE

	You	Mother	Father	Sibling(s)	MGM	MGF	PGM	PGF
Miscarriage								
Recurrent Miscarriage								
Condition of only one (1) ovary								
Premature Ovarian Failure								
Polycystic Ovaries								
Ovarian Cancer								
Cervical Cancer								
Cervical Dysplasia								
Endometrial Cancer								
Vaginal Cancer								
Endometriosis								
Ovarian Cysts								
Uterine Fibroids								
Breast Cancer								
Hypospadiasis								
Prostate Cancer								
Undescended Testicle								
Testicular Cancer								

If you checked **any** boxes in the above REPRODUCTIVE conditions, please explain EACH BOX CHECKED with three bits of information: the **age of onset of symptom or age of diagnosis**, the **treatment given** (surgery, name of drug, etc.), AND **if the treatment cured the problem-how well did the treatment work?**

131 Carefully read the following chart and **check** the appropriate box if you or any family member has ever had any of the following conditions:

MENTAL/PSYCHE

	You	Mother	Father	Sibling(s)	MGM	MGF	PGM	PGF
Depression								
Manic Depression (bipolar)								
Schizophrenia								
Anxiety								
Drug/Alcohol Abuse/Addiction								
Anorexia/Bulimia (eating disorder)								
Any Psychological Problem								
Attention Deficit Disorder (ADD)								
Attention Deficit Hyperactivity Disorder (ADHD)								
Dyslexia								
Psychosis								
Neurosis								
Seizure Disorder								
Autism								
Epilepsy								
PMDD (premenstrual dysphoric disorder)								

If you checked **any** boxes in the above MENTAL/PSYCHE conditions, please explain EACH BOX CHECKED with three bits of information: the **age of onset of symptom or age of diagnosis**, the **treatment given** (surgery, name of drug, etc.), AND **if the treatment cured the problem-how well did the treatment work?**

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132 Carefully read the following chart and **check** the appropriate box if you or any family member has ever had any of the following conditions:

HEMATOLOGIC

	You	Mother	Father	Sibling(s)	MGM	MGF	PGM	PGF
Hemophilia								
Hemochromatosis								
von Willebrand's Disease								
Thalassemia								
Tay-Sachs								
Anemia (any kind)								
Sickle Cell Anemia								
Fanconi Anemia								
Leukemia (any kind)								
Hemorrhagic Telangiectasia								
Spherocytosis								
Immune Deficiency (any kind)								
Bleeding Disorder (any kind)								

If you checked **any** boxes in the above HEMATOLOGICAL conditions, please explain EACH BOX CHECKED with three bits of information: the **age** of onset of symptom or **age** of diagnosis, the **treatment given** (surgery, name of drug, etc.), AND **if the treatment cured the problem-how well did the treatment work?**

133. Carefully read the following chart and **check** the appropriate box if you or any family member has ever had any of the following conditions:

GASTROINTESTINAL

	You	Mother	Father	Sibling(s)	MGM	MGF	PGM	PGF
Ulcers								
Gastritis								
Gallstones								
Pancreatitis								
Pancreatic Cancer								
Liver Cirrhosis								
Hepatitis (any kind)								
Liver Cancer								
Gilbert's Disease								
Peutz-Jegher's Syndrome								
Gardner's Syndrome								
Familial polyposis								
Crohn's Disease								
Ulcerative Colitis								
Esophageal Cancer								
Intestinal or Colon Cancer								
Intestinal Lymphoma								
Stomach or Rectal Cancer								
Diverticulitis								

If you checked **any** boxes in the above GASTROINTESTINAL conditions, please explain EACH BOX CHECKED with three bits of information: the **age** of onset of symptom or **age** of diagnosis, the **treatment given** (surgery, name of drug, etc.), AND **if the treatment cured the problem-how well did the treatment work?**

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134. Carefully read the following chart and **check** the appropriate box if you or any family member has ever had any of the following conditions:

RESPIRATORY

	You	Mother	Father	Sibling(s)	MGM	MGF	PGM	PGF
Asthma								
Allergies								
Allergic Bronchitis								
Chronic Bronchitis								
Cystic Fibrosis								
Cystic Fibrosis Carrier? / Number of Egg Donations								
Emphysema								
Pneumocystis								
Tuberculosis								
Pneumonia								
Chronic Sinusitis								
Hereditary Angioneurotic Edema								
Lung Cancer								

If you checked **any** boxes in the above RESPIRATORY conditions, please explain EACH BOX CHECKED with three bits of information: **the age of onset of symptom or age of diagnosis**, **the treatment given** (surgery, name of drug, etc.), AND **if the treatment cured the problem-how well did the treatment work?**

135. Carefully read the following chart and **check** the appropriate box if you or any family member has ever had any of the following conditions:

ENDOCRINE

	You	Mother	Father	Sibling(s)	MGM	MGF	PGM	PGF
Hyperthyroidism								
Hypothyroidism								
Thyroiditis								
Medullary Thyroid Carcinoma-Pheochromocytoma Syndrome								
Goiter								
Familial hyperparathyroidism								
Multiple endocrine adenomatosis								
Diabetes Mellitus								
Hunter's Syndrome								
Hurler's Syndrome								
Dwarfism								
Pituitary Disorders								
Adrenal Disorders								
Phenylketonuria								
San Filippo Syndrome								
Scheie Syndrome								
Morquio Syndrome								
Maroteaux-Lamy Syndrome								
B-Glucuronidase Deficiency								

If you checked **any** boxes in the above ENDOCRINE conditions, please explain EACH BOX CHECKED with three bits of information: **the age of onset of symptom or age of diagnosis**, **the treatment given** (surgery, name of drug, etc.), AND **if the treatment cured the problem-how well did the treatment work?**

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136. Carefully read the following chart and **check** the appropriate box if you or any family member has ever had any of the following conditions:

METABOLIC

	You	Mother	Father	Sibling(s)	MGM	MGF	PGM	PGF
Phenylketonuria								
Maple Syrup Urine Disease								
Homocystinuria								
Tyrosinemia								
Glycogen Storage Disease								
Galactosemia								
Gaucher's Disease								
Neimann-Pick Disease, Type A or B								
Fabry's Disease								
Fatty Acid Oxidation Disorders								
Pyruvate Metabolism Disorders								
Mucopolidosis IV								

If you checked **any** boxes in the above METABOLIC conditions, please explain EACH BOX CHECKED with three bits of information: **the age of onset of symptom or age of diagnosis**, **the treatment given** (surgery, name of drug, etc.), AND **if the treatment cured the problem-how well did the treatment work?**

137. Carefully read the following chart and **check** the appropriate box if you or any family member has ever had any of the following conditions:

URINARY

	You	Mother	Father	Sibling(s)	MGM	MGF	PGM	PGF
Kidney Stones								
Polycystic Kidney Disease								
Alport's Syndrome								
Nail-patella Syndrome								
Nephrotic Syndrome								
Renal Failure								
Kidney Transplant								
Renal Tubular Acidosis								

If you checked **any** boxes in the above URINARY conditions, please explain EACH BOX CHECKED with three bits of information: **the age of onset of symptom or age of diagnosis**, **the treatment given** (surgery, name of drug, etc.), AND **if the treatment cured the problem-how well did the treatment work?**

138. Carefully read the following chart and **check** the appropriate box if you or any family member has ever had any of the following conditions:

SKIN

	You	Mother	Father	Sibling(s)	MGM	MGF	PGM	PGF
Teenage Acne								
Acne Vulgaris (deep scaring type)								
Albinism								
Skin Cancer: basal or squamous cell								
Melanoma (black mole cancer)								
Neurofibromatosis								
Psoriasis								
Basal-cell Nevus Syndrome								
Vitiligo (Pigmentation Disorders)								
Dermatitis								
Waardenburg Syndrome								

If you checked **any** boxes in the above SKIN conditions, please explain EACH BOX CHECKED with three bits of information: **the age of onset of symptom or age of diagnosis**, **the treatment given** (surgery, name of drug, etc.), AND **if the treatment cured the problem-how well did the treatment work?**

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139. Carefully read the following chart and **check** the appropriate box if you or any family member has ever had any of the following conditions:

BONES / MUSCLES / JOINTS / CONNECTIVE TISSUE

	You	Mother	Father	Sibling(s)	MGM	MGF	PGM	PGF
Arthritis (Osteoarthritis, wear and tear)								
Arthritis (Rheumatoid Arthritis, crippling)								
Lupus								
Osteogenesis Imperfecta								
Muscular Dystrophy								
Scoliosis (spinal curvature)								
Achondroplasia								
Marfan's Syndrome								
Ehlers-Danlos Syndrome								
Cutis Laxa								
Homocystinuria								
Gout								

If you checked **any** boxes in the above BONES/MUSCLES/JOINTS/CONNECTIVE TISSUE conditions, please explain EACH BOX CHECKED with three bits of information: **the age of onset of symptom or age of diagnosis, the treatment given (surgery, name of drug, etc.), AND if the treatment cured the problem-how well did the treatment work?**

140. Carefully read the following chart and **check** the appropriate box if you or any family member has ever had any of the following conditions:

OTHER

	You	Mother	Father	Sibling(s)	MGM	MGF	PGM	PGF
Eating Disorders								
Drug abuse								
Cancer (any kind)								
Lymphoma								
Non-Hodgkins Lymphoma								
Deafness								
Blindness								
Sudden Infant Death Syndrome								
Down's Syndrome								
Fragile X Syndrome								
Bloom Syndrome								
Prader-Willi Syndrome								
West Nile Virus								

If you checked **any** boxes in the above OTHER conditions, please explain EACH BOX CHECKED with three bits of information: **the age of onset of symptom or age of diagnosis, the treatment given (surgery, name of drug, etc.), AND if the treatment cured the problem-how well did the treatment work?**

141. Carefully read the following chart and **check** the appropriate box if you or any family member had any of the following defects at birth or within the first year of life:

BIRTH AND FIRST YEAR OF LIFE DEFECTS

	Family Member	Treatment
Brain, spinal cord		
Hydrocephalus		
Heart/circulation		
Neuro/sensory		
Missing limbs/digits		
Stomach/intestines		
Disorders of metabolism		
Disorders of immunology		
Genital/urinary system		
Respiratory		

If you checked **any** boxes in the above BIRTH AND FIRST YEAR OF LIFE DEFECTS conditions, please explain EACH BOX CHECKED with three bits of information: **the age of onset of symptom or age of diagnosis, the treatment given (surgery, name of drug, etc.), AND if the treatment cured the problem-how well did the treatment work?**

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142. Please check all that apply. I am:

- An extrovert _____
- An introvert _____
- Musically inclined _____
- Vocally Gifted _____
- Artistic _____
- Athletic _____

If you checked any above, please explain. _____

143. What are your career goals? _____

144. Describe your personality, talents, and special interests. _____

145. What are your reasons for wanting to become an egg donor? _____

146. Can you share the "positives" in your life right now? _____

147. Can you share the stressors or "negatives" in your life right now? _____

148. Will you share your potential egg donation with your family, friends or significant other?
Yes _____ Who? _____ No _____

149. Who is the most supportive person in your life? _____

150. If you would like to say something to either the couple that has selected you or to the child you may help them with, please do so.

I, the undersigned, declare **under penalty of perjury** pursuant to the applicable state law that the above statements are true, accurate, and complete.

Signature of Donor

Date

Print Name: _____
(Donor)

Address: _____

Signature of Donor's spouse
(If applicable)

Date

Print Name: _____
(SPOUSE, IF APPLICABLE)

Address: _____

REMEMBER TO ENCLOSE AT LEAST 3 PHOTOGRAPHS OF YOURSELF. WE WILL RETURN THEM UPON REQUEST, UNHARMED. ALSO, REMEMBER TO ENCLOSE A COPY OF YOUR SAT/ACT SCORES FROM YOUR SCHOOL REGISTRAR.

Return to:
EDCD
1720 Avenue K
Plano, Texas 75074