Northeastern Ohio Fertility Center
Egg Donation Facilitation Agency
www.drspirtos.com
468 East Market St
Akron, OH 44304
(330)376-2300 Fax (330) 376-4807
neofc@sbcglobal.net

Egg Donor Application

Date of Application ______________________

Note: This first page is for office use only and will not be released to the prospective parents.
Your confidentiality is extremely important to us.

First Name ______ Last Name ______ Middle Initial ______

Maiden name or any other names used ______

Date of birth ______ last 4 digits of Social Security # ______

Address ______

Cell phone ______ May we leave messages at this number? ______

Alternative Phone ______ May we leave messages at this number? ______

Email ______

Marital Status single married separated divorced partner widow

Partner's Full name, if applicable ______

Emergency Contact name: ______ Phone # ______

Relationshiop to you? ______

Do you have a means of transportaion for office visits? Yes No Do you have Medical Insurance? Yes No

Are you adopted? Yes No If yes, do you have information regarding your biological family? Yes No

Under penalty of perjury, I attest that all of the information I have provided in my application is true, to the best of my knowledge. I understand that this is the initial step in egg donation and that I will be contacted if and when I am chosen as a donor for further information. I understand that I will be contacted annually to confirm my continued interest and update any of my profile information. I understand that, if at any time, I choose to retract my application, I may do so, as long as I am not under a current contract.

Signature: ______ Date: ______

EGG DONOR PROFILE

	Yourself	Sibling	Sibling	Your mother	Your Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandfather	Paternal Grandmother	notes
Month and Year of Birth										
Height										
Weight										
Eye Color										
Hair Color										
Hair Texture (Straight / Curly)										
Skin Tone: Fair, Light, Med, Dark, Other										
Race: Caucasion, Hispanic , African American etc										
Ethnicity: German, Italian, Irish, etc										
Past or present Smoker?										
College degree?										
Number of siblings?										
Personality: Quiet, Outgoing, Bold										
Geneneral Health Poor, Good, or Excellent										
Age at death										
Cause of death (if applicable)										

Measurements: Bust Waist Hips

Marital Status: single married separated divorced partner widow

Have you ever been pregnant? Yes No Do you have children? Yes No

Child 1: Male Female Year of birth? Child 2: Male Female Year of birth?

Have you ever experienced any pregnancy complications? Yes No Describe:

Has anyone in your family given birth to twins? Elaborate:

Have you ever had an abortion? Yes No If yes, Dates?

Education

What is the highest level of education? Degree? From:

Outstanding Achievements:

Extracurricular activities:

Current Occupation:

Previous Occupations:

Personal Information:

Do you prefer anonymous donation?	Yes	No
Are you willing to meet or talk with prospective parents?	Yes	No
Are you willing to donate to same sex couples?	Yes	No
Are you willing to donate to a single prospective parent?	Yes	No
Are your family / friends supportive of your decision?	Yes	No
Have you smoked in the past? Quit date:	Yes	No
Do you use illegal drugs?	Yes	No
Have you ever been treated for drug or alcohol abuse?	Yes	No

Describe your personality:

Why have you decided to undergo egg donation?

What are your special interests/hobbies/talents?

Did you participate in High School Extracurricular activities? (sports, clubs etc)

Favorite Color? Favorite type of food? Favorite type of music?

Favorite Movie? Favorite Book?

Is there anything else you would like to tell the prospective parents?

Medical History

At what age did menses begin?

What is the average length of your menstrual cycle? (normal is 28 days)

How long does your menstrual cycle flow typically last?

Do you experience PMS related symptoms? Explain:

Are you currently taking birth control? Yes No If yes, what type?

Have you ever had an abnormal PAP smear? Yes No When?

How was it treated?

Have you ever tested positive for and Sexually Transmitted Disease? Yes No When?

How was it treated?

Please list all medication you are currently taking, icluding prescription, vitamins, or herbal remedies etc.

Name	Dosage	How often?	Why?
Name	Dosage	How often?	Why?
Name	Dosage	How often?	Why?

Have you ever been under the treatment of a pshchologist or psychiatrist? When?

Why?

Please list any surgeries or hospitalizations and the dates they occurred:

Have you ever been screened for the Cystic Fibrosis Gene? Tay-Sach's?

SMA? Sickle Cell Anemia?

How often do you exercise?

How do you exercise?

<table>
<tr><td colspan="3">Have you donated eggs with a different facility? Yes NO If Yes, Where?</td></tr>
<tr><td>When:</td><td>How many eggs were retrieved?</td><td>Did recipient achieve pregnancy?</td></tr>
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</table>

Medical History

	Yourself	Sibling	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunt / Uncle / Cousin
ADD, ADHD, OCD									
Adrenal Dysfunction									
Alcoholism									
Allergies									
Alzheimers Disease									
Anemia									
Arthritis									
Asthma									
Bipolar Disorder									
Bleeding Disorders									
Blindness									
Cerebal Palsy									
Cirrhosis									
Cleft lip/palate									
Club Foot									
Color Blindness									
Crohn's Disease									
Cystic Fibrosis									
Deafness by age 60									
Death of Newborn									
Depression									
Diabetes									
Down Syndrome									
Drug Addiction									
Dwarfism									
Eczema									
Emphysema									
Endometriosis									
Epilepsy / Seizures									
Gall Stones									
Glasses or contacts									
Goiter									
Gout									
Heart Attack									
Heart Disease									
Hemophilia									
Hepatitis (A, B, C)									
High Blood Pressure									
High Cholesterol									
HIV									
Huntington's Disease									
Kidney Disease									

	Yourself	Sibling	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunt / Uncle / Cousin
Kleinfelter Syndrome									
Lupus									
Male Pattern Baldness									
Mental Retardation									
Miscarriages (2+)									
Migraines									
Multiple Sclerosis									
Muscular Dystrophy									
Myasthenia Gravis									
Neonatal Jaundice									
Neurofibromatosis									
Osteoporosis									
Ovarian Cysts									
Paraplegia									
Parkinson's Disease									
Pigmentation Disorder									
Pneumonia									
Psychotic Disorder									
Pyloric Stenosis									
Rectal Disorder									
Scoliosis									
Spina Bifida									
Stillborn									
Stroke									
Thyroid Disease									
Tourette's Syndrome									
Tuberculosis									
Turner Syndrome									
Ulcer									
Urinary Tract Disease									
Uterine Fibroids									
Wilson's Disease									
Cancer									

Please specify: Breast, Colon, Thyroid etc

Other - Please list any other medical condition.