UNIVERSITY OF CONNECTICUT HEALTH CENTER

CENTER FOR ADVANCED REPRODUCTIVE SERVICES

ANONYMOUS EGG DONOR PROGRAM

Donor Family History Screening Form

To become an egg donor at The Center, we need to learn some information about your personal and medical history. Your responses to these questions will help us to make sure that your health and genetic make-up are compatible with the egg donation process, and that being an egg donor will not involve any special risks for you. This effort will also help us to match you to an appropriate recipient.

Please provide complete and accurate information to these questions. If you don't know the answer, ask a parent or family member. Any information you provide during the egg donation process, remain completely confidential. Information from this questionnaire will be given to the recipient couple, but with all identifying information removed.

Instructions:

1. **Please fill in all blanks completely.** Please complete all questions.
2. Please be specific. Avoid expressions such as "natural" or "old age" (for causes of death). List any health problems as specifically as possible. If you do not know the age, put the approximate age or ask a relative to help you. List exact relationships such as "first cousin through my mother's sister".
3. Please provide information on all the relatives requested. Do not write their names.

If you have any questions, call 860-679-8491 to speak with the nurse coordinator of the program.

Name ____

Address ____

____

Telephone 1st choice _______________________________

2nd choice _______________________________

May we leave a telephone message? ☐ Yes ☐ No

Social Security # ____________________________________ Date of Birth _______________

How did you learn about our program? ____

I, the undersigned, acknowledge that the following answers are accurate and truthful to the best of my knowledge and included all relevant information.

Signature: ____ Date: ______________________

Please list the first & last names of your brothers & male first cousins. (This information will be used to prevent the donation of your eggs to a family member).

Donor Genetic History Screening Form

Donor # ____________________

Personal History

1. Month/year of birth _______/_______
2. Are you married? ______________ or are you in a committed relationship? ______________
3. Have you ever tried to conceive? ___________
4. Do you take birth control pills? ____________ What kind? ___________________________
5. If you take birth control pills, how long have you been taking them? ____________________
6. Would you object to being taken off birth control pills for a short time, if needed, to participate in the donor program? ____________
7. Number of pregnancies: _____________
8. Number of miscarriages: ____________ Number of abortions: ___________
9. Have you ever been told you have any gynecological problems (endometriosis, fibroids, ovarian cysts, abnormal Pap smears, etc.)? ____
10. Religion: _________________________
11. Education – How many years of school/highest degree and year awarded/College major (if applicable):

    ____
12. Were you ever in special education classes? ☐ Yes ☐ No
13. Occupation: ____
14. Height ___________________
15. Weight: ___________________
16. Eye color: _________________
17. Hair color: _________________
18. Hair type: wavy curly straight
19. What is your ethnic background (how do you define yourself)?

    ______ Hispanic ______ French Canadian ______English
    ______ Jewish ______ Black ______German
    ______ Greek ______ Italian ______Irish
    ______ Asian ______ Indian (from India) ______Scotch
    ______ Other (please specify in detail) ____
20. Skin tone: fair light medium dark olive
21. Body & facial features: small medium large

Family Information

Mother	Father
Height ______________________________	Height ______________________________
Build _______________________________	Build _______________________________
Eye Color ___________________________	Eye Color ___________________________
Hair Color __________________________	Hair Color __________________________
Complexion __________________________	Complexion __________________________
Nationality _________________________	Nationality _________________________
Level of schooling ___________________	Level of schooling ___________________
Occupation __________________________	Occupation __________________________

Recreational History

22. List the drugs, prescription & nonprescription, that you currently or regularly take: ______________________
    ____
23. Do you smoke cigarettes? ________ How many packs per day? ________ If you do not smoke now, did you ever smoke cigarettes? _______ How many packs a day? _______ When did you stop smoking? _________ Are you exposed to second hand smoke? ________ If yes, how much? ________________________________
24. What types of alcoholic beverages do you drink? ____
25. How many drinks (beer, wine, alcohol) do you consume per: day?____ week?____ month?____
26. Have you ever used any kind of recreational drugs (marijuana, LSD, heroin or cocaine)? Yes___ No___
    If yes, please give details and state last date used: ____
27. Have you ever used medication to treat an emotional or psychological problem such as anti-depressants? If yes, give details and state date last used: ____
28. Have you ever been in jail? ____
29. Have you ever used an injected drug or had a sexual partner who did so? _______________________________

Social History

30. Have you been sexually involved with an HIV-positive person ____________________
31. Number of sexual partners in the last year Male _________ Female __________
32. Have you been sexually active during the past 6 months? ____
33. Are you in a monogamous relationship? ______________
34. Have you ever had a sexual partner who was gay or bisexual? ____________________________
35. Has your partner been in a gay or bisexual relationship? __________________________________
36. Has there been sex in exchange for money in the last 5 years? _______ If so, when _____________________
37. Have you acquired a tattoo or had skin piercing? How many_________When__________________________
    Where are they located____

Health History

38. Have you ever been refused as a blood donor? ____________ Why? ________________________________

39. Have you received a blood transfusion within the last 12 months? ___________________________________

40. Have you ever received factor VIII or factor IX concentrates (blood transfusion) that were not heat treated or otherwise vial inactivated? ________________ If yes, when?__________________

41. Have you or your partner had or been exposed to West Nile Virus? _________________________________

42. Have you or your partner had or been exposed to or had Severe Acute Respiratory Syndrome? ___________

43. Have you or your partner had a smallpox vaccination? ______ If so, when and in what country? __________

44. Have you been exposed to radiation or toxic chemicals in your work or personal life? ___________________

    ____

45. Within the last six months have you received a bite from an animal that might have rabies? _______________

46. Have you been outside the country in the last two years? If so, what country? _________________________

47. Do you wear glasses or contact lenses? ☐ Yes ☐ No

    Are you: ☐ Nearsighted ☐ Farsighted ☐ Other (specify)

    ____

    Your vision is: Right eye: __20/___ Left eye: __20/___

48. Do you have any health problems or have you had any health problems in the past?______yes _____no

    If yes, please explain:____

    ____

    ____

YOUR MEDICAL HISTORY

1. Please indicate with a check mark (√) if you have had any of the following:

___ Gonorrhea ___ Venereal warts ___ Kidney disease ___ Blood clots

___ Syphilis ___ AIDS/HIV ___ Liver disease ___ Phlebitis

___ Chlamydia ___ Diabetes ___ Hepatitis B ___ Excessive facial hair

___ Herpes ___ Trichomonas ___ Hepatitis

___ Hemophilus vaginalis ___ Heart disease ___ Pelvic inflammatory disease

___ Tuberculosis of the genital tract

___ Other medical disorders

___ Psychiatric disorders (such as depression, anxiety, eating disorders, manic-depression, schizophrenia, suicide attempt)

___ Have you ever been seen by a psychiatrist, psychologist, social worker or other mental health worker for any reason (please specify) ____

____

Operations (Gynecologic surgery)

___ Laparoscopy

___ Tubal ligation

___ Cesarean section

___ Other (please specify) ____

MENSTRUAL HISTORY

Menarche (1st menstrual period) ____

How frequently do you menstruate? (be specific) ______________________________

How long do your periods last? ____

Type of flow (light, heavy) ____

Menstrual cramps (none, mild, moderate, severe) ______________________________

OBSTETRIC HISTORY

(Mode of delivery: Miscarriage = M; Abortion = A; Vaginal delivery = V; Cesarean delivery = C; Ectopic pregnancy = E)

Year	Mode of Delivery	Outcome (sex, birth weight, medical complications)

2. Are there any known genetic conditions or birth defects in your family? ☐ Yes ☐ No

   If yes, please explain: ____

3. Have you ever been tested for:

   a. Tay-Sachs disease (if of Jewish or French Canadian ancestry): ___carrier ___non-carrier ___not tested

   b. Sickle cell disease (if Black or Hispanic): ___carrier ___non-carrier ___not tested

   c. Thalassemia (if African, Asian, Indian, Yugoslavian, Bulgarian, Hungarian, Turkish, Middle Eastern or Afghanistani, Mediterranean, Spanish, Portuguese, French, Italian, Greek, etc.):

      ___carrier ___non-carrier ___not tested

   d. Cystic Fibrosis: ___carrier ___non-carrier ___not tested

4. Have you ever been on a special diet? ☐ Yes ☐ No

   If yes, describe diet and reason: ____

5. Do you have any health problems? ☐ Yes ☐ No (high blood pressure, asthma, allergies, etc.)

   If yes, please explain and give age when diagnosed: ____

6. Were you born with any birth defects or differences? (e.g. heart defect, cleft of the lip or palate, hearing problems, seizures, open spine, club feet) ☐ Yes ☐ No

   If yes, please explain and give age when diagnosed: ____

7. Were you born with any genetic conditions, such as PKU (phenylketonuria), Gaucher disease or any other?

   ☐ Yes ☐ No If yes, please explain and give age when diagnosed: ____________________________

   ____

FATHER'S FAMILY (Please don't use names)

1. Grandfather (*your father's father*): ___ living ___ deceased

   Age (*or age at death*) ______ If deceased, cause of death ____

   Health Problems (past and present) and age diagnosed

   ____

   ____

   ____

2. Grandmother (*your father's mother*): ___ living ___ deceased

   Age (*or age at death*) ______ If deceased, cause of death ____

   Health Problems (past and present) and age diagnosed

____

____

____

3. Aunts and uncles (*your father's brothers and sisters*), **LIVING**:

	Sex	Age	Health Problems (past and present)	Age Diagnosed
1.				
2.				
3.				
4.				
5.				
6.				

4. Aunts and uncles (*your father's brothers and sisters*), **DECEASED** (*including stillborns, infant deaths and child-hood deaths*):

	Sex	Age	Cause of Death	Age Diagnosed	Other Health Problems
1.					
2.					
3.					
4.					

5. Father: ___ living ___ deceased

Age (*or age at death*) ______ If deceased, cause of death ____

Health Problems (past and present) and age diagnosed

____

____

____

Is there anything else you think we should know about your father's family?

____

____

____

MOTHER'S FAMILY (Please don't use names)

1. Grandfather (*your mother's father*): ___ living ___ deceased

   Age (*or age of death*) ______ If deceased, cause of death ______________________________

   Health Problems (past and present) and age diagnosed

   ____

   ____

   ____

   ____

2. Grandmother (*your mother's mother*): ___ living ___ deceased

   Age (*or age at death*) ______ If deceased, cause of death ______________________________

   Health Problems (past and present) and diagnosed

   ____

   ____

   ____

   ____

3. Aunts and uncles (*your mother's brothers and sisters*), **LIVING**:

	Sex	Age	Health Problems (past and present)	Age Diagnosed
1.				
2.				
3.				
4.				
5.				
6.				

4. Aunts and uncles (*your mother's brothers and sisters*), **DECEASED** (*including stillborns, infant deaths and childhood deaths*):

	Sex	Age	Cause of Death	Age Diagnosed	Other Health Problems
1.					
2.					
3.					
4.					

5. Mother: ___ living ___ deceased

Age (*or age at death*) ______ If deceased, cause of death ____

Health Problems (past and present) and age diagnosed

____

____

____

____

Is there anything else you think we should know about your mother's family?

____

____

____

____

SIBLINGS (Please don't use names)

1. Your brothers and sisters, **LIVING:**

	Sex	Age	Health Problems (past and present)	Age Diagnosed
1.				
2.				
3.				
4.				
5.				
6.				

2. Your brothers and sisters, **DECEASED** (*including stillborns, infant and childhood deaths*):

	Sex	Age	Cause of Death	Age Diagnosed	Other Health Problems
1.					
2.					

CHILDREN (Please don't use names)

1. Your children, **LIVING**:

	Sex	Age	Health Problems (past and present)	Age Diagnosed
1.				
2.				
3.				
4.				

2. Your children, **DECEASED** *(including stillborns, infant and childhood deaths*):

	Sex	Age	Cause of Death	Age Diagnosed	Other Health Problems
1.					
2.					

Medical/Genetic Family History Questionnaire

		Yourself		Blood Relative		
		Yes	**No**	**Yes**	**No**	**Relationship**
1.	BLINDNESS or other visual problems					
2.	DEAFNESS, HEARING DIFFICULTIES Unusual shape or missing ear					
3.	SPEECH PROBLEMS					
4.	DENTAL PROBLEMS (ex. missing or extra teeth)					
5.	CLEFT LIP (harelip)					
6.	CLEFT PALATE					
7.	LEARNING DISABILITY or slow learner					
8.	MENTAL RETARDATION or developmental delay					
9.	ATTENTION DEFICIT DISORDER and/or HYPERACTIVITY					
10.	DOWN' SYNDROME (also called Mongolism)					
11.	MENTAL ILLNESS (e.g. manic depression, Schizophrenia, nervous breakdown					
12.	HYDROCEPHALUS (water on the brain)					
13.	MICROCEPHALUS (small head)					
14.	PATCHES OF HAIR OF DIFFERENT COLOR					
15.	PATCHES OF SKIN OF DIFFERENT COLOR (e.g. white spots or brown spots)					
16.	BIRTHMARKS of unusual shape, size or number					
17.	SKIN PROBLEMS (severe eczema, acne or other)					
18.	BLEEDING PROBLEMS OR HEMOPHILIA					
19.	SICKLE CELL ANEMIA					
20.	THALASSEMIA					
21.	HYPERTENSION or HIGH BLOOD PRESSURE					
22.	STROKE					
23.	HEART ATTACK before age 50 (Coronary)					

IF YES TO ANY OF THE ABOVE, PLEASE ANSWER THE FOLLOWING:

NUMBER from above	AGE WHEN first affected	RELATIONSHIP to yourself	COMMENTS (name of disorder if known)

____

____

____

____

____

____

____

____

____

____

Medical/Genetic Family History Questionnaire

		Yourself		Blood Relative		
		Yes	**No**	**Yes**	**No**	**Relationship**
24.	Born with HEART DEFECT (e.g. hole in heart)					
25.	Born with OPEN SPINE – SPINA BIFIDA					
26.	Born with MISSING BRAIN					
27.	Born with HIP PROBLEMS					
28.	DWARFISM or SHORT STATURE					
29.	SPINAL CURVATURE (Scoliosis)					
30.	MALFORMED BONES or MANY BROKEN BONES					
31.	MALFORMED HANDS (e.g. extra/missing/webbed Fingers)					
32.	MALFORMED FEET (e.g. extra/missing/webbed Toes)					
33.	CLUB FOOT					
34.	ARTHRITIS, JOINT PROBLEMS					
35.	MUSCULAR DYSTROPHY					
36.	MUSCLE WEAKNESS					
37.	LOSS OF MUSCLE CONTROL					
38.	PYLORIC STENOSIS (projectile vomiting)					
39.	BREAST CANCER					
40.	COLON CANCER					
41.	OVARIAN CANCER					
42.	OTHER CANCERS (type and site)					
43.	CYSTIC FIBROSIS					
44.	ALZHEIMER'S DISEASE					
45.	HUNTINGTON'S DISEASE (chorea)					
46.	NEUROFIBROMATOSIS					

IF YES TO ANY OF THE ABOVE, PLEASE ANSWER THE FOLLOWING:

NUMBER from above	AGE WHEN first affected	RELATIONSHIP to yourself	COMMENTS (name of disorder if known)

Medical/Genetic Family History Questionnaire

		Yourself		Blood Relative		
		Yes	**No**	**Yes**	**No**	**Relationship**
47.	MULTIPLE SCLEROSIS					
48.	TAY SACHS DISEASE					
49.	CEREBRAL PALSY					
50.	SEIZURES, CONVULSIONS, EPILEPSY					
51.	CHILDHOOD DIABETES					
52.	ADULT DIABETES					
53.	THYROID DISORDER (underactive or overactive)					
54.	KIDNEY PROBLEMS					
55.	RESPIRATORY OR BREATHING PROBLEMS (e.g. emphysema)					
56.	ASTHMA, HAY FEVER					
57.	ALLERGIES TO FOOD (specify)					
58.	ALLERGIES TO MEDICINE (specify)					
59.	CHEMICAL DEPENDENCY on alcohol or drinking problem					
60.	CHEMICAL DEPENDENCY on drugs (specify)					
61.	WEIGHT PROBLEMS (specify) Obesity, Anorexia, Bulimia or other					
62.	INFERTILITY					
63.	MISCARRIAGES (If yes, how many?)					
64.	STILLBIRTHS (If yes, how many?)					
65.	INFANT DEATHS (died before one month old)					
66.	CHILDHOOD DEATHS					
67.	HIV POSITIVE (Human Immunodeficiency Virus)					
68.	AIDS (Acquired Immunodeficiency Syndrome)					

IF YES TO ANY OF THE ABOVE, PLEASE ANSWER THE FOLLOWING:

NUMBER from above	AGE WHEN first affected	RELATIONSHIP to yourself	COMMENTS (name of disorder if known)

Is there anything else you think we should know about your family? ______________________________

____

____

____

How did you hear about our egg donation program? ______________________________

____

____