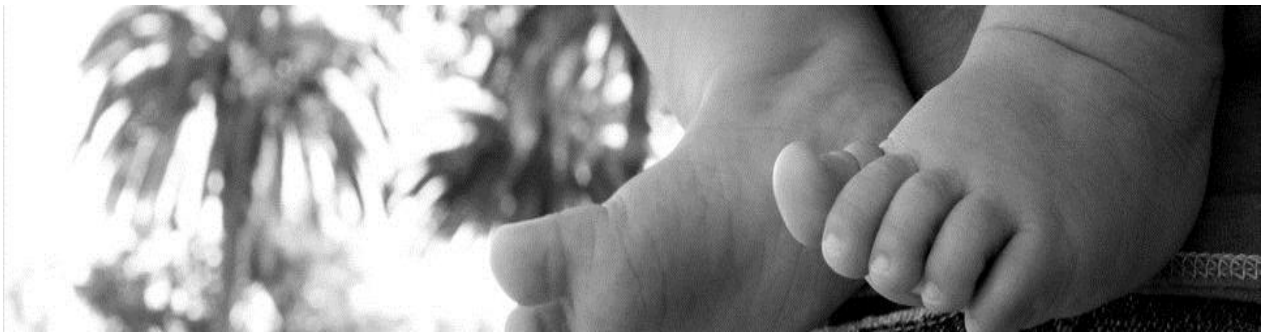
Donor # _____

*Precious Gifts Surrogacy & Egg Donor Program*



**DONOR INFORMATION:**

First Name: _____ MI: _____ Last: _____

Address: _____ City: _____ State: ____ Zip: _____

Birth date: _____ Age: _____ □ Female □ Male

Home Phone: _____

Cell Phone Number: _____

Email Address: _____

Skype ID: _____

Marital Status: □ Single □ Married □ Divorced □ Widow □ Widower

Do we have permission to leave messages on home phone, cell or email: □ Yes □ No

Are you willing to meet the Intended Parent(s) : □ Yes □ No

Are there types of parents you won't donate to? □ Yes □ No

Please explain:

_____

_____

How did you hear about us? _____

Signature: _____ Date: _____

Donor # _____

# DONOR PROFILE

FEMALE

Date Completed: _____ Age: _____ Date of Birth: _____

Place of Birth: _____ Marital Status: _____

**Race:**

Caucasian: ____ African American: ____ Asian: ____ Other: _____ (please specify)

**Ethnic Origin:**

Mother's Family: _____ Father's Family: _____

**Religion:**

Mother's Family: _____ Father's Family: _____

**Personal Characteristics:**

Height:_____ Weight:_____ Braces: Y or N

Hair Type:_____ Hair Color:_____ Dimples: Y or N

Skin Tone:_____ Eye Color:_____ Glasses: Y or N

Blood Type:_____ Bone Structure:_____ Handed: R or L

Donor # _____

## EDUCATION:

High School GPA: _____ College / University GPA: _____

SAT Score: _____ ACT Score: _____

High School Attended: _____

College / University Attended: _____

College Major: _____ College Minor: _____

Post – graduate Degrees obtained: _____

What was your favorite academic subject: _____

What was your least favorite academic Subject: _____

Learning disabilities in your family: _____

Do you have plans to further your education: _____

If yes, what studies do you plan to pursue**:** _____

What is your IQ: _____

## PERSONALITY

Interest and Hobbies:

_____

_____

_____

Are you outgoing: Y or N Are you athletic: Y or N

Sports you like: _____

Favorite sports team: _____

Are you Artistic: Y or N

What types of art do you enjoy: _____

What type of music do you enjoy: _____

Donor # _____

Do you play an instrument: _____

Do you like to read: _____

What is your favorite book: _____

What is your favorite movie: _____

What is your favorite color: _____

Do you have any tattoos? Y or N

If yes, when did you get the last one done? (Month and year) _____

Say something special about yourself:

_____

_____

_____

_____

Why do you want to become an egg donor?

_____

_____

_____

_____

What would you like the Intended Parents to know about you?

_____

_____

_____

_____

Are you willing to meet the intended parents? Yes or NO - Please explain;

_____

_____

_____

_____

Donor # _____

## PERSONAL AND FAMILY HISTORY

| | Height | Weight | Hair Color | Hair Type | Eye Color | Skin Tone | Bone Structure | Blood Type | Birth Marks Y or N | Dimples Y or N | Glasses Y or N | Braces Y or N | Handed R or L |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Mother | | | | | | | | | | | | | |
| Father | | | | | | | | | | | | | |
| Brother/Sister | | | | | | | | | | | | | |
| Brother/Sister | | | | | | | | | | | | | |
| Brother/Sister | | | | | | | | | | | | | |
| Brother/Sister | | | | | | | | | | | | | |
| Maternal Grandmother | | | | | | | | | | | | | |
| Maternal Grandfather | | | | | | | | | | | | | |
| Paternal Grandmother | | | | | | | | | | | | | |
| Paternal Grandfather | | | | | | | | | | | | | |

Do you smoke: Y or N  If so how much: _____

Does anyone in your household smoke: Y or N

If so who: _____

Recreational drug use: Y or N  If so what: _____

Any family history of mental illness: Y or N

Please explain

Donor # _____

## PERSONAL INFORMATION

Are your menstrual cycles regular: Y or N

Interval between periods: _____ days / duration of bleeding: _____

Last menstrual period start date: _____

Have you even been pregnant: Y or N How many times: _____

Do you have any living children: Y or N How many: _____

Any birth defects or problems: _____

Do you have twins or triplets: Y or N Explain: _____

Do you have or have you ever been treated for endometriosis: Y or N

Allergies: _____

Do you take any medication: _____

**Contraceptive Practices:**

Intrauterine devices (IUD) Y or N Dates _____

Diaphragm Y or N Dates _____

Oral contraceptives Y or N Dates _____

Tubal ligation Y or N Dates _____

Other _____ Dates _____

When was your last pap smear: _____

Any abnormal pap smears: _____

Any procedures on your cervix: _____

When was your last mammogram: _____

Donor # _____

Toxicant Exposure:

Alcohol Y or N Dates _____

None Y or N Dates _____

Weekend Y or N Dates _____

Daily Y or N Dates _____

Smoking Y or N Dates _____ (amount)

Pesticides Y or N Dates _____

Radiation Y or N Dates _____

Coffee / Caffeine Y or N Dates _____ (amount)

Other chemicals Y or N Dates _____

Drugs Y or N Dates _____

Do you have or ever had (check ALL that applies):

| **Infectious Diseases:** | | **Gynecologic Problems:** | | **Medical Problems:** | |
|---|---|---|---|---|---|
| Chicken Pox ( varicella ) | | Abnormal mammogram | | Bleeding disorders | |
| Hepatitis A, B, or C | | Abnormal pap smear | | Blood clots | |
| German Measles- Rubella | | Blocked fallopian tubes | | Blood transfusion | |
| Rheumatic Fever | | Pelvic Adhesions | | Appendicitis | |
| Chronic Bronchitis | | Endometriosi | | Mitral valve | |
| Chlamydia | | Cervical strnosis | | Uterine anomalies | |
| Gonorrhea | | DES exposure | | Kidney infection | |
| Syphilis | | Breast discharge | | Kidney disease | |
| Pelvic Infection (PID) | | Hot flashes or night sweats | | Liver problems | |
| Mycoplasma / Ureaplasma | | | | Recurrent urinary infections | |
| Condyloma - Venereal Warts | | **Immunizations:** | | Rh sensitized | |
| Herpes - Genital | | Chicken pox vaccine | | Lost > 15 lbs last year | |
| Other ( explain ): | | German Measles - Rubella | | Gained > 15 lbs last year | |

Comments

_____

_____

Have you ever been hospitalized? _____

Donor # _____

List all surgeries you have had (including cervix, uterus, ovarian cyst, tubes, endometriosis, appendix, etc):

| (Type of surgery) | (Date) |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

List all other serious illnesses for which you have been under the care of a physician:

| (Illness) | (Date) |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Special dietary habits: _____

Any food allergies? □ Yes □ No _____

How much do you exercise: _____

What do you do for exercise: _____

_____

| | | | | |
|---|---|---|---|---|
| Number of Siblings | Male | _____ | Female | _____ |
| Number of Aunts | Paternal | _____ | Maternal | _____ |
| Number of Uncles | Paternal | _____ | Maternal | _____ |
| Number of Maternal Cousins | Male | _____ | Female | _____ |
| Number of Paternal Cousins | Male | _____ | Female | _____ |

Donor # _____

| | | | | Siblings | | Grandparents | | | | Aunt | | Uncle | | M-Cousins | | P-Cousins | | **NO** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Medical Problems | You | Mother | Father | B | S | MGM | MGF | PGM | PGF | Mat | Pat | Mat | Pat | F | M | F | M | **ONE** |
| **Heart** | | | | | | | | | | | | | | | | | | |
| Heart Disease | | | | | | | | | | | | | | | | | | |
| 1. from birth | | | | | | | | | | | | | | | | | | |
| 2. other | | | | | | | | | | | | | | | | | | |
| Heart attack | | | | | | | | | | | | | | | | | | |
| Hardening of arteries | | | | | | | | | | | | | | | | | | |
| High blood pressure | | | | | | | | | | | | | | | | | | |
| **Blood** | | | | | | | | | | | | | | | | | | |
| Anemia | | | | | | | | | | | | | | | | | | |
| Slckle cell anemia | | | | | | | | | | | | | | | | | | |
| Hemophilla | | | | | | | | | | | | | | | | | | |
| Leukemia | | | | | | | | | | | | | | | | | | |
| Immune defictency | | | | | | | | | | | | | | | | | | |
| Clotting disorders | | | | | | | | | | | | | | | | | | |
| **Respiratory** | | | | | | | | | | | | | | | | | | |
| Hay fever | | | | | | | | | | | | | | | | | | |
| Asthma | | | | | | | | | | | | | | | | | | |
| Emphysema | | | | | | | | | | | | | | | | | | |
| Tuberculosis | | | | | | | | | | | | | | | | | | |
| Lung cancer | | | | | | | | | | | | | | | | | | |
| Pneumonia | | | | | | | | | | | | | | | | | | |
| Other lung diseases | | | | | | | | | | | | | | | | | | |
| **Skin** | | | | | | | | | | | | | | | | | | |
| Sever acne | | | | | | | | | | | | | | | | | | |
| Eczema | | | | | | | | | | | | | | | | | | |
| Skin cancer | | | | | | | | | | | | | | | | | | |
| Pigmentation | | | | | | | | | | | | | | | | | | |
| Melanoma | | | | | | | | | | | | | | | | | | |
| Other | | | | | | | | | | | | | | | | | | |

COMMENTS _____

_____

Donor # _____

| | | | | Siblings | | Grandparents | | | | Aunt | | Uncle | | M-Cousins | | P-Cousins | | NO |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Medical Problems | You | Mother | Father | B | S | MGM | MGF | PGM | PGF | Mat | Pat | Mat | Pat | F | M | F | M | ONE |
| **Gastrointestinal** | | | | | | | | | | | | | | | | | | |
| Ulcer of stomach | | | | | | | | | | | | | | | | | | |
| Gallstones | | | | | | | | | | | | | | | | | | |
| Hepatitis A | | | | | | | | | | | | | | | | | | |
| Hepatitis B | | | | | | | | | | | | | | | | | | |
| Other liver diseases | | | | | | | | | | | | | | | | | | |
| Colon cancer | | | | | | | | | | | | | | | | | | |
| Ulcerative colitis | | | | | | | | | | | | | | | | | | |
| Crohn's disease | | | | | | | | | | | | | | | | | | |
| Cystic Fibrosis | | | | | | | | | | | | | | | | | | |
| Intestinal cancer | | | | | | | | | | | | | | | | | | |
| Other diseases | | | | | | | | | | | | | | | | | | |
| **Reproductive** | | | | | | | | | | | | | | | | | | |
| Testicular disease | | | | | | | | | | | | | | | | | | |
| Hypospadias | | | | | | | | | | | | | | | | | | |
| Uterine fibroids | | | | | | | | | | | | | | | | | | |
| Ovarian cysts | | | | | | | | | | | | | | | | | | |
| Ovarian cancer | | | | | | | | | | | | | | | | | | |
| Uterine cancer | | | | | | | | | | | | | | | | | | |
| Cervical cancer | | | | | | | | | | | | | | | | | | |
| **Musculoskeletal** | | | | | | | | | | | | | | | | | | |
| Muscular dystrophy | | | | | | | | | | | | | | | | | | |
| Lupus | | | | | | | | | | | | | | | | | | |
| Osteoporosis | | | | | | | | | | | | | | | | | | |
| Gout | | | | | | | | | | | | | | | | | | |
| Arthritis | | | | | | | | | | | | | | | | | | |
| Dwarfism | | | | | | | | | | | | | | | | | | |
| Club feet | | | | | | | | | | | | | | | | | | |
| Congenital hip disease | | | | | | | | | | | | | | | | | | |

COMMENTS _____

_____

Donor # _____

| | | | | Siblings | | Grandparents | | | | Aunt | | Uncle | | M-Cousins | | P-Cousins | | NO |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Medical Problems | You | Mother | Father | B | S | MGM | MGF | PGM | PGF | Mat | Pat | Mat | Pat | F | M | F | M | ONE |
| **Metabolic** | | | | | | | | | | | | | | | | | | |
| Diabetes mellitus | | | | | | | | | | | | | | | | | | |
| Hypoglycemia | | | | | | | | | | | | | | | | | | |
| Thyroid disease | | | | | | | | | | | | | | | | | | |
| Goiter | | | | | | | | | | | | | | | | | | |
| Thyroid cancer | | | | | | | | | | | | | | | | | | |
| Adrenal disease | | | | | | | | | | | | | | | | | | |
| Tay - Sachs disease | | | | | | | | | | | | | | | | | | |
| Other | | | | | | | | | | | | | | | | | | |
| **Neurologic** | | | | | | | | | | | | | | | | | | |
| Migraines | | | | | | | | | | | | | | | | | | |
| Mental retardation | | | | | | | | | | | | | | | | | | |
| Senility before 50 | | | | | | | | | | | | | | | | | | |
| Alzheimer's disease | | | | | | | | | | | | | | | | | | |
| Multiple sclerosis | | | | | | | | | | | | | | | | | | |
| Cerebral palsy | | | | | | | | | | | | | | | | | | |
| Epilepsy or seizures | | | | | | | | | | | | | | | | | | |
| Hydrocephalus | | | | | | | | | | | | | | | | | | |
| Spinal cord disease | | | | | | | | | | | | | | | | | | |
| Spina bifida | | | | | | | | | | | | | | | | | | |
| Huntington's disease | | | | | | | | | | | | | | | | | | |
| Gaucher's disease | | | | | | | | | | | | | | | | | | |
| Wilson's disease | | | | | | | | | | | | | | | | | | |
| Other | | | | | | | | | | | | | | | | | | |
| **Urinary** | | | | | | | | | | | | | | | | | | |
| Kidney disease | | | | | | | | | | | | | | | | | | |
| Bladder cancer | | | | | | | | | | | | | | | | | | |
| Prostate cancer | | | | | | | | | | | | | | | | | | |
| Other | | | | | | | | | | | | | | | | | | |

COMMENTS _____

_____

Donor # _____

| | | | | Siblings | | Grandparents | | | | Aunt | | Uncle | | M-Cousins | | P-Cousins | | NO |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Medical Problems | You | Mother | Father | B | S | MGM | MGF | PGM | PGF | Mat | Pat | Mat | Pat | F | M | F | M | ONE |
| **Ear, Eye, Face** | | | | | | | | | | | | | | | | | | |
| Deafness before 60 | | | | | | | | | | | | | | | | | | |
| Ear deformity | | | | | | | | | | | | | | | | | | |
| Cataracts before 50 | | | | | | | | | | | | | | | | | | |
| Blindness | | | | | | | | | | | | | | | | | | |
| Color blindness | | | | | | | | | | | | | | | | | | |
| Glaucoma | | | | | | | | | | | | | | | | | | |
| Cleft lip or palate | | | | | | | | | | | | | | | | | | |
| **Mental Health** | | | | | | | | | | | | | | | | | | |
| Schizophrenia | | | | | | | | | | | | | | | | | | |
| Manic / Depression | | | | | | | | | | | | | | | | | | |
| Severe depression | | | | | | | | | | | | | | | | | | |
| Other disoders | | | | | | | | | | | | | | | | | | |
| **Other diseases** | | | | | | | | | | | | | | | | | | |
| Alcoholism | | | | | | | | | | | | | | | | | | |
| Drug abuse | | | | | | | | | | | | | | | | | | |
| Breast cancer | | | | | | | | | | | | | | | | | | |
| Other cancers not mentioned above | | | | | | | | | | | | | | | | | | |
| Any other conditions not mentioned above | | | | | | | | | | | | | | | | | | |
| Down's syndrome | | | | | | | | | | | | | | | | | | |
| Other birth defects | | | | | | | | | | | | | | | | | | |
| Two or more miscarriages | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |

COMMENTS _____