

Reproductive Care Center

Egg Donor – Pre-cycle Screening Information

Name: _____
(last) (first) (middle)

Date: _____

Medical History

List all medication you take now (prescription, non-prescription, vitamins, aspirin, Motrin, herbal and sports supplements, antacids, laxatives, Accutane, creams, steroids, and over the counter preparations):

(drug)	(indication)	(dose)	(date)
_____	_____	_____	_____
_____	_____	_____	_____

List all medication you have taken in the past 12 months:

(drug)	(indication)	(dose)	(date)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have any new **allergies** (medicines, food, pollens, other allergens)? Yes No
If yes, please list substance, reaction caused and date: _____

List all illnesses for which you are currently or have been under the care of a physician:

(illness)	(date)
_____	_____
_____	_____

List all surgery you have had in the last 24 months:

(type of surgery)	(date)
_____	_____
_____	_____

List all hospitalizations other than surgery in the last 24 months

(illness)	(date)
_____	_____

Infectious History

Do you have, have you had or have you ever been treated for:

Acute flaccid paralysis	Yes	No	Hepatitis B	Yes	No
AIDS	Yes	No	Hepatitis C	Yes	No
Adult T cell leukemia	Yes	No	HIV	Yes	No
Chickenpox (varicella)	Yes	No	HTLV	Yes	No
Cytomegalovirus (CMV)	Yes	No	Malaria or antimalarial drugs	Yes	No
Chlamydia	Yes	No	Mononucleosis	Yes	No
Dysentery (amoebic, salmonella, shigella, etc)	Yes	No	Opportunistic infections	Yes	No
Elevated AST, bilirubin or prothrombin time	Yes	No	Pelvic infection (PID)	Yes	No
Encephalitis, meningitis or meningoencephalitis	Yes	No	SARS	Yes	No
Fever above 100.5°F (in the past 3 months)	Yes	No	Syphilis	Yes	No
Fever, prolonged	Yes	No	Trichomoniasis	Yes	No
Genital warts or human papilloma virus (HPV)	Yes	No	Tuberculosis (TB)	Yes	No
German measles (rubella)	Yes	No	Urethritis or urethral discharge	Yes	No
Gonorrhea	Yes	No	Vaginitis, recurrent	Yes	No
Hepatitis - other	Yes	No	West Nile virus	Yes	No
Hepatitis A	Yes	No			
Herpes simplex virus, oral (cold sores or fever blisters)	Yes	No	Herpes simplex virus, genital	Yes	No
Prior reactive or repeatedly reactive screening assay for HIV-1, HIV-2, Hepatitis C, Hepatitis B or HTLV-1/2 antibody?				Yes	No
Sepsis (including bacteremia (positive blood cultures), septicemia, sepsis syndrome, systemic infection or septic shock)				Yes	No

If yes above, please describe: _____

Sexual History

Sexual preference (circle): homosexual heterosexual both neither

Number of sexual partners: current ____ last 6 months ____ last 12 months ____ Total ____

In the past 12 months, have you had sex (vaginal, anal or oral) with:

A person having non-medical intravenous, intramuscular, or subcutaneous injection of drugs not prescribed by a physician for medical purposes in the preceding five years?	Yes	No
A person having engaged in sex in exchange for money or drugs in the preceding five years?	Yes	No
A person diagnosed with or suspected of having HIV or viral hepatitis infection?	Yes	No
A person diagnosed with or suspected of having gonorrhea, Chlamydia or trichomoniasis?	Yes	No
A person who received the smallpox vaccine in the preceding 12 months?	Yes	No
A person who has a blood clotting disorder (i.e. hemophilia or a related disorder)?	Yes	No
A person who has had a tattoo, electrolysis, acupuncture or their ear(s) or body pierced in the preceding 12 months?	Yes	No
A man who has had sex with another man in the past 5 years?	Yes	No
Anyone who was born in or lived in any African Country, such as Cameroon, Central Africa, Chad, Congo, Equatorial Guinea, Gabon, Niger, or Nigeria since 1977?	Yes	No
A person who has had a blood transfusion in the preceding 12 months?	Yes	No
A person who has been in jail for more than 72 hours?	Yes	No
A person who has had sex with another person described in any of the above in the preceding 12 months?	Yes	No

Have you:

Engaged in sex in exchange for money or drugs in the preceding five years?	Yes	No
Had close contact* with a person having chronic viral hepatitis?	Yes	No

**"Close contact" is defined as sexual contact or contact resulting in exchange of body fluids and includes living in the same household, where sharing of kitchen and toilet facilities occurs regularly

Toxicant Exposure

The following questions refer to exposures in the past 12 months

Alcohol use:	Yes	No
If yes: daily occasionally rarely never approximate oz./week: _____		
Tobacco use:	Yes	No
Have you used non-medical intravenous, intramuscular, or subcutaneous injection of drugs?	Yes	No
Have you used any recreational drugs?	Yes	No
Have you used intra-nasal cocaine drugs?	Yes	No
Have you been exposed to excessive pesticides, chemicals, drugs, gases or radiation?	Yes	No
Have you been in jail for more than 72 hours?	Yes	No
Have you had a tattoo, electrolysis, acupuncture or your ear(s) or body pierced when shared instruments were used?	Yes	No
Have you been tested for HIV (AIDS) other than at RCC?	Yes	No
If yes, date and results: _____ Reason for testing: _____		
Have you been vaccinated for any reason in the past 12 months?	Yes	No
Have you acquired a clinically recognizable smallpox (vaccinia) virus infection (scab, small blisters or skin lesions) by close contact with someone who received the smallpox vaccine in the preceding three months?	Yes	No
Have you had a blood transfusion?	Yes	No
Have you received any transfusion of blood or blood components in the United Kingdom (UK) between 1980 and the present?	Yes	No
Have you been diagnosed with hemophilia or a related clotting disorder and received human derived clotting factor concentrates (non-viral inactivated Factor VIII or Factor IX concentrate)?	Yes	No
Have you spent three months or more cumulatively in the UK from the beginning of 1980 through the end of 1996?	Yes	No
Are you a current or former U.S. military member, civilian military employee, or dependent of a military member or civilian employee who resided at U.S. military bases in Northern Europe for 6 months or more from 1980 through 1990 or elsewhere in Europe for 6 months or more from 1980 through 1996?	Yes	No
Have you lived cumulatively for 5 years or more in Europe between 1980 and the present?	Yes	No
Have you received pituitary-derived human growth hormone (pit-hGH)?	Yes	No
Have you received transplants of human dura matter?	Yes	No
Have you ever been in contact with someone who has Creutzfeldt-Jakob (Mad Cow) disease?	Yes	No
Have you been exposed to known or suspected HIV, Hepatitis B, or Hepatitis C infected blood through percutaneous inoculation or through contact with an open wound, non-intact skin or mucous membrane within the preceding 12 months?	Yes	No
Have you within the previous 14 days had close contact with persons with SARS or suspected SARS or traveled to or resided in areas affected by SARS?	Yes	No
If you answered yes to the previous question, complete the following:		
Have had a moderate respiratory illness with a temperature of greater than 100.4 F and lower respiratory illness (e.g., cough, shortness of breath, difficulty breathing or hypoxia (low concentration of oxygen)?	Yes	No
Have had a severe respiratory illness with a temperature of greater than 100.4 F and lower respiratory illness (e.g., cough, shortness of breath, difficulty breathing or hypoxia) and radiographic evidence of pneumonia or respiratory distress syndrome?	Yes	No
Have had lymphopenia (low lymphocyte count) with normal or low white blood cell count?	Yes	No
Have had elevated hepatic transaminases (liver enzymes), creatine phosphokinase, lactate dehydrogenase or C-reactive protein?	Yes	No

Have you ever been exposed to "agent orange" or any other significant herbicides or chemicals in military action or elsewhere? (forest service, highway maintenance, etc.)	Yes	No
Have you been diagnosed with or exposed to West Nile Virus?	Yes	No
Have you had contact with someone having or suspected of having West Nile Virus?	Yes	No
Have you within the previous 21 days had a mosquito bite?	Yes	No
Have you or your current sexual partner(s) ever had a transplant or other medical procedure that involved being exposed to live cells, tissues, or organs from an animal?	Yes	No
Have you received a bite from an animal suspected of carrying rabies?	Yes	No
Have you had prolonged activated partial thromboplastin time?	Yes	No
Have you had recent evidence of infection with unexplained temperature of great than 100.4 F, elevated heart rate, elevated respiratory rate or elevated white blood cell count?	Yes	No
Have you had severe signs of sepsis including unexplained hypoxemia, elevated lactate, oliguria (less than normal urination), altered mentation and hypotension (low blood pressure)?	Yes	No
Have you been refused as a blood donor?	Yes	No
Were you born, or have you lived in or traveled to any African Country, such as Cameroon, Central Africa, Chad, Congo, Equatorial Guinea, Gabon, Niger, or Nigeria since 1977?	Yes	No
If yes, when you were in the African Country did you receive a blood transfusion or any other medical treatment with a product made from blood?	Yes	No
Have you been refused as a blood donor?	Yes	No
Have you traveled outside the United States or Canada?	Yes	No
If yes to any of the above, explain and give dates: _____		

Review of Systems

Check the appropriate space for conditions you have currently or had in the past 12 months:

Constitutional

Cancer	Yes	No	Unexplained fatigue	Yes	No
More than 10 pound recent weight loss	Yes	No	Unexplained fevers, sweats, nightsweats, chills	Yes	No
Unexplained weight loss	Yes	No	Fever and a headache (simultaneously) in the past 7 days	Yes	No
Fever, headache, body aches, or eye pain, accompanied by skin rash on the trunk of the body				Yes	No
Fever, headache, body aches, or eye pain, accompanied by swollen lymph glands				Yes	No
Symptoms of severe illness, including headache, high fever, neck stiffness, stupor, disorientation, coma tremors, convulsions, and muscle weakness or paralysis				Yes	No

Eyes, ears and nose

Prolonged stuffy nose	Yes	No	Recurrent nosebleeds	Yes	No
			Sinus trouble	Yes	No

Cardiovascular

Blood clots	Yes	No	High blood pressure	Yes	No
Fast or irregular heartbeat	Yes	No	Swelling of feet or ankles	Yes	No

Respiratory

Chest pain, pleurisy	Yes	No	Persistent cough, chest colds	Yes	No
Exercise induced asthma	Yes	No	Recurrent or persistent pneumonia	Yes	No
Hemoptysis (coughing up blood)	Yes	No	Shortness of breath	Yes	No

Gastrointestinal

Black stools	Yes	No	Persistent diarrhea	Yes	No
Blood in stool	Yes	No	Unexplained nausea, vomiting	Yes	No
Hepatomegaly (enlarged liver)	Yes	No	Yellow jaundice		

Genitourinary

Dysuria (painful urination)	Yes	No	Recurrent kidney infection	Yes	No
Hematuria (blood in the urine)	Yes	No	Recurrent vaginal infections	Yes	No
Intermenstrual bleeding	Yes	No	Unexplained vaginal bleeding	Yes	No
Recurrent genital ulcers	Yes	No			

Musculoskeletal

Pain or swelling in joints, arthritis	Yes	No	Persistent back or neck pain	Yes	No
Unexplained paraparesis (weakness in the lower extremities)	Yes	No			

Skin/Hair

Blue or purple spots on the skin or mucous membranes typical of Kaposi's sarcoma	Yes	No	Persistent sores or discharge	Yes	No
Eczema/lumps/hives	Yes	No	Prolonged or persistent itching	Yes	No
Moles with unusual color change	Yes	No	Warts	Yes	No
Persistent rash	Yes	No			

Breast

Breast lumps	Yes	No	Nipple discharge	Yes	No
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Neurological

Convulsions, seizures, fits	Yes	No	Numbness, tingling	Yes	No
Dizziness, fainting	Yes	No	Shaking, tremor	Yes	No
Headaches, severe	Yes	No	Weakness, paralysis	Yes	No

Psychologic/Psychiatric

Anxiety	Yes	No	Depression	Yes	No
Crying, upset, worry	Yes	No	Nervousness, tension	Yes	No

Endocrine

Cold or heat intolerance	Yes	No	Goiter	Yes	No
Excessive urination	Yes	No	Hot flashes	Yes	No

Hematologic/Lymphatic

Lymph node or gland swelling	Yes	No	Prolonged bleeding or easy bruising	Yes	No
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If yes to any of the above review of systems questions, please explain and give dates: _____

Would you be willing to be contacted by the Reproductive Care Center at a point in time when a child born from your donations reaches 18 years of age, in order to consider meeting the child or children?

(A yes means only that you are willing to evaluate the possibility of meeting a child. At that point in time you may choose to meet the child or not to meet the child)

Yes No Uncertain

Would you be willing to be contacted by the Reproductive Care Center in order to consider meeting with a recipient of your donations?

(A yes means only that you are willing to evaluate the possibility of meeting a recipient. At that point in time you may choose to meet the recipient or not to do so)

Yes No Uncertain

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 **not** 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 **RCC** 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 Cyropreserved 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 **RCC**, its 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.

Donor applicant signature

Date

Donor Egg Pre-cycle History reviewed by:

Comments

Approved to continue the cycle process?

Yes No

Signature (Nursing - Reproductive Care Center)

Date

Approved to continue the donation cycle process?

Yes No

Signature (Physician - Reproductive Care Center)

Date