



## Donor Application Form

1. Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_
2. Address: \_\_\_\_\_  
\_\_\_\_\_ Last Menstrual Period: \_\_\_\_\_  
\_\_\_\_\_ Date of Birth: \_\_\_\_\_
3. Phone #: h: \_\_\_\_\_ c: \_\_\_\_\_ w: \_\_\_\_\_
4. Email Address: \_\_\_\_\_
5. Occupation: \_\_\_\_\_
6. Education: \_\_\_\_\_
7. Marital Status: S M W D
8. Current Relationship: Y N Duration: \_\_\_\_\_ Monogamous: Y N
9. Current contraceptive method: \_\_\_\_\_
10. Which brand of birth control pills /patch /ring are you taking, if any? \_\_\_\_\_
11. Have you ever been pregnant? Y N Outcome: \_\_\_\_\_
12. Complications? \_\_\_\_\_
13. Race: \_\_\_\_\_ Religion: \_\_\_\_\_ Blood Type: \_\_\_\_\_
14. Family history of infertility, genetic abnormalities or birth defects? Y N  
If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_
15. Past/Present Medical Conditions: \_\_\_\_\_  
\_\_\_\_\_
16. Have you ever tested positive for Chlamydia, Gonorrhea, or HIV? Y N
17. Last medical exam: \_\_\_\_\_ Allergies: \_\_\_\_\_ Ht: \_\_\_\_\_ Wt: \_\_\_\_\_
18. Previous Surgery: \_\_\_\_\_
19. Current medications: \_\_\_\_\_
20. How often do you use tobacco products? \_\_\_\_\_
21. How often do you consume alcohol? \_\_\_\_\_
22. Do you use illegal drugs? \_\_\_\_\_
23. Work hours: \_\_\_\_\_ Days: \_\_\_\_\_ Flexible: Y N
24. Would you be able to come to our office for frequent or daily monitoring between 7:30-9:30 am? Y N
25. Are you willing to self-administer daily injections for up to 5 weeks? Y N
26. Do you still wish to be considered for the possibility of being an egg donor? Y N
27. How did you hear about our program? \_\_\_\_\_
26. Why do you want to be an egg donor? \_\_\_\_\_