The Utah Center for Reproductive Medicine
675 Arapeen Drive, Suite 205
Salt Lake City, Utah 84108
801 587-3475 Office
801 585 2231 Fax

DONOR PERSONAL HISTORY

Donor #: Date:

GENERAL

Year of Birth: Age: Eye Color:

Height: Weight: BMI:

☐ Right Handed ☐ Left Handed ☐ Ambidextrous

HAIR

How would you best describe your hair type?

☐ Straight ☐ Wavy ☐ Curly
☐ Thick ☐ Thin ☐ Fine
☐ Coarse

What is your natural hair color?

☐ Light Blonde ☐ Med Brown ☐ Auburn
☐ Med Blonde ☐ Dark Brown ☐ Red
☐ Light Brown ☐ Black

COMPLEXION

How would you best describe your complexion?

☐ Light/Fair ☐ Freckled ☐ Medium Olive
☐ Medium ☐ Light Olive ☐ Bronze

BODY FRAME

How would you best describe your body frame?

☐ Small ☐ Small to Medium ☐ Medium

VISION

Do you wear or have you worn glasses/contacts? ☐ Y ☐ N

If yes, please describe your eye condition and at what age you began wearing glasses/contacts.

The Utah Center for Reproductive Medicine
675 Arapeen Drive, Suite 205
Salt Lake City, Utah 84108
801 587-3475 Office
801 585 2231 Fax

DONOR PERSONAL HISTORY

Donor #: Date:

HEARING

How would you best describe your hearing?

☐ Normal ☐ Abnormal

If abnormal, please describe your hearing problem.

TEETH

What is the current condition of your teeth?

☐ Excellent ☐ Good Dental problems, explain

Have you worn braces? ☐ Y ☐ N

ALLERGIES

Do you have any known allergies? ☐ Y ☐ N

If yes, are your allergies:

☐ Food(s) ☐ Medication(s) ☐ Environmental ☐ Other

For each allergy, please describe the reaction(s) and age first noticed.

SUBSTANCE	REACTION	AGE

DIET

How would you best describe your daily diet?

☐ Vegetarian ☐ Non-Vegetarian ☐ Vegan

The Utah Center for Reproductive Medicine
675 Arapeen Drive, Suite 205
Salt Lake City, Utah 84108
801 587-3475 Office
801 585 2231 Fax

DONOR PERSONAL HISTORY

Donor #: ______________________________ Date: ______________

EXERCISE

How would you best describe your daily exercise?

☐ Regular ☐ Occasional ☐ None

Please describe your type of exercise.

____

____

____

EDUCATION

What is the highest level of education that you have completed?

☐ High School
☐ Some College
☐ College
☐ Pursuing Advanced Degree
☐ Advanced Degree

Where did you place upon high school graduation?
☐ The Upper Third ☐ The Middle Third ☐ The Lower Third

Please list your high school accomplishments (honors/AP classes, athletics, awards, scholarships, etc).

____

____

____

What classes, courses or subjects did/do you especially enjoy and excel?

____

____

SAT/ACT Score (if known): ______________________________

If you are in the process of obtaining a college or advanced degree or have obtained a degree, what is your field of study? (List any degrees/major(s) and minor(s))

____

____

Do you have any other specialized training? (Trade school, military, EMT etc.)

____

____

If currently not in school, please describe what you are doing now, i.e., homemaker/mother, type of employment. **Do not name company**.

____

____

The Utah Center for Reproductive Medicine
675 Arapeen Drive, Suite 205
Salt Lake City, Utah 84108
801 587-3475 Office
801 585 2231 Fax

DONOR PERSONAL HISTORY

Donor #: Date:

SOCIAL HISTORY

Do you smoke now or have you ever smoked? ☐ Y ☐ N
If yes, how much and for how long?

Do you consume alcohol? ☐ Y ☐ N
If yes, how much and how often?

Other substances? How often? ☐ Y ☐ N
If yes, please specify.

Please list your hobbies and interests. Please be thorough and detailed.

CURRENT MEDICATIONS

Are you taking any prescribed medications or other over the counter medications, such as vitamins or mineral or mineral or herbal supplements? ☐ Y ☐ N

If yes, please list each medication you are currently taking, the dose, the length of time you have been taking the medication and the reason for taking the medication.

MEDICATION	DOSE	LENGTH OF TIME	REASON

PAST MEDICAL HISTORY

Have you ever had surgery? ☐ Y ☐ N

If yes, please list the procedure, the year the procedure was done, and any complications resulting from the surgery.

PROCEDURE	YEAR	COMPLICATIONS

The Utah Center for Reproductive Medicine
675 Arapeen Drive, Suite 205
Salt Lake City, Utah 84108
801 587-3475 Office
801 585 2231 Fax

DONOR PERSONAL HISTORY

Donor #: Date:

PAST MEDICAL HISTORY (CONTINUED)

Have you ever had any major illnesses? ☐ Y ☐ N

If yes, please explain.

Have you ever had **major and/or frequent** radiation or x-ray exposure? ☐ Y ☐ N
Have you ever been exposed to toxic chemicals in your living or work environment? ☐ Y ☐ N

If yes, please explain.

FAMILY HEALTH HISTORY

Please describe your family members according to the following characteristics (please use natural eye and hair color; complexion: fair, medium, dark, etc; body type: small frame, etc.

MGM: Maternal Grandmother
MGF: Maternal Grandfather
PGM: Paternal Grandmother
PGF: Paternal Grandfather

	EYE COLOR	HAIR COLOR	COMPLEXION	HEIGHT	BODY TYPE
MOTHER					
FATHER					
MGM					
MGF					
PGM					
PGF					

Please describe your maternal ancestry, i.e., German, English, Italian, etc. (Do not put American, white, etc.)

Please describe your paternal ancestry, i.e., German, English, Italian, etc.

The Utah Center for Reproductive Medicine
675 Arapeen Drive, Suite 205
Salt Lake City, Utah 84108
801 587-3475 Office
801 585 2231 Fax

DONOR PERSONAL HISTORY

Donor #: Date:

FAMILY HEALTH HISTORY (CONTINUED)

How many biological siblings are in your immediate family?

Number of Siblings Number of Females Number of Males

Are there any twins or triplets in your family? ☐ Y ☐ N
If yes, what relation are they to you?

Circle appropriate sibling

	EYE COLOR	HAIR COLOR	COMPLEXION	HEIGHT	BODY TYPE
Brother/Sister					
Brother/Sister					
Brother/Sister					
Brother/Sister					
Brother/Sister					
Brother/Sister					

Please list below at what age members of your family died and the cause of their death; note if siblings were adopted.

	AGE (IF LIVING)	AGE (AT TIME OF DEATH)	CAUSE OF DEATH
MOTHER			
FATHER			
BROTHER(S)			
SISTER(S)			
MGM			
MGF			
PGM			
PGF			

Are there any known genetic diseases or conditions that run in your family? ☐ Y ☐ N
If yes, please explain.

The Utah Center for Reproductive Medicine
675 Arapeen Drive, Suite 205
Salt Lake City, Utah 84108
801 587-3475 Office
801 585 2231 Fax

DONOR PERSONAL HISTORY

Donor #: Date:

FAMILY HEALTH HISTORY (CONTINUED)

Have you ever been tested as a carrier of any of the following?
***Mark unknown unless testing has actually been done

Tay-Sach's Disease (Jewish Ancestry)	☐ Carrier	☐ Non-Carrier	☐ Unknown
Sickle Cell Disease (African American)	☐ Carrier	☐ Non-Carrier	☐ Unknown
Cystic Fibrosis (Caucasian)	☐ Carrier	☐ Non-Carrier	☐ Unknown
Thalassemia (Italian/Greek)	☐ Carrier	☐ Non-Carrier	☐ Unknown

The above diseases are not specific to the ancestries noted; rather they tend to occur most commonly in those ancestries.

The Utah Center for Reproductive Medicine
675 Arapeen Drive, Suite 205
Salt Lake City, Utah 84108
801 587-3475 Office
801 585 2231 Fax

DONOR PERSONAL HISTORY

Donor #: Date:

Carefully review the following list of medical problems and identify which are present in each of the listed family members. If the medical problem is not applicable to any of the listed family members, please check the N/A column.

	YOU	MOTHER	FATHER	SIBLINGS	MGM	MGF	PGM	PGF	Other	N/A
HEART										
Hardening of the Arteries										
Heart Attack										
• Heart Disease										
• From Birth										
High Blood Pressure										
High Cholesterol Level										
Stroke										
Other										
BLOOD										
Hemophilia/ Other Bleeding Disorders										
Other Blood Disorders										
Sickle Cell Anemia										
Thalassemia										
RESPIRATORY										
Asthma										
Cystic Fibrosis										
Other Lung Disease										
GASTROINTESTINAL										
Colon Cancer										
Crohn's Disease										
Ulcerative Colitis										
METABOLIC/ENDOCRINE										
Diabetes Mellitus										
Goiter										
Thyroid Cancer										
Thyroid Disease										
URINARY										
Kidney Disease										
Other Disease of Urinary Tract (Urethra, Bladder, Ureter)										

The Utah Center for Reproductive Medicine
675 Arapeen Drive, Suite 205
Salt Lake City, Utah 84108
801 587-3475 Office
801 585 2231 Fax

DONOR PERSONAL HISTORY

Donor #: Date:

FAMILY HEALTH HISTORY (CONTINUED)										
	YOU	**MOTHER**	**FATHER**	**SIBLINGS**	**MGM**	**MGF**	**PGM**	**PGF**	**Other**	**N/A**
GENITAL/REPRODUCTIVE										
Hypospadias										
Ovarian Cancer										
Prostate Cancer										
Testicular Cancer										
Undescended Testicle										
Uterine Fibroids										
REPRODUCTIVE OUTCOMES										
3 or More Miscarriages										
Stillborn										
Death of a Newborn Infant										
Neonatal Jaundice (G6PD)										
NEUROLOGICAL										
Epilepsy/Seizures										
Gaucher's Disease										
Huntington's Disease										
Hydrocephalus										
Mental Retardation										
Migraines										
Multiple Sclerosis										
Parkinson's Disease										
Scoliosis										
Senility Before Age 50										
Tourette's Syndrome										
Other Disease of Nervous System										
MENTAL HEALTH										
ADHD										
Learning Disabilities										
Manic Depressive or Bipolar Disorder										
Schizophrenia										
Other Mental Health Disorder(s) Requiring Hospitalization										

The Utah Center for Reproductive Medicine
675 Arapeen Drive, Suite 205
Salt Lake City, Utah 84108
801 587-3475 Office
801 585 2231 Fax

DONOR PERSONAL HISTORY

Donor #: Date:

FAMILY HEALTH HISTORY (CONTINUED)										
	YOU	MOTHER	FATHER	SIBLINGS	MGM	MGF	PGM	PGF	Other	N/A
MUSCLE/BONE/JOINT										
Arthritis										
Loss of Muscle Coordination										
Lupus										
Muscular Dystrophy										
Myasthenia Gravis										
Other Chronic Muscle Disease										
SIGHT/SOUND/SMELL										
Blindness										
Cataracts Before Age 50										
Color Blindness										
Deafness Before Age 60										
Glaucoma										
Any Other Sight/Sound/ Smell Disorder										
SKIN										
Acne										
Eczema										
Hirsutism										
Melanoma										
Pigmentation Disorders										
Neurofibromatosis										
Other Disorders of the Skin										
BIRTH DEFECTS										
Cleft Lip/Palate										
Congenital Hip Problems										
Other Birth Defects										
Uterine Anomaly										
CHROMOSOMAL ABNORMALITIES										
Abnormal Number of Chromosomes										
Down's Syndrome (Trisomy 21)										
Kleinfelter Syndrome										
Mental Retardation										
Translocation Carrier										
Turner Syndrome										

The Utah Center for Reproductive Medicine
675 Arapeen Drive, Suite 205
Salt Lake City, Utah 84108
801 587-3475 Office
801 585 2231 Fax

DONOR PERSONAL HISTORY

Donor #: Date:

FAMILY HEALTH HISTORY (CONTINUED)

	YOU	MOTHER	FATHER	SIBLINGS	MGM	MGF	PGM	PGF	Other	N/A
OTHER										
*Alcoholism										
*Drug Addiction										
*Breast Cancer (age of onset)										
Any Other Condition Not Mentioned										

*Describe treatment done for any condition listed above:
____

____

LIKES/DISLIKES

Favorite Movie/TV Series?______________________

Favorite Play or Musical?______________________

Favorite Type of Music?______________________

Favorite Musician/Band?______________________

Favorite Book/Author?______________________

Favorite Sport(s)?______________________

Favorite Food/Candy?______________________

Who is your hero and why?______________________

____

Do you own a pet? If so what kind?______________________

Do you enjoy traveling?______________________

Name a few places you have traveled to?______________________

Where would you most like to visit and why?______________________

Describe an ideal vacation and why?______________________

____

What language(s) did you grow up with?______________________

What language(s) do you speak?______________________

What are your special interests/hobbies/talents?______________________

What personal achievements are you most proud of?______________________

The Utah Center for Reproductive Medicine
675 Arapeen Drive, Suite 205
Salt Lake City, Utah 84108
801 587-3475 Office
801 585 2231 Fax

DONOR PERSONAL HISTORY

Donor #: Date:

It is helpful for our recipients when trying to decide which donor to select, to know more about you. Please write a couple of paragraphs to describe yourself. Here are some ideas you might want to include: Are you energetic, laid back, adventurous, outgoing? If you like to read, what books do you enjoy reading? Your strengths/weaknesses: such as loyalty, resilient, compassionate, extracurricular. What activities did you enjoy as a child/young adult? (dance, singing, sports, etc.) What activities do you enjoy as an adult?

The Utah Center for Reproductive Medicine
675 Arapeen Drive, Suite 205
Salt Lake City, Utah 84108
801 587-3475 Office
801 585 2231 Fax

DONOR PERSONAL HISTORY

Donor #: Date:

Medical Personnel Use Only (Donor, Please complete)

MENSTRUAL HISTORY

What was your age at your first menstrual cycle?
Approximate number of days between the start of one period to the start of the next? ____________________
Have you missed any periods? ☐ Y ☐ N
Are your menstrual cycles regular? ☐ Y ☐ N
Please describe any cycle irregularities.

CONTRACEPTION

Are you currently using birth control? ☐ Y ☐ N
(You cannot be an egg donor while using Depo-Provera. We would be happy to consider you in the future if you are using an alternate form of birth control)

If yes, which type?

☐ Birth Control Pills ☐ Condoms ☐ Nuva Ring
☐ Diaphragm ☐ IUD (Mirena, Paragard) ☐ Other ______________

If you are currently using birth control or have an IUD, were your periods regular before taking birth control/IUD?

☐ Y How many days between cycles ____

☐ N Explain frequency____

SEXUAL HISTORY

Are you sexually active at this time? ______________________
Number of sexual partners within the past 12 months? _________
Have you ever been treated for a sexually transmitted infection? ☐ Y ☐ N

Have you or any of your partners had or have any of the following?

	SELF	PARTNER	WHEN	HOW OFTEN
NON-SPECIFIC URETHRITIS				
SYPHILIS				
CHLAMYDIA				
VENEREAL/GENITAL WARTS				
HERPES				
HEPATITIS				
IV DRUG USE				
HIV/AIDS				
GONORRHEA				
OTHER STD'S				

The Utah Center for Reproductive Medicine
675 Arapeen Drive, Suite 205
Salt Lake City, Utah 84108
801 587-3475 Office
801 585 2231 Fax

DONOR PERSONAL HISTORY

Donor #: ______________________ Date: ______________

GYNECOLOGIC HISTORY

Date of Last Pap Smear: ______________________

Have you ever had an abnormal Pap Smear? ☐ Y ☐ N
If yes, please include date and explain.

____

____

____

If you have had an abnormal Pap Smear, did you have any follow up procedures? ☐ Y ☐ N
If yes, please explain.

____

____

____

Have you had a normal Pap Smear since your abnormal Pap Smear? ☐ Y ☐ N

REPRODUCTIVE HISTORY

Have you ever attempted to become pregnant? ☐ Y ☐ N ☐ N/A
Have you ever been pregnant? ☐ Y ☐ N ☐ N/A
Have you been an egg donor in the past? ☐ Y ☐ N ☐ N/A
Have you ever been told that you are infertile? ☐ Y ☐ N ☐ N/A
Has anyone in your family had fertility problems (difficulty conceiving or miscarriage)? ☐ Y ☐ N ☐ N/A
Have you ever had trouble conceiving? ☐ Y ☐ N ☐ N/A
Have you ever had any miscarriages? ☐ Y ☐ N ☐ N/A
Have you ever had any abortions? ☐ Y ☐ N ☐ N/A
Have you had ectopic/tubal pregnancies? ☐ Y ☐ N ☐ N/A
Have you had stillborn deliveries? ☐ Y ☐ N ☐ N/A
Have you had pregnancies with birth defects? ☐ Y ☐ N ☐ N/A
Are you currently pregnant? ☐ Y ☐ N ☐ N/A
Are you breastfeeding? ☐ Y ☐ N ☐ N/A

Total Number of Pregnancies? ______________________

YEAR	C-SECTION/DELIVERY	MISCARRIAGE	ECTOPIC	TERMINATION

The Utah Center for Reproductive Medicine
675 Arapeen Drive, Suite 205
Salt Lake City, Utah 84108
801 587-3475 Office
801 585 2231 Fax

DONOR PERSONAL HISTORY

Donor #: Date:

Please sign and date this form. Your signature signifies that the information given is complete and accurate to the best of your knowledge. If you fax or email form to clinic, please bring original with you to your appointment. Also, please bring childhood pictures ages 1-5 years old and if you are willing to show an adult picture, please bring several with you to your appointment.

Donor Signature: **Date:**

RN Signature: Date:

MD Signature: Date: