



## Egg Donor Application Form

Dear Prospective Donor,

We appreciate your interest in our program. On the following pages, you will find an application and information about egg donation. The process of becoming an egg donor involves a series of psychological and medical screenings. These appointments are made at no cost to you.

- The psychological screening involves approximately 2-3 office visits with our program's social worker.
- The medical screening involves approximately 2 appointments: the first is an ovarian volume (vaginal sonogram and blood testing for hormone levels), and the second is a physical exam which consists of a pelvic exam, drug testing, and blood tests for communicable diseases and genetic disorders.
- Your significant other will also need to see the social worker.

Once your screening is complete, you can be anonymously offered to an intended parent or couple for selection as an egg donor. If you are selected, you will be required to undergo the following:

- Once you begin stimulation for a donor cycle, you will need to come in to one of our monitoring offices between 6:30am-7:45am for blood work and sonograms for approximately 14 days.
- There will also be a day that you will need to come in to RMA Long Island IVF's Ambulatory Care Site, located at our Melville facility, for retrieval (harvesting of eggs). You are given anesthesia via IV sedation for this procedure, and you may resume normal activities the following day. You will need a responsible driver to bring you to the appointment and stay for the procedure.
- We will see you again after your next period for a resolution sonogram to examine your ovaries and uterus.

**All donors are compensated \$10,000** for the time and effort spent going through a donation cycle. You may be eligible to donate for our program up to six times.

If you are interested in proceeding, complete as much of the following application as you can and return it to us. **Please attach a current photo of yourself for office use only.** Additionally, if you have medical records pertaining to any medical conditions or previous donations, please enclose them. If you are unsure of any of the answers to the family health history questions, we recommend asking your parents and extended family for help. The personal sections help the intended parents sense what kind of person you are and how much thought was given to why you want to donate, so spelling and punctuation are important. **Please do not use white-out to correct mistakes. Instead, draw a line through the error.** You may contact the Egg Donation Team for assistance by calling (631) 768-8714 or (631) 768-8799. We will notify you when the review of your application is complete.

Thank you for your interest in helping infertile couples.

Sincerely yours,

Jasmine D'Alessandro, RN  
Third Party Manager

## Donor Information

Date: \_\_\_\_\_

Donor's Name: \_\_\_\_\_

Donor's Maiden Name (if married): \_\_\_\_\_

Donor's Marital Status:  Single  Married  Engaged  Divorced  Dating  Other

Partner/Husband's Name: \_\_\_\_\_

Address: \_\_\_\_\_ Apartment Number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Donor's Date of Birth: \_\_\_\_\_ Partner/Husband's Date of Birth: \_\_\_\_\_

Religion Born Into: \_\_\_\_\_

Complexion: \_\_\_\_\_ Eye Color: \_\_\_\_\_

Hair Color/Type: \_\_\_\_\_

Children/Ages: \_\_\_\_\_

Donor's Occupation: \_\_\_\_\_

Donor Weight: \_\_\_\_\_ Donor Height: \_\_\_\_\_

Highest Level of Education: \_\_\_\_\_

Donor's Medical Insurance Company: \_\_\_\_\_

Donor's SSN: \_\_\_\_\_ Partner/Husband's SSN: \_\_\_\_\_

Donor's Blood Type (if known): \_\_\_\_\_

Name of Primary Care Physician: \_\_\_\_\_

May we contact your physician?  Yes  No

Physician's Phone: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

## Substance Use

Have you ever smoked?  Yes  No

If yes, for how many years? \_\_\_\_\_ How many cigarettes per day? \_\_\_\_\_

If you quit smoking, when did you quit? \_\_\_\_\_

Drug History?  Yes  No |  Current  Past

From when to when? \_\_\_\_\_

If yes, what types? \_\_\_\_\_ How often? \_\_\_\_\_

## Alcohol

Do you drink alcoholic beverages?  Yes  No

If yes, what kind? \_\_\_\_\_

How many drinks (beer, wine, alcohol) do you consume on average per day? \_\_\_\_\_

How many drinks (beer, wine, alcohol) do you consume on average per week? \_\_\_\_\_

How many drinks (beer, wine, alcohol) do you consume on average per month? \_\_\_\_\_

Have you ever sought help for an alcoholic problem?  Yes  No

If yes, please explain: \_\_\_\_\_

If you do not drink at all, what is your reason? \_\_\_\_\_

## Allergies

Current allergies?  Yes  No

If yes, to what? (include drug allergies) \_\_\_\_\_

How long? \_\_\_\_\_

Any treatment given? \_\_\_\_\_

## Medications

Drug Name	Dosage	Frequency	Dates Taken	Reason	Current	Past
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>

## Previous Surgery

Date	Type of Surgery	Physician Name

## Menstrual History

Age of first menses: \_\_\_\_\_ Cycle Length: \_\_\_\_\_  Regular  Irregular

Dates last 3 periods started: 1: \_\_\_\_\_ 2: \_\_\_\_\_ 3: \_\_\_\_\_

Describe any menstrual related difficulties since puberty:

How bad were your menstrual cramps as a teenager? \_\_\_\_\_ Now? \_\_\_\_\_

Premenstrual Syndrome (PMS)?  Yes  No

Symptoms, duration, and severity: \_\_\_\_\_

Describe any medical treatment for menstrual problems:

## Reproductive History

Have you ever been pregnant?  Yes  No

If yes, how many times? \_\_\_\_\_

If yes, how many stillbirths? \_\_\_\_\_

How many live births? \_\_\_\_\_

How many miscarriages? \_\_\_\_\_

How many abortions? \_\_\_\_\_

Is there a history of infertility in your family? Explain:

Describe any reproductive complications:

## Pregnancy History

Child's Date of Birth	Infertility Therapy (if any)	Miscarriage (D&C done?)	Abortion	Ectopic Pregnancy	C-Section or Vaginal Delivery	Weight and Sex	Pregnancy Complications	Name of Child's Biological Father

## Children

Age	Hair Color	Hair Type	Eye Color	Skin Tone

Please be completely candid when answering the following questions. A “yes” response will not necessarily eliminate you as a potential donor. Many applicants have at least one of these conditions. Please answer all questions openly and honestly. The accuracy of the information you provide will have an impact on the future generations you may help to create.

If you are accepted as a donor, a portion of your statements will be made anonymous and then circulated amongst our patients. This information will remain a confidential part of your medical record unless you agree to allow us to share it. If you choose not to share this information with our patients, you will not be allowed to donate with our program.

Are you a citizen of the United States?

Yes     No

Some people cannot provide a complete family history (including grandparents). For example, if you are adopted, or do not know one side of your family, your ability to provide a complete family history may be compromised. Is there any reason you cannot complete a family history?

Yes     No

If yes, please explain:

How did you hear about our program? (Please be specific with the publication or website where you saw/heard our ad, or with the name of the person who referred you.)

Have you ever been an egg donor before?

Yes     No

If yes, where and how many times?

Please describe any concerns or complications from prior donations:

## Personal History Recap

Today's Date: \_\_\_\_\_ Age: \_\_\_\_\_ Year of Birth: \_\_\_\_\_  
Religion Born Into: \_\_\_\_\_ Place of Birth (Country/State): \_\_\_\_\_  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Race/Ethnicity: \_\_\_\_\_  
Countries of Ancestry: \_\_\_\_\_

## Physical Characteristics

Body Type/

Bone Structure:  Small  Medium  Large

Hands:  Right-handed  Left-handed  Ambidextrous

## Eyes

Color:  Brown  Hazel  Green  Blue

Set:  Narrow  Average  Wide

Size:  Small  Average  Large

Shape:  Round  Oval  Almond

Shade:  Light  Medium  Dark

## Hair

Color as a Young Child:  Blonde  Brown  Black  Red Other: \_\_\_\_\_

Natural Color:  Blonde  Brown  Black  Red Other: \_\_\_\_\_

Shade:  Light  Medium  Dark

Type:  Straight  Wavy  Curly

Fullness:  Thin  Medium  Thick

Texture:  Fine  Medium  Coarse

## Nose

Size:  Small  Medium  Large

Width:  Narrow  Average  Wide

Length:  Short  Average  Long

Nostril Flare  Small  Average  Wide

## Cheekbones

Set:  Low  Average  High

Prominence:  Slight  Medium  Strong

## Mouth

Size:  Small  Average  Large

Lips:  Thin  Average  Full

## Chin

Shape:  Square  Oval  Round  
Prominence:  Slight  Average  Strong  
Dimples:  None  Slight  Medium  Strong

## Skin

Skin Tone:  Light  Med-light  Medium  Med-dark  Dark  
Tanning Ability:  Slight  Medium  Easy  
Condition:  Oily  Medium  Dry  Combination  
Acne:  None  Slight  Medium  Severe At What Age: \_\_\_\_\_

## Other Facial Features

Moles:  None  One  Several  Numerous Where: \_\_\_\_\_  
Freckles:  None  Several  Moderate  Numerous Where: \_\_\_\_\_  
Dimples:  None  Slight  Medium  Deep Where: \_\_\_\_\_

## Vision Aids

Vision:  Normal  Far-sighted  Near-Sighted  
Glasses/ Contacts:  None  Single  Bifocal  Trifocal Age Diagnosed: \_\_\_\_\_  
Laser Corrective Surgery:  Yes  No When: \_\_\_\_\_

## Dental Devices

Device:  None  Braces  Retainer Other: \_\_\_\_\_  
Reason:  Cosmetic  Accident  Disease Other: \_\_\_\_\_  
Age During Use: \_\_\_\_\_ to \_\_\_\_\_ years of age

## Other Physical Aids

List: \_\_\_\_\_  
Reason/Cause: \_\_\_\_\_

## Religion

Are you an atheist/agnostic?  Yes  No  
Religion born into: \_\_\_\_\_ What religion did you belong to as a child? \_\_\_\_\_  
As an adult? \_\_\_\_\_  
How religious are you now?:  Very  Moderately  Occasionally Attend  Not at All

## Education

Have you completed grade school?  Yes  No

Have you completed high school?  Yes  No

Currently in college, pursuing a degree in: \_\_\_\_\_

Completed college degree in: \_\_\_\_\_

Currently pursuing an advanced degree in: \_\_\_\_\_

Completed an advanced degree in: \_\_\_\_\_

## Languages

Speak: \_\_\_\_\_ Read: \_\_\_\_\_ Write: \_\_\_\_\_

## Athletic Activity

Athletic  Active  Average  Inactive

What physical activities do you engage in? \_\_\_\_\_

Have you excelled in any physical activities?  Yes  No

Please list them: \_\_\_\_\_

## Manual Dexterity

Dexterous  Average  Clumsy

What manual skills do you have?

What other skills or talents do you have (e.g., painting, writing, reading, ability to do games, crossword puzzles, handcrafts, etc.) Please describe:

## Musical Ability

Musical  Average  Tone Deaf

## Work/Occupational History

\*(Please DO NOT list employers, or company names; only your occupation/job title)

What were your strengths in school?

What were your weaknesses in school?



Were you ever diagnosed with any learning disabilities?

What is your current or most recent occupation?

What other types of employment have you had?

Describe any weight problems you may have had:

Describe your dietary preferences and dislikes:

Have you ever been convicted of a crime, or at present, have any pending legal action?

Yes     No    If yes, please describe: \_\_\_\_\_

Describe yourself as a child (e.g., personality, health, interests, activities, etc.):

What are your favorite foods?

What is your favorite color?

Do you like pets? If so, which animal is your favorite?

Where would you most like to travel and why?

How would you describe your personality?

What is your ultimate ambition or goal in life?

What were your reasons for becoming a donor?

What would you especially like your genetic offspring to know about you (if anything)?

Would you be willing to be contacted by RMA Long Island IVF in the future, if your genetic offspring needed further genetic or medical information?

Yes     No

## Family History

Please complete the chart below for each of your immediate family members. Please fill in each family member's current age (or age at death). Please list any medical problems they have currently (and/or their specific cause of death), AND any medical problems they may have had in the past. Be sure to list any brothers or sisters who may have died in infancy. Please ask your family members if you are unsure about their medical history.

Family Member	Age (If Alive)	Medical Problems	Age at Death (If Applicable)	Cause of Death (If Applicable)
Mother				
Father				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
<input type="checkbox"/> Brother <input type="checkbox"/> Sister				
<input type="checkbox"/> Brother <input type="checkbox"/> Sister				
<input type="checkbox"/> Brother <input type="checkbox"/> Sister				
<input type="checkbox"/> Brother <input type="checkbox"/> Sister				

What is your ethnic background? (Please check all that apply. If none apply, please write in next to Other:)

- |  |  |
|--|--|
| <input type="checkbox"/> Northern European (Ireland, Denmark, Finland, UK, etc.) | <input type="checkbox"/> West Indies / Caribbean |
| <input type="checkbox"/> Western European (Austria, France, Germany, etc.)       | <input type="checkbox"/> French Canadian / Cajun |
| <input type="checkbox"/> Southern Europe (Italy, Spain, Portugal, etc.)          | <input type="checkbox"/> Puerto Rican            |
| <input type="checkbox"/> Southeast Asian (Cambodia, Vietnam, etc.)               | <input type="checkbox"/> Dominican Republic      |
| <input type="checkbox"/> Far East Asian (China, Japan, Philippines, etc.)        | <input type="checkbox"/> Mexican                 |
| <input type="checkbox"/> Middle Eastern (Iran, Israel, Syria, Egypt, etc.)       | <input type="checkbox"/> Native American         |
| <input type="checkbox"/> Ashkenazi Jewish / Sephardic Jewish                     | <input type="checkbox"/> Indian                  |
| <input type="checkbox"/> African   | Other: _____                                     |
| <input type="checkbox"/> South American (Brazil, Peru, Argentina, etc)           |  |

When completing the family history section on the following pages, please DO NOT write the names of your family members or the names of their places of employment (for Occupation: just list their job title/type of employment, for example: office clerk, bank manager, or school teacher, etc.). Please request additional page if needed.

### Mother

Place of Birth: \_\_\_\_\_  
Racial Group: \_\_\_\_\_  
Religion: \_\_\_\_\_  
Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Eye Color: \_\_\_\_\_ Natural Hair Color: \_\_\_\_\_ Complexion: \_\_\_\_\_  
Body Type: \_\_\_\_\_ Bone Structure: \_\_\_\_\_  
Other Distinguishing Features: \_\_\_\_\_  
Occupation: \_\_\_\_\_  
Education: \_\_\_\_\_  
Special skills, characteristics, achievements: \_\_\_\_\_  
Describe her personality: \_\_\_\_\_

### Father

Place of Birth: \_\_\_\_\_  
Racial Group: \_\_\_\_\_  
Religion: \_\_\_\_\_  
Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Eye Color: \_\_\_\_\_ Natural Hair Color: \_\_\_\_\_ Complexion: \_\_\_\_\_  
Body Type: \_\_\_\_\_ Bone Structure: \_\_\_\_\_  
Other Distinguishing Features: \_\_\_\_\_  
Occupation: \_\_\_\_\_  
Education: \_\_\_\_\_  
Special skills, characteristics, achievements: \_\_\_\_\_  
Describe his personality: \_\_\_\_\_

### Sibling 1

Brother  Sister

Place of Birth: \_\_\_\_\_  
Racial Group: \_\_\_\_\_  
Religion: \_\_\_\_\_  
Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Eye Color: \_\_\_\_\_ Natural Hair Color: \_\_\_\_\_ Complexion: \_\_\_\_\_  
Body Type: \_\_\_\_\_ Bone Structure: \_\_\_\_\_  
Other Distinguishing Features: \_\_\_\_\_  
Occupation: \_\_\_\_\_  
Education: \_\_\_\_\_  
Special skills, characteristics, achievements: \_\_\_\_\_  
Describe his/her personality: \_\_\_\_\_

## Sibling 2

Brother    Sister

Place of Birth: \_\_\_\_\_

Racial Group: \_\_\_\_\_

Religion: \_\_\_\_\_

Age: \_\_\_\_\_      Height: \_\_\_\_\_      Weight: \_\_\_\_\_

Eye Color: \_\_\_\_\_      Natural Hair Color: \_\_\_\_\_      Complexion: \_\_\_\_\_

Body Type: \_\_\_\_\_      Bone Structure: \_\_\_\_\_

Other Distinguishing Features: \_\_\_\_\_

Occupation: \_\_\_\_\_

Education: \_\_\_\_\_

Special skills, characteristics, achievements: \_\_\_\_\_

Describe his/her personality: \_\_\_\_\_

## Sibling 3

Brother    Sister

Place of Birth: \_\_\_\_\_

Racial Group: \_\_\_\_\_

Religion: \_\_\_\_\_

Age: \_\_\_\_\_      Height: \_\_\_\_\_      Weight: \_\_\_\_\_

Eye Color: \_\_\_\_\_      Natural Hair Color: \_\_\_\_\_      Complexion: \_\_\_\_\_

Body Type: \_\_\_\_\_      Bone Structure: \_\_\_\_\_

Other Distinguishing Features: \_\_\_\_\_

Occupation: \_\_\_\_\_

Education: \_\_\_\_\_

Special skills, characteristics, achievements: \_\_\_\_\_

Describe his/her personality: \_\_\_\_\_

## Sibling 4

Brother    Sister

Place of Birth: \_\_\_\_\_

Racial Group: \_\_\_\_\_

Religion: \_\_\_\_\_

Age: \_\_\_\_\_      Height: \_\_\_\_\_      Weight: \_\_\_\_\_

Eye Color: \_\_\_\_\_      Natural Hair Color: \_\_\_\_\_      Complexion: \_\_\_\_\_

Body Type: \_\_\_\_\_      Bone Structure: \_\_\_\_\_

Other Distinguishing Features: \_\_\_\_\_

Occupation: \_\_\_\_\_

Education: \_\_\_\_\_

Special skills, characteristics, achievements: \_\_\_\_\_

Describe his/her personality: \_\_\_\_\_

Has any member of your family, including yourself, had a problem or defect AT BIRTH in any of the following body systems?

	Yes	No	Type of Defect	Affected Family Member	Relevant Circumstances
Organ (heart, lung, kidney, etc.)					
Blood circulation	<input type="checkbox"/>	<input type="checkbox"/>			
Respiratory system	<input type="checkbox"/>	<input type="checkbox"/>			
Gastrointestinal system	<input type="checkbox"/>	<input type="checkbox"/>			
Genital/Urinary	<input type="checkbox"/>	<input type="checkbox"/>			
Metabolic (hormones, enzymes, etc.)	<input type="checkbox"/>	<input type="checkbox"/>			
Nervous system, brain, spinal cord	<input type="checkbox"/>	<input type="checkbox"/>			
Bones, muscles, joints, limbs	<input type="checkbox"/>	<input type="checkbox"/>			
Cleft Lip / Cleft Palate	<input type="checkbox"/>	<input type="checkbox"/>			
Other	<input type="checkbox"/>	<input type="checkbox"/>			

Are there any diseases, abnormalities or conditions that appear to run in your family?

Yes    No

If yes, please indicate the disease(s) and the family members affected:

Has anyone in your family, including yourself, experienced recurring and/or chronic physical symptoms that have not been evaluated by a physician? (Please include those symptoms that you may not consider serious).

Yes    No

If yes, please explain:

In the following charts, please indicate the number of relatives who have been diagnosed with each condition in the corresponding boxes. **If you have the condition, mark an X under "You."** **If none of your family members have the condition, you must mark an X under "No One."**

### Heart Conditions

Family Member:	You	Mom	Dad	Siblings		Grandparents				Aunts		Uncles		Maternal Cousins		Paternal Cousins		No One	
	-	-	-	F	M	MGM	MGF	PGM	PGF	Mat	Pat	Mat	Pat	F	M	F	M	-	
Heart Disease/ Defect From Birth																			
Other Heart Disease/Defect																			
Heart Attack																			
Hardening of Arteries																			
High Blood Pressure																			
Hypertrophic Idiopathic Subaortic Stenosis (HISS)																			
Other Heart Conditions																			

## Blood Conditions

Family Member	You	Mom	Dad	Siblings		Grandparents				Aunts		Uncles		Maternal Cousins		Paternal Cousins		No One	
				F	M	MGM	MGF	PGM	PGF	Mat	Pat	Mat	Pat	F	M	F	M		
	-	-	-																-
Anemia																			
Leukemia																			
Other Blood Disorders																			

## Respiratory Conditions (Lungs)

Family Member:	You	Mom	Dad	Siblings		Grandparents				Aunts		Uncles		Maternal Cousins		Paternal Cousins		No One	
				F	M	MGM	MGF	PGM	PGF	Mat	Pat	Mat	Pat	F	M	F	M		
	-	-	-																-
Hay Fever																			
Asthma																			
Emphysema																			
Tuberculosis																			
Lung Cancer																			
Pneumonia																			
Other Lung Disease																			

## Urinary Tract Conditions

Family Member	You	Mom	Dad	Siblings		Grandparents				Aunts		Uncles		Maternal Cousins		Paternal Cousins		No One	
				F	M	MGM	MGF	PGM	PGF	Mat	Pat	Mat	Pat	F	M	F	M		
	-	-	-																-
Kidney Disease																			
Alport's Syndrome																			
Adult Onset Polycystic Kidney																			
Other Disorders/ Diseases																			

## Gastro-Intestinal Conditions

Family Member:	You	Mom	Dad	Siblings		Grandparents				Aunts		Uncles		Maternal Cousins		Paternal Cousins		No One	
				F	M	MGM	MGF	PGM	PGF	Mat	Pat	Mat	Pat	F	M	F	M		
Ulcer of Stomach/ Duodenum																			
Gall Stones																			
Hepatitis A (Infectious)																			
Hepatitis B (Serum)																			
Other Liver Disease																			
Colon Cancer																			
Ulcerative Colitis																			
Crohn's Disease																			
Cystic Fibrosis																			
Intestinal Cancer																			
Hereditary Hypercholesterolemia																			
Familial Colon Polyps																			
Other Disorders/ Diseases																			

## Skin Conditions

Family Member:	You	Mom	Dad	Siblings		Grandparents				Aunts		Uncles		Maternal Cousins		Paternal Cousins		No One	
				F	M	MGM	MGF	PGM	PGF	Mat	Pat	Mat	Pat	F	M	F	M		
Acne																			
Eczema																			
Skin Cancer																			
Pigmentation Disorders																			
Melanoma																			
Albinism																			
Neurofibromatosis																			
Other Skin Disorders																			

## Genetic Conditions

Family Member:	You	Mom	Dad	Siblings		Grandparents				Aunts		Uncles		Maternal Cousins		Paternal Cousins		No One	
				F	M	MGM	MGF	PGM	PGF	Mat	Pat	Mat	Pat	F	M	F	M		
Hereditary Spherocytosis																			
Sickle-Cell Anemia																			
Hemophilia/Other																			
Fragile X Syndrome																			
Thalassemia																			
Tay Sachs Disease																			
G6DP Deficiency																			
Spinal Muscular Atrophy																			
Other Disorders/ Diseases																			

## Genital/Reproductive System Conditions

Family Member:	You	Mom	Dad	Siblings		Grandparents				Aunts		Uncles		Maternal Cousins		Paternal Cousins		No One	
				F	M	MGM	MGF	PGM	PGF	Mat	Pat	Mat	Pat	F	M	F	M		
Prostate Cancer																			
Uterine Fibroids																			
Ovarian Cysts																			
Cancer of Cervix/Ovaries/Uterus																			
DES Exposure																			
Breast Cancer																			
Infertility Workup																			
Balanced Translocation																			
Other Disorders/ Diseases																			



## Metabolic/Endocrine Conditions

Family Member:	You	Mom	Dad	Siblings		Grandparents				Aunts		Uncles		Maternal Cousins		Paternal Cousins		No One	
				F	M	MGM	MGF	PGM	PGF	Mat	Pat	Mat	Pat	F	M	F	M		
Diabetes (Type 2)																			
Hypoglycemia																			
Thyroid Cancer																			
Hyper/Hypo Thyroid																			
Goiter																			
Adrenal Dysfunction/ Disorder																			
Other Disorders/ Diseases																			

## Mental Health Conditions

Family Member:	You	Mom	Dad	Siblings		Grandparents				Aunts		Uncles		Maternal Cousins		Paternal Cousins		No One	
				F	M	MGM	MGF	PGM	PGF	Mat	Pat	Mat	Pat	F	M	F	M		
Schizophrenia																			
Bi-Polar/Manic Depression																			
Other Mental Disorders Requiring Hospitalization/ Medications																			
Severe Depression/ Anxiety/Phobias/ Inability to Function																			
Alcoholism																			
Drug Abuse/Misuse/ Addiction																			

## Neurological Conditions

Family Member:	You	Mom	Dad	Siblings		Grandparents				Aunts		Uncles		Maternal Cousins		Paternal Cousins		No One	
				F	M	MGM	MGF	PGM	PGF	Mat	Pat	Mat	Pat	F	M	F	M		
Migraines																			
Mental Retardation																			
Senility Before Age 50																			
Alzheimer's Disease																			
Multiple Sclerosis																			
Tuberculosis Sclerosis																			
Cerebral Palsy																			
Amyotrophic Lateral Sclerosis																			
Epilepsy or Seizures																			
Hydrocephalus (Water on Brain)																			
Congenital Hydrocephalus (Aqueduct Obstruction)																			
Huntington's Disease																			
Gaucher's Disease																			
Wilson's Disease																			
Creutzfeldt-Jakob disorder or other neurological disorder																			

## Muscle, Bone, and Joint Conditions

Family Member:	You	Mom	Dad	Siblings		Grandparents				Aunts		Uncles		Maternal Cousins		Paternal Cousins		No One	
				F	M	MGM	MGF	PGM	PGF	Mat	Pat	Mat	Pat	F	M	F	M		
Muscular Dystrophy																			
Duchenne-Becker's Muscular Dystrophy																			
Myotonic Dystrophy																			
Autoimmune Disease																			
Lupus																			
Deformity of Spine																			
Osteoporosis																			
Dwarfism																			
Low Back Disease																			
Arthritis: Rheumatoid, Osteo, Other																			
Gout																			
Cleft Palate																			
Cleft Lip																			
Congenital Hip Dislocation																			
Other Disorders/ Diseases																			

## Sight, Sound, Smell Conditions

Family Member:	You	Mom	Dad	Siblings		Grandparents				Aunts		Uncles		Maternal Cousins		Paternal Cousins		No One	
				F	M	MGM	MGF	PGM	PGF	Mat	Pat	Mat	Pat	F	M	F	M		
Deafness Before Age 60																			
Significant Hearing Loss																			
Deformity of the Ear																			
Cataracts Before Age 50																			
Blindness																			
Color Blindness																			
Glaucoma																			
Deviated Septum																			
Severe Myopia (Poor Vision)																			
Retinitis (Inflamed Retina)																			
Retinoblastoma (Retina Cancer)																			
Retinitis Pigmentosa (Night Blindness, Tunnel Vision)																			
Other Disorders/ Diseases																			

## Miscellaneous

Family Member	You	Mom	Dad	Siblings		Grandparents				Aunts		Uncles		Maternal Cousins		Paternal Cousins		No One	
				F	M	MGM	MGF	PGM	PGF	Mat	Pat	Mat	Pat	F	M	F	M		
	-	-	-	F	M	MGM	MGF	PGM	PGF	Mat	Pat	Mat	Pat	F	M	F	M	-	
Other Cancer Not Mentioned																			
Other Condition Not Mentioned																			

## Risk Factor Questionnaire

	Yes	No	Don't Know	Donor Comments	Nurse's Comments
Have you injected drugs for a non-medical reason in the last 5 years, including intravenous, intramuscular, or subcutaneous injection?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Do you have a clotting disorder for which you have received human-derived clotting factor concentration? Or had sex with anyone who has?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Have you had sex for drugs or money in the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
In the past 12 months, have you given money or drugs to anyone to have sex with you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Have you had sex in the past 12 months with anyone who would answer yes to the above 4 questions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
In the past 12 months, have you had sex with a man who has had sex with another man in the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
In the past 12 months, have you had sex with a person known or suspected to have HIV, or active hepatitis B or C?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
In the past 12 months, have you been exposed to known or suspected HIV, hepatitis B and/or hepatitis C infected blood through percutaneous inoculation, contact with an open wound, non-intact skin or mucous membrane?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
In the past 12 months, have you been in close contact or had sex with or shared a kitchen or bathroom with a person having active viral hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
In the past 12 months, have you had tattooing, ear or body piercing? If so, please give dates.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
After the age of 11, have you ever had viral hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Have you yourself received or had intimate contact (i.e. exchanged bodily fluids, including sharing toothbrushes and razors) with someone who has received organs or cells from non-human sources?(Xenotransplation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Have you had or been in contact with anyone who has had a recent small pox vaccination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Have you been diagnosed with West Nile Virus?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Have you had a headache and a fever within the last 7 days?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
In the past 12 months, have you had acupuncture, electrolysis, an accidental needle stick, or a sharp instrument injury? If so, please give dates.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Have you ever received growth hormone made from human pituitary glands or any blood products?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Have you ever received a dura mater (brain covering) bone or skin graft? Give dates.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

	Yes	No	Don't Know	Donor Comments	Nurse's Comments
Have you or your blood relatives ever had Creutzfeldt-Jakob disease or any neurological disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
In the past 12 months, have you had a positive syphilis test?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
In the past 12 months, have you had or been treated for syphilis, gonorrhea, or Chlamydia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Have you ever been in jail? For how long?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
From 1980 through 1996, were you a member of the US military, a civilian military employee, or a dependent of a member of the US military?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
In the past 3 years, have you ever been outside of the United States? Where and when?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Since 1980, have you ever lived in or traveled to Europe? (Includes: England, Ireland, Scotland, Wales, the Isle of Man, the Channel Islands, Gibraltar or the Falkland Islands) Give dates.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Have you ever been in a place affected by SARS (i.e., China) or been treated or been with an affected person in the past 14 days?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Were you born in, have you lived in, or have you traveled to any African country since 1977?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Have you had sexual contact with anyone who was born in or lived in any African country since 1977?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Have you had a blood transfusion, or were you deferred as a blood donor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Have you ever been diagnosed with T.cruzi or Chagas?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Have you had immunoglobulin or Rhogam vaccine? If so, which, and when?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Have you ever been exposed to toxic substances?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Does your occupation put you at risk for exposure of radiation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
In the last six months have you or a sexual partner lived in or travelled to any area affected by Zika? Have you or a sexual partner been diagnosed with Zika Infection in the past 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Within the preceding six months, have you been the recipient of a bite from an animal suspected of rabies?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

I have reviewed all risk factor questions and verify my answers to be true:

Donor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

DE Coordinator Review Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Dates: Created 9/9/08 VL  
Revised 03/13/20 TS

I, \_\_\_\_\_, have carefully read and answered all of the questions in this donor egg application. My responses are true and correct to the best of my knowledge. In addition, with the exception of all personally identifying information, I have agreed to allow RMA Long Island IVF, P.C. ("RMA Long Island IVF") to share a portion of this application that contains potentially-identifying information about me (pages 1-13 of this packet, referred to as the "Abstract"), with intended parents. Although the Abstract does not contain my name, date of birth, or address, etc. it may be possible for someone to identify me based on the combination of other information disclosed in the Abstract. I, therefore, waive my rights to privacy under HIPAA and any other pertinent federal and state laws concerning privacy and/or confidentiality. I also hereby release and forever discharge RMA Long Island IVF, its directors, officers and employees from and against any claims stemming from the provision of the Abstract to any intended parents. I further understand that while RMA Long Island IVF will avoid disclosure to every extent possible, intended parents and donors assume the risk of identification via participation in this program.

Potential Donor's Signature \_\_\_\_\_  
Date \_\_\_\_\_

I hereby authorize RMA Long Island IVF to release to my insurance carrier records pertaining to my medical history, services rendered, or treatment given to me.

Potential Donor's Signature \_\_\_\_\_  
Date \_\_\_\_\_

If you have any comments or concerns, please feel free to share them with us:

Please save your work and email this completed application as an attachment to **[dmathys@rmaliivf.com](mailto:dmathys@rmaliivf.com)** and **[trothwell@rmaliivf.com](mailto:trothwell@rmaliivf.com)**, OR you may print and mail it to:

**RMA Long Island IVF Donor Egg Program  
8 Corporate Center Drive, Suite 101  
Melville, NY 11747**



Daniel Kenigsberg, M.D., Medical Director  
Aviva Zigelman, LCSW, Program Director  
Jasmine D'Alessandro, RN, Third Party Manager  
Theresa Rothwell, RN  
Karen Froehlich, RN  
Debra Mathys, Admin Assistant