

P.O. Box 1646
Castle Rock, Colorado 80104
720-733-0184
Toll Free 1-877-745-3447
info@donatedeggs.com

Donor Number: _____ **(For Agency Use Only)**

Today's Date: _____

Date of Birth: _____

How did you hear of An Eggceptional Match? (If website, pls. specify): _____

Full Legal Name and any aliases: _____

Social Security #: _____ Insurance Co: _____

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

Home Phone: _____ Work Phone: _____

Cell Phone: _____ May we leave a voicemail message at: **(Pls. Circle)**: Home Work Cell

Are email communications permissible? If so, what is your E-mail Address:

I check my email: all day once a day several times a week rarely

Are text messages permissible and if so at what telephone numbers? Yes No _____

Are you currently listed with any other clinics or agencies? _____ If yes, whom? _____

Have you signed a contract with any other clinic or agency? _____ If so, please provide a complete copy to me.

Have you ever been denied entry into another egg donor program? _____ If yes, please explain in detail:

How soon are you able to begin your donation? _____

Who may we contact in case of an emergency? _____

Relationship _____ Ph: _____

Who may we contact in case your demographics change? _____ Ph: _____

Are you (Pls. Circle): Married Single with relationship Single without relationship

Are you a U.S. Citizen? Yes No

Do you have medical insurance? Yes No

If so, provide name of your health plan and identification number: _____

Are you willing to travel for an egg donation? Yes No Possibly if: _____

Do you have any lawsuits or other legal claims pending against you? Yes No

Have you ever filed bankruptcy? Yes No If so, when? _____

Have you ever been convicted of a crime? Yes No If yes, please provide details including date, name of criminal offense, date of conviction, location, etc.:

PHYSICAL CHARACTERISTICS

Age: _____ Height: _____ Weight: _____ Measurements: Bust _____ Hips _____ Waist _____

Race: _____ (Caucasian, African American, Asian, Hispanic, etc...)

Ethnicity: (Pls. Be specific, ie...German, French, Irish, etc...) _____

Mother's Side: _____

Father's Side: _____

Blood Type: _____ (+ or -) Place of Birth: _____

What celebrity do people most commonly say you look like? _____

***Once you are chosen as an egg donor, first morning appointments are mandatory. You are not able to choose the dates of your appointments, as they will coincide with the clinic's requirements and timing of your cycle. You will be required to attend 7-10 monitoring appointments prior to the actual egg retrieval. Most clinics are open between 7:30-8:00 a.m. If your schedule cannot accommodate this criterion, you will not qualify for the egg donation process**

PLEASE CIRCLE (OR HIGHLIGHT) APPROPRIATE RESPONSE

| | | | | | | | |
|---------------------------|---|-------------|--------------|---------------------|-------------|-------------------|-------|
| 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: | *Natural Color | blond | brown | black | red | other _____ | |
| | *Color as child | blond | brown | black | red | | |
| | *Shade | light | medium | dark | | | |
| | *Type | straight | wavy | curly | | | |
| | *Fullness | thin | medium | thick | | | |
| | *Texture | fine | medium | course | | | |
| Nose: | *Size | small | medium | large | | | |
| | *Width | narrow | average | wide | | | |
| | *length | short | average | wide | | | |
| | *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 | | | |
| | *Cleft | none | slight | medium | | | |
| Skin: | *Tone | light | med-light | medium | med-dark | dark | olive |
| | *Tan Ability | none | slight | medium | easy | | |
| | *Condition | normal | dry | oily | medium | combination | |
| | *Acne | none | slight | medium | severe | at what age _____ | |
| Other Facial Features: | *Moles | none | one | several | numerous | | |
| | *Freckles | none | several | moderate | numerous | | |
| | *Dimples | none | slight | medium | deep | | |
| Eyesight: | *Vision | normal | far-sighted | near-sighted | | | |
| | *Glasses | none | single | bifocal | | | |
| | *Astigmatism | yes | no | age diagnosed _____ | | | |
| Dental: | *Device | none | braces | retainer | other _____ | | |
| | *Reason | cosmetic | accident | disease | other _____ | | |
| | *Age during use _____ to _____ years of age | | | | | | |

REPRODUCTIVE HISTORY

Age at first period? _____ Are your cycle's regular? _____

How long are your cycles from day one to the next day one? _____ How long do they last? _____

Do you experience cramps? None Mild Average Severe

Method of birth control? _____ If none, in the past? _____

Have you ever been pregnant? _____ If yes, did you have trouble conceiving? _____

Have you ever been treated for infertility? _____

Did your mother take DES while she was pregnant with you? _____

LIST OF PREGNANCIES AND OUTCOMES

| Year | Delivery ♀ or ♂ Section/Vag | Miscarriage | Ectopic | Blighted Ovum | Termination |
|------|--------------------------------|-------------|---------|---------------|-------------|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |
| 5. | | | | | |
| 6. | | | | | |

Any complications? _____

DONATION HISTORY

Have you ever donated your eggs before? _____ If yes, Please list dates and outcomes:

| Mo/Year | # Eggs Retrieved | # Eggs Fertilized | Did a pregnancy occur? | Did a live birth occur? |
|---------|------------------|-------------------|------------------------|-------------------------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Were their embryos left to cryopreserve (freeze)? _____ If yes, approximately how many per cycle? _____

What is the compensation you are asking for your donation? _____ (1st time donors \$5,000)

What is the least amount you would consider? _____

Will you require missed wages from work? _____

If yes, what is your hourly wage? _____ How many hours per week do you work? _____

Will you require childcare reimbursement? _____ If yes, what is the hourly rate? _____ X _____ kids

MEDICAL HISTORY

Have you ever had any surgeries? If so please list type and date:

1. _____
2. _____

Have you had a blood transfusion in the last 12 months? _____

If yes, please list date and reason: _____

Any hospitalizations not mentioned above? _____ If yes, please explain: _____

Have you been exposed to radiation or toxic chemicals in your work or personal life? _____

Have you received a bite from an animal suspect for rabies within the last 6 months? _____

Have you ever had a reaction to anesthesia? _____ If yes, please explain reaction in detail: _____

*Do you smoke cigarettes? _____ Packs per day? _____ # of years _____ # of years quit _____

Do you now or have you ever taken recreational drugs? _____ If so, What? _____

Do you drink alcohol? _____ If yes, how many drinks per: day? _____ week? _____ month? _____

Do you have any allergies to drugs or environmental exposures? _____ Pls. explain: _____

Describe any childhood allergies that you have outgrown: _____

Do you have any medical illnesses (diabetes, asthma, etc...)? _____ If yes, pls. explain: _____

Do you have frequent nose bleeds, bleeding gums while brushing your teeth and or clots with menstrual periods?

Have you been sexually active in the past 6 months? _____

Are you currently sexually active? _____ If yes, is it a monogamous relationship? Yes No

If yes, for how long? _____

If no, will your partner consent to standard blood testing? _____

Have you or your partner ever had a sexually transmitted disease (trichomonias, chlamydia, syphilis, condyloma, gonorrhea, herpes)? Yes No

If yes, when and what was your treatment regimen?

Have you ever been diagnosed with any gynecological problems such as endometriosis, ovarian cysts, abnormal Pap smears, fibroids, polyps? Yes No If yes, please explain treatment _____

Please list all prescription or over the counter medications including dosage you are currently taking:

***To become an egg donor, you must be completely drug free. You must also be nicotine free for at least 6 mos. You may be tested for this substance at any time.**

EDUCATION

Highest Level of Education Completed: Grade School _____
Jr. High School _____
Sr. High School (GPA: _____)
Currently in College pursuing a degree in: _____
Completed College with degree in: _____
Currently pursuing advanced degree in: _____
Completed advance degree in: _____
Vocational/Trade School: _____

Test Scores: SAT's: _____ ACT's: _____ College GPA: _____

Please list names and year of all colleges attended:

| | <u>College</u> | <u>Year</u> |
|----|----------------|-------------|
| 1. | _____ | _____ |
| 2. | _____ | _____ |
| 3. | _____ | _____ |

What was your favorite subject in school? _____ You're least favorite? _____

Dean's List or Honor Roll? _____

As an adult I am most proud of: _____

Currently I have a career in: _____

I have been in this profession for _____ days/mos/years

*I have flexibility in my current profession: Yes No

Languages: Speak: _____

Read: _____

Write: _____

I consider myself: Athletic Active Average Inactive

Physical activities include: _____

Have you excelled in any physical activities? _____

Manual Dexterity: Dexterous Average Clumsy

I would describe my diet as: _____

Other skills or talents? _____

Do you show artistic or musical ability? _____ If yes please explain: _____

FAMILY HEALTH HISTORY

| | Hair Color | Eye Color | Height Weight | Skin Tone | Age If Living | Age at Death | Cause of Death |
|----------------------|------------|-----------|---------------|-----------|---------------|--------------|----------------|
| Mother | | | | | | | |
| Father | | | | | | | |
| Brother: 1. | | | | | | | |
| 2. | | | | | | | |
| 3. | | | | | | | |
| 4. | | | | | | | |
| Sister: 1. | | | | | | | |
| 2. | | | | | | | |
| 3. | | | | | | | |
| 4. | | | | | | | |
| Maternal Grandmother | | | | | | | |
| Maternal Grandfather | | | | | | | |
| Paternal Grandmother | | | | | | | |
| Paternal Grandfather | | | | | | | |
| Children: (If Any) | | | | | | | |
| 1. | | | | | | | |
| 2. | | | | | | | |
| 3. | | | | | | | |
| 4. | | | | | | | |

Are you adopted? _____ If yes, do you have access to your biological health history? _____

Twins or multiple births in the family? _____ If yes, how many sets? _____

Are there any known genetic diseases that run in your family? _____ If yes, please identify all such diseases and explain in as much detail as possible:

Has anyone in your family been born with a birth defect? _____ If yes, please explain in detail: _____

Have you had a brother or sister die in infancy or early childhood? _____ If yes, please explain the cause of death:

Have you ever been tested for:

Cystic Fibrosis (Caucasian) _____

Sickle Cell (African American) _____

Thalassemia (Greek/Italian) _____

Tay-Sach's (Jewish) _____

If yes to any of the above, were you determined a carrier? _____

How would you describe your personality and temperament? _____

What is your philosophy of life? _____

What qualities and characteristics would you hope the recipient parents possess? _____

How does it make you feel at the possibility of their offspring knowing about the donation? _____

How would you describe your childhood? _____

What is the earliest memory you hold as a child? _____

What was it like growing up in your family? _____

What religion did you belong to as a child? _____

When I Was A Child:

My favorite thing to do was: _____

At home I was expected to: _____

My parents were strict about: _____

My parents taught me to value: _____

What I loved most about my father was: _____

What I loved most about my mother was: _____

My favorite relatives were: _____

I loved to visit: _____

In comparison to others I was: _____

Your Teenage Years:

Describe yourself as a teenager: _____

Describe your achievements: _____

Did you do poorly at anything? _____

Did you have any problems as a teenager (e.g., health, acne, social, educational, etc.)? _____

What do you hope to achieve by volunteering in an egg donor program? _____

What message would you like passed on to the recipient of your eggs/their offspring? _____

What helped you decide to become an egg donor? _____

Do you consider yourself a reliable person? _____

Do you consider yourself a punctual person? _____

Would you describe yourself as a religious or spiritual person? _____

Do you have any ethical, moral or religious reservations about being an egg donor?

What are your personal goals? Have you achieved any of these goals? _____

What do you see yourself doing in the next 5-10 years? _____

What would you like your recipient couple to know about you that has not already been asked? _____

What is your favorite color? _____

Favorite type of food? _____

Favorite movie? _____

Favorite type of music? _____

Favorite Book? _____

Would you be willing to donate to gay or single prospective parents? _____ Please specify: _____

Would you be willing to meet a child conceived as the result of your donation? _____ Please elaborate:

Would you be interested in possibly meeting the prospective parents?

What are your beliefs concerning selective reduction or aborting a fetus due to an anomaly(s) (birth defect)?

How do you feel about the possibility of any remaining embryos being donated to another infertile couple that cannot afford the cost of infertility treatment? Will you sign a consent permitting such donation?

How do you feel about any remaining embryos being discarded or donated to scientific research? Will you sign a consent permitting such medical or scientific research or destruction of such remaining embryos?

Some clinics have their Prospective Parents sign away rights to any left over embryos to be used at the clinic's discretion, how do you feel about not knowing the outcome of their decision?

What are your thoughts on the possibility of this couple using a gestational carrier (surrogate) or a qualified sperm donor?

Please read the list of medical problems carefully and indicate your answer in the appropriate box. Remember, this is the only information that your intended parents have to make a healthy and intuitive choice for their offspring.

| HEART | You | Mother | Father | Siblings | Grandparents | Other Family | Explain |
|--|-----|--------|--------|----------|--------------|--------------|---------|
| A. Stroke | | | | | | | |
| B. heart attack | | | | | | | |
| C. heart disease | | | | | | | |
| 1. from birth | | | | | | | |
| 2. lifestyle | | | | | | | |
| D. hardening of the arteries | | | | | | | |
| E. high blood pressure | | | | | | | |
| BLOOD | | | | | | | |
| A. anemia | | | | | | | |
| B. sickle-cell anemia | | | | | | | |
| C. hemophilia or other bleeding problem | | | | | | | |
| D. leukemia | | | | | | | |
| E. Immune Deficiency | | | | | | | |
| F. other blood disorder | | | | | | | |
| RESPIRATORY (LUNGS) | | | | | | | |
| A. hay fever | | | | | | | |
| B. asthma | | | | | | | |
| C. emphysema | | | | | | | |
| D. tuberculosis | | | | | | | |
| E. lung cancer | | | | | | | |
| F. pneumonia | | | | | | | |
| G. other lung disease | | | | | | | |
| GASTRO-INTESTINAL | | | | | | | |
| A. ulcer of stomach or duodenum | | | | | | | |
| B. gall stones | | | | | | | |
| C. hepatitis A | | | | | | | |
| D. hepatitis B | | | | | | | |
| E. cirrhosis | | | | | | | |
| F. colon cancer | | | | | | | |
| G. ulcerative colitis | | | | | | | |
| H. Crohn's disease | | | | | | | |
| I. cystic fibrosis | | | | | | | |
| J. intestinal cancer | | | | | | | |
| K. any other cancer/digestive prob. | | | | | | | |
| METABOLIC/ENDOCRINE | | | | | | | |
| A. diabetes mellitus | | | | | | | |
| B. hypoglycemia | | | | | | | |
| C. thyroid cancer | | | | | | | |
| D. thyroid disease | | | | | | | |
| E. goiter | | | | | | | |
| F. adrenal dysfunction or disorder | | | | | | | |
| G. hyperactivity | | | | | | | |
| URINARY | | | | | | | |
| A. kidney disease | | | | | | | |
| B. other disease of urinary tract (urethra, bladder, ureter) | | | | | | | |
| GENITAL/REPRODUCTIVE | | | | | | | |
| A. undescended testicle | | | | | | | |
| B. hypospadias | | | | | | | |
| C. prostate cancer | | | | | | | |
| D. uterine fibroids | | | | | | | |
| E. ovarian cysts | | | | | | | |
| F. cancer of cervix, ovaries or uterus | | | | | | | |

| | You | Mother | Father | Siblings | Grandparents | Other Family | Explain |
|--|-----|--------|--------|----------|--------------|--------------|---------|
| NEUROLOGICAL | | | | | | | |
| A. migraines | | | | | | | |
| B. mental retardation | | | | | | | |
| C. senility before age 50 | | | | | | | |
| D. Multiple Sclerosis | | | | | | | |
| E. Cerebral Palsy | | | | | | | |
| F. epilepsy | | | | | | | |
| G. hydrocephalus | | | | | | | |
| H. disorder of the spinal cord | | | | | | | |
| I. Huntington's chorea | | | | | | | |
| J. Gaucher's disease | | | | | | | |
| K. Wilson's disease | | | | | | | |
| L. Creutzfeldt-Jacob disease | | | | | | | |
| M. Alzheimer's disease | | | | | | | |
| N. other diseases of the nervous system | | | | | | | |
| MENTAL HEALTH | | | | | | | |
| A. schizophrenia | | | | | | | |
| B. bipolar or manic depressive | | | | | | | |
| C. depression | | | | | | | |
| MUSCLE/BONE/JOINTS | | | | | | | |
| A. muscular dystrophy | | | | | | | |
| B. other chronic muscle disease | | | | | | | |
| C. lupus | | | | | | | |
| D. deformity of the spine | | | | | | | |
| E. osteoporosis | | | | | | | |
| F. dwarfism | | | | | | | |
| G. heredity low back disease | | | | | | | |
| H. arthritis | | | | | | | |
| I. gout | | | | | | | |
| SIGHT/SOUND/SMELL | | | | | | | |
| A. deafness before age 60 | | | | | | | |
| B. deformity of the ear | | | | | | | |
| C. cataracts before age 50 | | | | | | | |
| D. blindness | | | | | | | |
| E. color blindness | | | | | | | |
| F. glaucoma | | | | | | | |
| G. deviated septum | | | | | | | |
| H. any other sight/sound/smell disorders | | | | | | | |
| SKIN | | | | | | | |
| A. acne | | | | | | | |
| B. eczema | | | | | | | |
| C. skin cancer | | | | | | | |
| D. pigmentation disorders | | | | | | | |
| E. other disorders of the skin | | | | | | | |
| OTHER | | | | | | | |
| A. alcoholism | | | | | | | |
| B. drug abuse, misuse or addiction | | | | | | | |
| C. breast cancer | | | | | | | |
| D. any other cancer not mentioned above | | | | | | | |
| E. any other condition not mentioned above | | | | | | | |

RISK FACTORS**Yes No****Comment**

Have you ever been sexually active with a male who was gay or bisexual?

Yes No

Have you ever injected drugs or had a sexual partner who did so?

Yes No

Have you ever had hemophilia or received any human derived clotting factor concentrates, including factor VIII or factor IX concentrate?

Yes No

Have you ever had a sexual partner with hemophilia or who received any human derived clotting factor concentrates?

Yes No

Have you ever had sex in exchange for money or drugs?

Yes No

Have you ever been sexually active with a person who has had sex in exchange for money or drugs?

Yes No

Have you ever been sexually active with a person Who was known or suspected to have HIV, hepatitis B or hepatitis C?

Yes No

Have you been exposed to body fluids, open wounds, Non-intact skin or mucus membranes of any person Known or suspected to have HIV, hepatitis B and/or C?

Yes No

Have you had an accidental needle stick within the Past 12 months?

Yes No

Have you ever been or have you had a sexual partner who was incarcerated for 72 consecutive hours or longer?

Yes No

In the past 12 months, have you lived with or had contact with anyone known or suspected to have hepatitis?

Yes No

(Cont'd)

Have you acquired a tattoo or other skin piercing procedure within the preceding 12 months? **Yes** **No**

Have you ever been diagnosed with hepatitis? **Yes** **No**

Have you been vaccinated or had contact with anyone Vaccinated for smallpox within the past 2 months? **Yes** **No**

Have you ever been diagnosed with or suspected to have West Nile Virus? **Yes** **No** **if so, when?**

Have you ever been treated for or diagnosed with Chlamydia, gonorrhea, herpes or syphilis? **Yes** **No** **if so, when?**

Have you or any of your blood relatives been diagnosed and/or have a history of transmissible spongiform encephalopathy such as Creutzfeldt-Jakob disease or variant Creutzfeldt-Jakob disease? **Yes** **No** **if so, who?**

Have you ever received a non-synthetic dura mater transplant or a pituitary-derived growth hormone? **Yes** **No**

Do you have a history of changes in cognition, speech or gait? **Yes** **No**

Have you ever received a blood transfusion? **Yes** **No** **if so, where?**

Have you visited or lived in the United Kingdom for Three months or more between 1980-1996 Including England, Scotland, Wales, Ireland, Isle of Man, Channel Islands, Gibraltar or Falkland Islands? **Yes** **No**

(Cont'd)

Were you a member of the US military, civilian military, Employee or a dependent of a member of the military Stationed in Belgium, the Netherlands, Germany, Spain, Portugal, Turkey, Italy or Greece between 1980-1996? **Yes No**

From 1980 to present, have you spent time that adds up To 5 years or more in Europe? **Yes No if so, where?**

Were you born in or have you lived in any of the following Countries since 1977; Cameroon, Central Africa Republic, Chad, Congo, Equatorial, Guinea, Gabon, Niger or Nigeria? **Yes No If so, when?**

If yes, were you given a blood transfusion or any medical treatment with a product made from blood while you Were there? **Yes No**

Have you ever had sexual contact with anyone who was born Or lived in any Cameroon, Central Africa Republic, Chad, Congo, Equatorial, Guinea, Gabon, Niger or Nigeria since 1977? **Yes No**

Have you or someone you know been diagnosed, treated or suspected of having sudden acute respiratory syndrome? (SARS)? **Yes No if so, when?**

Have you, your sexual partner, and/or anyone you live with ever had a transplant or other medical procedure that involves Being exposed to live cells, tissues or organs from an animal? **Yes No if so, who?**

Have you been exposed to blood, saliva or fluids from the person described in the proceeding question? **Yes No**

Have you ever received a human organ, tissue transplant or human extract? **Yes No**

(Cont'd)

| | | | |
|---|------------|-----------|--------------------|
| Have you ever been excluded as a blood donor? | Yes | No | if so, why? |
|---|------------|-----------|--------------------|

| | | |
|---|------------|-----------|
| Have you been diagnosed or suspected to have Chagas' disease? | Yes | No |
|---|------------|-----------|

| | | |
|--|------------|-----------|
| Have you been exposed to significant levels of radiation, toxic chemicals, or heavy metals (such as lead, mercury or gold) in your home or work environment? | Yes | No |
|--|------------|-----------|

| | | |
|--|------------|-----------|
| Have you received a bite from an animal suspected for rabies within the last six months? | Yes | No |
|--|------------|-----------|

CONSENT FORM

Under the penalty of perjury, I attest that all of the information I have provided in my donor application is true and complete to the best of my knowledge. I also have a good understanding of the commitment involved in the egg donation process.

Donor's Printed Name: _____

Donor's Signature: _____

Date: _____

I _____ give An Eggceptional Match, LLC full authority to include my photographs on its web site, and to share my personal profile with prospective parents but without disclosing to them any of my identifying information. I hereby release An Eggceptional Match, LLC and Angela Bevill, and their agents, employees, successors and assigns, from any and all liability of any nature whatsoever as a result of such disclosures.

Donor's Signature: _____

Date: _____

Witness to Signatures above: _____

Date: _____