Piedmont Reproductive Endocrinology Group
17 Caledon Ct. Suite C
Greenville, SC 29615
(864)232-7734
North Grove Medical Center, Ste 2200
1330 Boiling Springs Road Spartanburg, SC 29303
(864)583-2669

Dear Prospective Egg Donor:

Thank you for your interest in the Donor Egg Program at Piedmont Reproductive Endocrinology Group (PREG). The first step in the donor screening process is to complete the brief online Egg Donor Preliminary Application found on the PREG website link http://www.pregonline.com/egg_donor.php . The online preliminary application will be reviewed to determine if you meet the general criteria for egg donation. You will be notified either way. If meeting initial qualifications, you will need to print and complete the full Egg Donor Profile which is enclosed and return it to our office. Dr. John Payne, Medical Director of the Donor Egg Program, will review your information and notify you for appropriate follow-up if you meet both the FDA screening criteria and the donor demographics we need at PREG. Once you are approved for further evaluation and screening, you will need to have labs (blood draw), pelvic ultrasound, and a physical exam. If that evaluation is normal, the next step will be for you to be scheduled for an interview with a clinical psychologist to determine if you have any psychological issues that would make donating eggs not in your best interest.

If all of your evaluation if favorable, you will be notified that you have been approved as a PREG egg donor and we will make your anonymous profile available for potential recipients. After your profile has been selected by a recipient, you will be contacted to ensure your availability, and then “matched” for an egg donation cycle. You will have a cycle orientation appointment with our donor egg coordinator nurse for medication instruction.

The Food and Drug Administration (FDA) has strict guidelines to which all Donor Egg Programs must adhere. These guidelines have been established for your safety as well as for the safety of the potential recipients. If you are not accepted, you will receive a letter in the mail stating why we did not select you for additional evaluation. Please know that all information provided will be kept confidential in agreement with Federal Privacy Laws and answer all questions in the profile truthfully and to the best of your abilities and leaving no unanswered questions.

Again, thank you for your interest in the Donor Egg Program. If you have any questions or concerns, you may reach me at (864)232-7734.

Sincerely,

John F. Payne, MD
Medical Director of the Donor Egg Program

Piedmont Reproductive Endocrinology Group (PREG)
Egg Donor Program

Help Dreams Come to Life
Be An Egg Donor

Egg donation in recent years has become a very successful option for couples that would otherwise be unable to have children. Dr. Nichols/Payne and the staff of PREG want to guide you through a very fulfilling experience of helping someone's dreams of having a family become a reality.

Egg donors are usually anonymous unless the recipient has a family member or friend that chooses to be a donor. Potential donors can come forward on a voluntary basis for many different reasons. All anonymous donors must undergo extensive screening to assure they are suitable candidates. Donors must be healthy women between the ages of 21 and 32, but PREG uses age 26 as our upper age cutoff to begin evaluation of potential donors. They are asked to complete a thorough questionnaire that is reviewed by our staff. If they are potentially good candidates then a very detailed personal medical history as well as past and present family medical history is reviewed. An interview with a Licensed Clinical Psychologist as well as an MMPI (a personality profile) is administered to ensure there are no underlying psychological issues present. They are also counseled on the psychological and physical effects of donating eggs to make sure they are able to adjust well. In addition, all donors are screened for sexually transmitted diseases and any other infectious disease.

The egg donors are anonymous and the potential recipient's information is not given to the donor or the outcome of the donor egg cycle itself. The recipient does have available to them parts of the donor's profile and psychological evaluation but no specific identifying information. This allows the recipient to make the best decision regarding potential donors. Please provide two baby pictures as well as two preschool pictures (age 3-5 years) of yourself which will be viewed by potential recipients. We also need a full length recent picture of yourself which will NOT be made available to potential recipients but will be used by PREG to help us to "match" you with a recipient.

Recipients and donors are matched using a list of specific requirements they want from their donor such as physical attributes, education, or ethnicity. Dr. Nichols/Payne and the PREG staff work very closely with donors and recipients in helping make appropriate matches.

While going through an egg donor cycle, the donor and the recipient's menstrual cycle will be synchronized together usually with medications. When both the donor and recipient are regulated, the donor starts fertility medications (daily injections) to stimulate her ovaries to produce multiple eggs. The recipient during this time will be monitored by using ultrasound and blood tests to make sure the lining (endometrium) of her uterus is optimal for receiving embryos.

When the eggs are matured, they are harvested by way of an ultrasound guided retrieval in which the donor is sedated and will feel no discomfort. After the eggs are retrieved, the egg donor participation is over. The retrieved eggs will then be fertilized in the lab with the recipient's partner's sperm by procedures that offer the best fertilization results. The embryologist in the IVF lab will determine the choice of fertilization method (IVF – in vitro fertilization versus ICSI – intracytoplasmic sperm injection).

Three to five days after retrieval of the eggs the resultant embryo(s) will be transferred to the recipient's uterus. After the embryo transfer the recipient will continue being monitored with blood work and a pregnancy test will be done in about two weeks. If there is an excess of embryos the recipient will be given the choice of freezing (cryopreservation). This will give the recipient additional attempts to conceive.

Split Donor Cycles are also offered to appropriate patients to help share the expenses of a donor cycle with another couple. A primary recipient will be matched for donation and then a secondary recipient candidate will be found. The eggs retrieved from the donor are split so that half of the eggs go to one recipient and half to the other. A potential risk of a split donor cycle is that an insufficient number of eggs are produced not allowing a split between the two recipients. In this case, all the eggs would go to the primary recipient and the secondary recipient would be dropped from the cycle and would be moved to a primary slot in another cycle.

Piedmont Reproductive Endocrinology Group
17 Caledon Court, Suite C
Greenville, SC 29615

Donor #_________

QUESTIONS FREQUENTLY ASKED BY EGG DONORS

CAN ANY WOMAN BE AN EGG DONOR?

Prior to being accepted as an egg donor at PREG, a medical history, physical exam and psychological screening will be required. This testing will be of no financial cost to you. Presently, women over the age of 31 are not accepted. Additionally, women at risk for HIV (AIDS) are not suitable candidates. Genetic risk factors are also exclusionary.

HOW MUCH OF MY TIME WILL IT TAKE?

Approximately one month of your time is required to complete a cycle. This will include lab work, ultrasounds, and egg retrieval. Most appointments are very short usually 15-30 minutes.

I WORK OR ATTEND SCHOOL. WILL I HAVE TO MISS A LOT OF TIME FROM WORK/SCHOOL?

We make every effort to accommodate students and working women. Most of the lab appointments can be made very early in the morning and are 15 minutes or less.

HOW ARE EGGS PRODUCED?

During any given month most women produce a single egg. To undergo egg donation, we will try to increase the number of eggs you produce. We will prescribe medication to increase the number of eggs that you produce. This medication is administered by injection. You or your partner will be instructed on injection techniques. Injections will be given one to two times per day. The injections may be from 10 to 24 days in duration. These injections will increase the number of eggs produced by your ovaries.

HOW ARE MY OVARIES MONITORED?

While taking injections, you will be required to have up to 6 blood estrogen levels drawn over a 14 day interval. Additionally, up to six vaginal ultrasounds will be preformed. Most women consider vaginal ultrasound painless. All blood tests will be required to be drawn in the morning with an ultrasound scan to follow. Depending on your response, monitoring may occur on both weekdays and weekends.

HOW ARE EGGS REMOVED FROM THE DONOR?

By monitoring your ovaries with ultrasound and occasional blood tests we can determine when your eggs are matured and ready for retrieval. For egg retrieval, you will come to the office at your scheduled time. Egg retrieval is performed under ultrasound guidance by placing a needle through the vagina and into the fluid around the eggs. You will have the option of being put to sleep during the retrieval. After the retrieval, you will have mild cramping. Pain medication will be available. Infrequently, you may have to continue injections for a short time after the retrieval. You will be required to take an antibiotic by mouth the day of the retrieval. You will be compensated for your time and pain required to complete the injections and retrieval. Retrieval may occur on a weekday or weekend.

CAN I GET PREGNANT DURING MY DONATION CYCLE?

We request complete abstinence during your egg donation cycle. Abstinence should start at the time of the injections and continue until the menstrual period <u>after</u> the retrieval was performed. If a donor elects not to abstain, pregnancy may occur in the cycle in which she donated the eggs. We will not be responsible for any pregnancies that occur in the donor during her egg donation

Donor #_________

cycle. If you are on the birth control pill, you will have to stop the pill for a total of two months to proceed with the egg donor cycle.

WILL DONATING EGGS AFFECT MY HEALTH?

In women who ovulate regularly, the medications we prescribe are safe. Occasionally, a woman's ovaries will over stimulate. This may lead to cancellation of the cycle. Over stimulation of the ovaries occurs infrequently. If over stimulation does occur, we will follow you closely in the office or potentially hospitalize you to monitor your ovaries. Be assured that he medications prescribed for you have been used for more than 15 years.

HOW MANY EGGS WILL I MAKE?

Women are born with approximately 500,000 eggs. If a woman has regular cycles every month, she will ovulate approximately 500 eggs during her reproductive life span (i.e., puberty to menopause). An average egg donor will make 10 to 15 eggs for a recipient. Medications to increase the number of eggs in a given cycle do not significantly decrease the pool of remaining eggs.

WILL DONATING EGGS AFFECT MY ABILITY TO HAVE CHILDREN IN THE FUTURE?

Your future ability to conceive will depend on many factors. One in ten couples has difficulty conceiving a pregnancy. Undergoing egg stimulation and retrieval (i.e. egg donation) will neither decrease nor increase your chances for infertility.

WILL I KNOW THE OUTCOME OF THE RECIPENTS CYCLE?

Your identity will not be made available to the recipient. Likewise, the results of the recipient's cycle will not be made available to you. Once you have signed our consent form, you have given all rights of these eggs to the recipient couple.

HOW MANY TIMES CAN I DONATE?

We recommend that a woman donate eggs no more than six (6) times during her lifetime, even if donations are performed at different IVF centers. Additionally, if you are married, your husband must sign the egg donor consent form.

CAN I EXERCISE DURING MY CYCLE?

Exercise is permitted, however, during the last week of the cycle it is recommended that you do not do any strenuous exercise such as running or aerobics due to the stimulation of the ovaries.

WILL THERE BE ANY COST TO ME?

All the cost for your evaluation and treatment will be paid by the recipient. There are no out of pocket expenses to the donor.

WHAT IS THE REIMBURSMENT PAID TO AN EGG DONOR?

Fees vary from state to state. Currently we are paying **$4000.00** to donors who successfully undergo egg retrieval. This payment is prorated if the donor does not successfully complete the entire process.

I have read the above information.

___________________________________ ___________________________

Signature Date

Donor Number____________

PIEDMONT REPRODUCTIVE ENDOCRINOLOGY GROUP (PREG)
FEMALE PATIENT HISTORY: DONOR EGG CANIDATE

I. Identifying Information

Date: ________________
Name (full): ____ SS#_____________________________
Age: _________ Date of Birth: _____________ Sex:___________
Birthplace (city, state, country): ____
Address: ____
City: ____________________________
State: __________________ Zip Code: ____________________
Telephone Number: Day ( )____________________ Evening ( )____________________
Cell ( )____________________ Email __________________________
Emergency Contact: ____Relationship__________________
Telephone Number of Contact: _____________________________
Family Physician: Name ____
Address ____

Have you ever been an egg donor in the past? _______Where? _____________# of times?_________

Height:__________ Weight:__________ Eye Color:_________ Blood Type/Rh:_________

Body Frame: Small:___________ Medium:__________ Large:__________

Hair (check all that apply): Natural hair color ______________________________

- ☐ Curly, wavy (naturally)
- ☐ Straight (naturally)
- ☐ Average texture
- ☐ Premature graying (at what age _____)
- ☐ Thin texture

Skin Color ☐ Fair ☐ Medium ☐ Olive ☐ Dk. Brown ☐ Birthmarks
☐ Ebony ☐ Freckled ☐ Lt. Brown ☐ Rosy

☐ Right Handed ☐ Left Handed ☐ Ambidextrous

Personal Characteristics:
Ethnic Origin: (Your parents' country of origin if you know it.)
Race (Check One): ☐ Caucasion ☐ African American ☐ Asian ☐ Hispanic ☐ Jewish ☐ Mediterranean
☐ Other:_____________
Mother_________________________ Father______________________________
Religion Born Into:____
Religion Practiced:____
Martial Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Duration of relationship with partner:____

Donor Number____________

Education: ☐ Completed Grade School
☐ Completed High School
☐ Currently in College, Pursuing degree in___________________.
☐ Completed college, Degree in ___________________________.
☐ Currently pursuing advanced degree in_____________________.
☐ Advanced degree in____________________________________.

Current Occupation:____

Personal Health History

Vision (without corrective lenses)
☐ Poor ☐ Fair ☐ Good ☐ Excellent
Do you wear corrective lenses? ☐ Yes ☐ No
For what problem(s)? ☐ Nearsighted ☐ Farsighted
☐ Other (explain) ____
Hearing (without corrective aids):
☐ Poor ☐ Fair ☐ Good ☐ Excellent
Do you wear corrective hearing aids? ☐ Yes ☐ No
Teeth: ☐ Poor ☐ Fair ☐ Good ☐ Excellent
Do you smoke cigarettes? ☐ Yes ☐ No
If yes, how many packs per day? _____ Have you ever smoked? ______Date stopped? ________
How long did you smoke? ___________

Diet: ☐ Vegetarian ☐ Non-vegetarian
Diet (nutrition): ☐ Poor ☐ Fair ☐ Good
Do you use alcohol? ☐ Yes ☐ No If yes, # of drinks per week? _______________

Allergies: ☐ Yes ☐ No
If yes, they are to: ☐ Food(s) ☐ Medication(s) ☐ Latex ☐ Iodine/Betadine
☐ Environmental ☐ Other___________________________
For each allergy, describe specific substance and reaction(s) and age first noticed:

Substance	Reaction	Age

Explain any allergies you have outgrown: __________________________________
____
____

Exercise: ☐ None ☐ Occasional ☐ Regular
Type of exercise(s):____

Have you had any surgery(s), if yes please list type and when?
____
____
____

Donor Number____________

____

____

Have you had any hospitalization(s) not mentioned above? _____________________

____

____

Have you had a blood transfusion? ____

____

Have you had major radiation or X-ray exposure? ☐ Yes ☐ No
If yes, please explain: ____

Are you currently taking any medications, prescribed or over the counter? ☐ Yes ☐ No
If yes, please list____

____

____

Are you currently taking any "natural" or herbal or alternative medicines? ☐ Yes ☐ No
If yes, please list____

____

Have you been exposed to the following in your living or work environment?

Exposed to	Year	How often/Type?
Toxic Chemicals		
Sprays		
Fumes/Exhaust		
Radiation		
Insecticides		
Lead/Lead Products		
Asbestos/Asbestos Products		
Cleaning Solutions		
Recreational Drugs		

List your special hobbies or talents and those of family members: ________________________

____

____

____

____

Reason for wanting to donate eggs: ____

____

____

____

____

Donor Number____________

II. Pregnancy History

How many pregnancies (including abortions) have you had? ____________________________________

	When (Year)	How Long to Conceive (Months)	Fertility Therapy Used (Yes/ No)	Is Current Partner the Father (Yes /No)	Duration of Pregnancy (Months)	Outcome*	Complications
1st Pregnancy							
2nd Pregnancy							
3rd Pregnancy							
4th Pregnancy							
5th Pregnancy							

*Outcomes: Vaginal Deliver = VD; Cesarean Section = CS; Abortion = AB; Miscarriage = MS; Ectopic (tubal) = EP

III. Gynecological History

How old were you when you started having periods? ______ Date your last period started: __________
Are your periods spontaneously regular? Yes_____ No_____
If yes, how many days between periods (start until start): _________________________________?
If no, how many periods per year do you have: ____
Do you require medicine (birth control pills or progesterone) to regulate your period? Yes_____ No_____
How many days do your periods last? _____ Do you have cramps with your periods? ☐YES ☐ NO
If yes, are they: ☐ Mild ☐ Moderate ☐ Severe
Have you ever missed work or school due to menstrual pain: YES ☐ NO ☐
Do you have pain with intercourse? ☐ YES ☐ NO
Have you ever been diagnosed with endometriosis? ☐ YES ☐ NO
What type of treatments/surgeries have you had for endometriosis? _________________________
____

Are you sexually active now? ___________ How many present partners? __________
How many lifetime sexual partners? ____________
Have you ever been diagnosed with HIV (AIDS virus)? ___________________
Have you ever been diagnosed with West Nile Virus or SARS? _________________
Have you ever been diagnosed with Hemophilia or blood clotting disorder? ___________________
Have you ever had a sexual partner who was gay or bisexual? _____________________
Have you ever been sexually involved with an HIV positive partner? ________________
Have you ever engaged in sexual prostitution? _________________
Have you ever been involved with a partner who was engaged in sexual prostitution? _______
Have you had a tattoo or any body piercing in the past 12 months? _____________ What type? _______
Have you ever used injectable illegal drugs before? ________________
Have you been sexually involved with a partner who used injectable illegal drugs? __________
Have you ever been refused as a blood donor? _________________Why? ________________
Have you ever been diagnosed with Hepatitis? __________________ What type? __________
Have you ever had a sexual partner who had Hepatitis? ______________________
Were you born outside of the United States? Yes____ No____ If so, where_____________________
Have you ever lived or traveled outside of the United States? Yes____ No____ If so, when, what country, and how long living/visiting there? ____

Donor Number____________

What type of contraception have you used now and in the past: (Check all that apply)

- ❑ Birth Control
- ❑ IUD
- ❑ Depo-Provera (birth control shots)
- ❑ Condoms
- ❑ Diaphragm
- ❑ Foams/Jellies
- ❑ Withdrawal
- ❑ Rhythm
- ❑ Tubal Ligation

Contraceptive Complications: ____
____

When did you last use contraception? What type? ____

Have you ever had an abnormal Pap smear: ☐ YES ☐ NO If so, when: ______________

What was done about it: ____

When was your last Pap smear: ____

Have you ever had any of the following: (Check all that apply)

❑ Gonorrhea	❑ Venereal Warts	❑ Syphilis
❑ Chlamydia	❑ Genital Herpes	❑ Pelvic Inflammatory Disease (PID)

IV. Medical History

Do you have or have you ever had: (Check all that apply)

❑ Anemia	❑ Depression/Anxiety	❑ Ovarian Cysts
❑ Asthma	❑ Diabetes	❑ Polycystic Ovarian Syndro
❑ Appendicitis	❑ Gallbladder Problems	❑ Pneumonia
❑ Arthritis	❑ Heart Disease	❑ Rheumatic Fever
❑ Blood Transfusions	❑ Hepatitis	❑ Rubella (German Measles)
❑ Breast Discharge	❑ Hirsutism (excess facial hair)	❑ Scarlet Fever
❑ Breast Pain	❑ High Blood Pressure	❑ Seizures
❑ Chicken Pox	❑ Kidney Infections	❑ Thyroid Problems
❑ Chronic Bronchitis	❑ Liver Problems	❑ Tuberculosis (TB)
❑ Chronic Headaches	❑ Migraine Headaches	❑ Ulcers
❑ Colitis	❑ Neurological Problems	❑ Vision Problems

V. Review of Systems

What is your height? ________________ Current weight: ________________ Ideal weight: ____________

Have you had more than a 10 pound weight gain___ or loss___ this past year? ☐ YES ☐ NO

If so, how much: ____________ Was this intentional? ☐ YES ☐ NO

What is your blood type (A, B, AB, O) and Rh (pos, neg) (if known)? ____________________________

Do you have problems with your eyes, ears, nose or throat: ❑ YES ❑ NO

If yes, please specify: ______________________________________

Do you have heart problems, chest pain or irregular heart beat: ❑ YES ❑ NO

If yes, please specify: ______________________________________

Do you have asthma, wheezing, shortness of breath or trouble breathing: ❑ YES ❑ NO

If yes, please specify: ____________________________________

Do you have breast pain, breast discharge or a lump in your breast: ❑ YES ❑ NO

If yes, please specify: ____________________________________

Do you have chronic nausea, twitching, stomach pain, blood in your stool or a history of ulcers: ❑ YES ❑ NO

If yes, please specify: ____________________________________

Do you have urinary burning, incontinence or blood in your urine ❑ YES ❑ NO

If yes, please specify: ____________________________________

Do you have chronic joint or muscle pain or swelling: ❑ YES ❑ NO

If yes, please specify: ____________________________________

Do you have any chronic skin rashes or moles: ❑ YES ❑ NO

If yes, please specify: ____________________________________

Do you have changes in cold or hot tolerance, changes in skin tone or body hair growth: ❑ YES ❑ NO

If yes, please specify: ____________________________________

Do you or any family members have a history of blood clots or bleeding disorders?__________________

____

Other current or past problems not listed above____

VI. Family History

Any history of breast cancer, ovarian or colon cancer? ❑ YES ❑ NO

Did your mother take diethylstilbestrol (DES; a tablet given to women with a history of miscarriage or bleeding during pregnancy) when she was pregnant with you? ☐ YES ☐ NO

Do any family members have significant health problems or inherited diseases? ❑ YES ❑ NO

Check all that apply:

❑ Birth Defects	❑ Down Syndrome	❑ Muscular Dystrophy
❑ Brain/Spinal Defects	❑ Fragile X Syndrome	❑ Sickle Cell Disease
❑ Cancer	❑ Heart Disease	❑ Tay-Sachs Disease
❑ Cystic Fibrosis	❑ Hemophilia	❑ Thalassemia
❑ Diabetes	❑ High Blood Pressure	❑ Thyroid Disease

<u>Father's Family</u>

1.) Grandfather (your father's father): ☐ Living ☐ Deceased

Age (or age at death):__________

If deceased, cause of death:______________

Health problems and age when diagnosed: ______________________________________

____

____

____

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2.) Grandmother (your father's mother): ☐ Living ☐ Deceased
Age (or age at death): ____________
If deceased, cause of death:____
Health problems and age when diagnosed:____
____
____
____

3.) Aunts and uncles (your father's brothers and sisters) who are still LIVING:

	Initials	Sex	Age	Health Problems	Age Diagnosed
1.	____	_____	______	____________________________________	_______________
2.	___	_____	______	____________________________________	_______________
3.	___	_____	______	____________________________________	_______________
4.	___	_____	______	____________________________________	_______________
5.	___	_____	______	____________________________________	_______________
6.	___	_____	______	____________________________________	_______________
7.	___	_____	______	____________________________________	_______________
8.	___	_____	______	____________________________________	_______________
9.	___	_____	______	____________________________________	_______________

4.) Aunts and uncles (your father's brothers and sisters) who are DECEASED (include stillborns, infant deaths, and childhood deaths):

	Initials	Sex	Age	Health Problems	Age Diagnosed
1.	____	_____	______	____________________________________	_______________
2.	___	_____	______	____________________________________	_______________
3.	___	_____	______	____________________________________	_______________
4.	___	_____	______	____________________________________	_______________
5.	___	_____	______	____________________________________	_______________
6.	___	_____	______	____________________________________	_______________
7.	___	_____	______	____________________________________	_______________
8.	___	_____	______	____________________________________	_______________
9.	___	_____	______	____________________________________	_______________

Donor Number____________

5.) Father: ☐ Living ☐ Deceased
Age (or age at death): ________
If deceased, cause of death:____
Health problems and age when diagnosed:____
____
NOTES: ____
____
____
____
____

Mother's Family

1.) Grandfather (your mother's father): ☐ Living ☐ Deceased
Age (or at death):_______
If deceased, cause of death:____
Health problems and age when diagnosed:____
____
____
____
____

2.) Grandmother (your mother's mother): ☐ Living ☐ Deceased
Age (or age at death):_________
If deceased, cause of death:____
Health problems and age when diagnosed:____
____
____
____
____

3.) Aunts and uncles (your mother's brothers and sisters) who are still LIVING:

	Initials	Sex	Age	Health Problems	Age Diagnosed
1.	____	_____	______	____	_______________
2.	___	_____	______	____	_______________
3.	___	_____	______	____	_______________
4.	___	_____	______	____	_______________
5.	___	_____	______	____	_______________
6.	___	_____	______	____	_______________
7.	___	_____	______	____	_______________
8.	___	_____	______	____	_______________
9.	___	_____	______	____	_______________

Donor Number____________

4.) Aunts and uncles (your mother's brothers and sisters) who are DECEASED (include stillborns, infant deaths, and childhood deaths):

	Initials	Sex	Age	Health Problems	Age Diagnosed
1.	____	_____	______	____	________________
2.	___	_____	______	____	________________
3.	___	_____	______	____	________________
4.	___	_____	______	____	________________
5.	___	_____	______	____	________________
6.	___	_____	______	____	________________
7.	___	_____	______	____	________________
8.	___	_____	______	____	________________
9.	___	_____	______	____	________________

5.) Mother: ☐ Living ☐ Deceased

Age (or age at death):__________

If deceased, cause of death:____

Health problems and age when diagnosed:____

____

____

____

NOTES:____

____

____

____

Siblings

1.) Your brothers and sisters who are still LIVING:

	Initials	Sex	Age	Health Problems	Age Diagnosed
1.	____	_____	______	____	________________
2.	___	_____	______	____	________________
3.	___	_____	______	____	________________
4.	___	_____	______	____	________________
5.	___	_____	______	____	________________

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2.) Your brothers and sisters who are DECEASED:

Initials	Sex	Age	Health Problems	Age Diagnosed
1.____	_____	______	____	_________________
2. ___	_____	______	____	_________________
3. ___	_____	______	____	_________________
4. ___	_____	______	____	_________________
5. ___	_____	______	____	_________________

Children

1.) Your children who are still LIVING:

Initials	Sex	Age	Health Problems	Age Diagnosed
1.____	_____	______	____	_________________
2. ___	_____	______	____	_________________
3. ___	_____	______	____	_________________
4. ___	_____	______	____	_________________

2.) Your children who are DECEASED:

Initials	Sex	Age	Health Problems	Age Diagnosed
1.____	_____	______	____	_________________
2. ___	_____	______	____	_________________
3. ___	_____	______	____	_________________
4. ___	_____	______	____	_________________

SPECIFIC CONDITIONS

Has anyone in your family had any of the following conditions? (Please circle yes or no)

YES NO 1. Down's Syndrome
YES NO 2. Mental retardation
YES NO 3. Seizure disorder
YES NO 4. Loss of muscle coordination or muscular atrophy (Multiple Sclerosis, Muscular Dystrophy, etc)
YES NO 5. Premature senility (before age 50)
YES NO 6. Deafness (before age 50)
YES NO 7. Blindness
YES NO 8. Cataracts (before age 50)
YES NO 9. Mental illness (Depression, Schizophrenic, Bipolar, etc)
YES NO 10. Serious birth defects
YES NO 11. Cleft lip and/or cleft palate
YES NO 12. Club foot

Donor Number____________

YES NO 13. “Open spine” or “water on the brain”
YES NO 14. Congenital heart defects
YES NO 15. Congenital hip problems
YES NO 16. Three or more miscarriages or stillborns
YES NO 17. Diabetes mellitus (onset before age 50)
YES NO 18. Thyroid disease
YES NO 19. Progressive kidney disease
YES NO 20. Skin disease
YES NO 21.Coffee-colored spots on the skin the size of a quarter or larger or lumps under the skin (neurofibromatosis)
YES NO 22.Early death (before age 50)
YES NO 23. Cystic fibrosis
YES NO 24. Arthritis
YES NO 25. Alcoholism
YES NO 26. Colon cancer (before age 50)
YES NO 27. Hypertension (high blood pressure)
YES NO 28. Blood-clotting disorder (DVT-leg, Pulmonary Embolism-lung, hemophilia)
YES NO 29. Breast Cancer (before age 50)
YES NO 30. Heart Disease (before age 50) (heart attack, MI, enlarged heart)
YES NO 31. Hyperlipidemia (elevated cholesterol and/or triglycerides) (before age 50)

If yes is circled for any of the above, please explain:

Question Number	Family Relationship	Specific Condition	Age Affected
______	____________________	____	__________________
______	____________________	____	__________________
______	____________________	____	__________________
______	____________________	____	__________________
______	____________________	____	__________________
______	____________________	____	__________________
______	____________________	____	__________________
______	____________________	____	__________________
______	____________________	____	__________________

Are you of Jewish ancestry? ________________________If yes, answer following questions:

Have you been tested or have any family members with the following diseases:

Tay Sachs	Yes	No
Gaucher	Yes	No
Canavan	Yes	No
Fanconi’s Anemia	Yes	No
Niemen-Pick	Yes	No
Mucolipidosis	Yes	No
Bloom’s Syndrome	Yes	No

Donor Number____________

Are you of Black ancestry? ___________

If yes, have you been tested or have any family members with sickle cell disease?

Yes No

Are you of Mediterranean, Chinese or South Asian ancestry? ____________

If yes, have you been tested or have any family members with Thalassemia?

Yes No

Don't Forget:

Please attach a recent (within the past year) full frontal (head to toe) color picture of yourself to be used by the doctor during matching of anonymous donor and recipient couple. The photo will be kept confidential. A baby picture of your self (under age 2) would also be helpful in allowing us to match you as well.

I confirm that all the above information is true and valid to the best of my knowledge. I also agree that this information or my medical records from this office may be subject to peer review by an outside agency if needed for any credentialing organization or process.

____

Patient's Signature (print and sign) Date

____

Patient's Spouse or Partner (if applicable) Date

For Office Use Only: Do not write below

☐ *Eligible by History, proceed with donor screening per protocol*

☐ *Deferred*

☐ *Ineligible*

*Reason(s) for Deferral or Ineligibility:*________________________________

____

____

____

____

Medical Director: ________________________ **Date:** _______________

Piedmont Reproductive Endocrinology Group
17 Caledon Court Suite C
Greenville, SC 29615

DONOR APPLICATION & MEDICAL /GENETIC HISTORY

To: Prospective Egg Donor

Thank you for your interest in becoming an egg donor. All prospective egg donors must complete this application, medical/genetic history questionnaire and risk factor questionnaire. We thank you for your honesty in supporting our efforts to maintain a safe Donor population for our community.

The undersigned agrees that, to the best of her knowledge and belief, the information provided in this application is complete and correct. The undersigned furthermore agrees to report to our office if any significant changes in the status of her health, especially in regards to sexually transmitted disease.

I certify that, to the best of my knowledge and belief, the following information provided by me in this document is complete and correct.

Egg Donor Name (Printed) Egg Donor Signature Date

Donor Application Number (Clinic will complete): ____________

Reviewed by John F. Payne, M.D. Date

Reviewed by Lindsay Thomason, RN, Donor Egg Program Coordinator Date

Piedmont Reproductive Endocrinology Group
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Greenville, SC 29615

Risk Factor Questionnaire

Printed Patient Name: ____________________Date:______ Donor #:__________

Please answer the following questions truthfully and to the best of your knowledge.

Question		For Office Use Only
1. Have you ever been in a same sex relationship or had sex with a male within the past 5 years who has had sexual contact with another male?	☐ No ☐ Yes	☐ Ineligible ☐ See flowchart
2. Have you ever used injectable drugs (with a needle including intravenous, intramuscular and subcutaneous) for non-medical use, including steroids, not prescribed by a doctor in the past 5 years?	☐ No ☐ Yes	☐ Ineligible ☐ See flowchart
3. Have you had sexual contact with a person who has hemophilia or related clotting disorders or has received human-derived clotting factor concentrates in the past 5 years? Or have you received human derived clotting factor concentrates once to treat an acute bleeding event in the last 12 months?	☐ No ☐ Yes	☐ Ineligible ☐ See flowchart
4. Have you ever had sex in exchange for money or drugs in past the 5 years?	☐ No ☐ Yes	☐ Ineligible ☐ See flowchart
5. Have you had sex with any person described in the previous 4 questions, with someone who has been in prison, or with any person known or suspected to have HIV infection, clinically active hepatitis B or C infections in the past 12 months?	☐ No ☐ Yes	☐ Ineligible ☐ See flowchart
6. Have you ever been exposed to known or suspected HIV or Hepatitis A, B, or C infection through a needle stick, open wound or mucous membrane in the past 12 months?	☐ No ☐ Yes	☐ Ineligible ☐ See flowchart
7. Have you had contact with blood that is known or suspected to be infected with HIV, Hepatitis B and/or Hepatitis C virus?	☐ No ☐ Yes	☐ Ineligible ☐ See flowchart
8. Have you been incarcerated (juvenile detention, lock-up, jail, or prison) for more than 72 consecutive hours during the previous 12 months?	☐ No ☐ Yes	☐ Ineligible ☐ See flowchart
9. Have you had <u>close contact</u> (i.e. living in the same household where sharing of kitchen and bathroom facilities occurs regularly, dormitories, etc) with a person with Hepatitis B or clinically active viral Hepatitis C in the past 12 months?	☐ No ☐ Yes	☐ Ineligible ☐ See flowchart
10. Have you undergone ear or body piercing or tattooing within the past 12 months?	☐ No ☐ Yes	☐ Ineligible ☐ See flowchart
11. Were you ever told you had viral hepatitis (either B or C)? Or a positive screening for viral hepatitis that was not identified as caused by Hepatitis A, EBV, or CMV?	☐ No ☐ Yes	☐ Ineligible ☐ See flowchart
12. Have you recently been diagnosed with or treated for a blood infection (sepsis), positive blood cultures or elevated white blood cell count?	☐ No ☐ Yes	☐ Ineligible ☐ See flowchart
13. Have you received the Small Pox Vaccination (vaccinia virus) within the past 8 weeks?	☐ No ☐ Yes	☐ Ineligible ☐ See flowchart
14. Have you had any skin rashes and/or skin sores since your Small Pox Vaccination or skin rashes/sores after contact with a person who has received the vaccination within past 3 months?	☐ No ☐ Yes	☐ Ineligible ☐ See flowchart
15. Have you been diagnosed with West Nile Virus (WNV) or suspected of having WNV or tested positive or reactive for WNV infection using a WNV NAT donor screening test in the previous 120 days?	☐ No ☐ Yes	☐ Ineligible ☐ See flowchart
17. Have you been diagnosed or treated for Syphilis or any other sexually transmitted disease within the last 12 months?	☐ No ☐ Yes	☐ Ineligible ☐ See flowchart
18. Have you been diagnosed or treated for Neisseria Gonorrhea or Chlamydia trachomatis infection or any other sexually transmitted disease in the preceding 12 months?	☐ No ☐ Yes	☐ Ineligible ☐ See flowchart
19. Have you been diagnosed with Creutzfeldt-Jakob Disease (CJD) or "variant CJD" or do you have a blood relative diagnosed with CJD?	☐ No ☐ Yes	☐ Ineligible ☐ See flowchart
20. Have you ever been diagnosed with dementia or any degenerative or demyelinating disease of the central nervous system or other neurological disease of unknown etiology	☐ No ☐ Yes	☐ Ineligible ☐ See flowchart

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Risk Factor Questionnaire

Printed Patient Name: ___________________Date:______ Donor #:_________

Question	Answer	Eligibility
21. Have ever you received Human Pituitary Growth Hormone or received a dura mater (brain covering) graft?	☐ No ☐ Yes	☐ Ineligible ☐ See flowchart
23. Have you visited or lived in United Kingdom (England, Northern Ireland, Scotland, Wales, the Isle of Man, Channel Islands, Gibraltar or Falkland Islands) for 3 months or more from 1980 through 1996?	☐ No ☐ Yes	☐ Ineligible ☐ See flowchart
24. Were you a member of the military or a military dependent stationed for 6 months or more cumulatively in Northern Europe (Belgium, the Netherlands, Germany) between 1980-1990 or Spain, Portugal, Turkey, Italy or Greece between 1980-1996?	☐ No ☐ Yes	☐ Ineligible ☐ See flowchart
25. Have you visited, lived, or spent 5 years or more cumulatively in Europe since 1980?	☐ No ☐ Yes	☐ Ineligible ☐ See flowchart
26. Have you received a transfusion of blood or blood components in the United Kingdom or France since 1980?	☐ No ☐ Yes	☐ Ineligible ☐ See flowchart
27. Were you or your sexual partner(s) born or ever lived in the African countries of Cameroon, Central African Republic, Chad, Congo, Equatorial Guinea, Gabon, Niger, or Nigeria after 1977?	☐ No ☐ Yes	☐ Ineligible ☐ See flowchart
28. Have you ever received a blood transfusion or any medical treatment that involved blood in the countries of Cameroon, Central African Republic, Chad, Congo, Equatorial Guinea, Gabon, Niger, or Nigeria after 1977?	☐ No ☐ Yes	☐ Ineligible ☐ See flowchart
29. Have you, your sexual partner, and/or any other member of your household, ever received a transplant (xenotransplantation) or other medical procedure that involves being exposed to live cells, tissues or organs from an animal? Who? _______________ (if someone in your household please answer the next question)	☐ No ☐ Yes	☐ Ineligible ☐ See flowchart
30. If this person is in your household, have you or will you be exposed to blood, saliva, or other body fluids from this person?	☐ No ☐ Yes	☐ Ineligible ☐ See flowchart
31. Have you ever had a prior positive or reactive screening test for HIV?	☐ No ☐ Yes	☐ Ineligible ☐ See flowchart
32. Have you had unexplained weight loss, night sweats, temperature of > 100.5 degrees for more than 10 days, persistent cough or shortness of breath, persistent diarrhea, persistent white spots or unusual blemishes in the mouth, blue or purple spots on or under the skin or mucous membranes, swollen lymph nodes for longer than one month, or opportunistic infections?	☐ No ☐ Yes	☐ Ineligible ☐ See flowchart
33. Have you ever had unexplained jaundice, hepatomegaly (enlarged liver), elevated or abnormal liver function tests/labs?	☐ No ☐ Yes	☐ Ineligible ☐ See flowchart
34. Have you had a recent severe illness with headache, high fever, neck stiffness, stupor, disorientation, coma, tremors, convulsions, muscle weakness or paralysis, swollen lymph nodes, eye pain, or skin rash or the trunk of the body?	☐ No ☐ Yes	☐ Ineligible ☐ See flowchart
35. In the past week, have you had an unexplained fever, headache, fast heart rate or fast breathing or elevated white blood cell (WBC) count on a blood lab?	☐ No ☐ Yes	☐ Ineligible ☐ See flowchart
36. In the past week, have you been diagnosed with sepsis (includes but not limited to, bacteremia, septicemia, sepsis syndrome, systemic infection, or septic shock?	☐ No ☐ Yes	☐ Ineligible ☐ See flowchart
37. Have you ever had a prior positive or reactive screening test for Human T-lymphotropic virus (HTLV) types 1 or 2, unexplained paraparesis, and/or Adult T-cell leukemia?	☐ No ☐ Yes	☐ Ineligible ☐ See flowchart
38. Have you received a rabies shot in the past 12 months?	☐ No ☐ Yes	☐ Ineligible ☐ See flowchart
39. Have you ever used/been injected with Bovine (beef) insulin?	☐ No ☐ Yes	☐ Ineligible ☐ See flowchart
40. Have you been diagnosed with Hepatitis A or received gamma globulin shot for Hepatitis A exposure?	☐ No ☐ Yes	☐ Ineligible ☐ See flowchart

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Risk Factor Questionnaire

Printed Patient Name: ___________________Date:______ Donor #:_________

41. Have you been exposed to, treated for, or suspected of having SARS in the past 28 days?	☐ No ☐ Yes	☐ Ineligible ☐ See flowchart
42. In the past 14 days have you cared for, lived with, or had direct contact with blood, saliva, or other body fluids from someone with SARS or suspected SARS?	☐ No ☐ Yes	☐ Ineligible ☐ See flowchart
43. Have you traveled to or resided in areas affected by SARS within the previous 14 days? (review current listing)	☐ No ☐ Yes	☐ Ineligible ☐ See flowchart
44. Are you feeling well today and feel that you are generally in good health?	☐ No ☐ Yes	☐ Ineligible ☐ See flowchart

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 Piedmont Reproductive Endocrinology Group (PREG) 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 effects. I agree to indemnify, defend and hold harmless PREG, 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.

Signature: ________________________________ Date: ___________________________

Interviewer: _______________________________Date: ___________________________

For Office Use Only: Do not write below

☐ ***Eligible***

☐ ***Ineligible***

Medical Director: __________________________ Date: ________________