

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 is 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. Please answer all questions in the profile truthfully and to the best of your ability, 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

**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.

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 performed. 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 after 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 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 the 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 have 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 RECIPIENTS 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 no more than six (6) times during her lifetime, including donations at different donor egg programs. 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 for the donor.

WHAT IS THE REIMBURSEMENT 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

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

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): Caucasian African American Asian Hispanic Jewish Mediterranean
 Other: _____

Mother _____ Father _____

Religion Born Into: _____

Religion Practiced: _____

Marital Status: Single Married Divorced Widowed

Duration of relationship with partner: _____

- 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
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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?

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: _____

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
1 st Pregnancy							
2 nd Pregnancy							
3 rd Pregnancy							
4 th Pregnancy							
5 th Pregnancy							

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

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? _____

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

- | | | |
|--|------------------------------------|---|
| <input type="checkbox"/> Birth Control | <input type="checkbox"/> IUD | <input type="checkbox"/> Depo-Provera (birth control shots) |
| <input type="checkbox"/> Condoms | <input type="checkbox"/> Diaphragm | <input type="checkbox"/> Foams/Jellies |
| <input type="checkbox"/> Withdrawal | <input type="checkbox"/> Rhythm | <input type="checkbox"/> 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)

<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Venereal Warts	<input type="checkbox"/> Syphilis
<input type="checkbox"/> Chlamydia	<input type="checkbox"/> Genital Herpes	<input type="checkbox"/> Pelvic Inflammatory Disease (PID)

Medical History

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

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

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 _____

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:

<input type="checkbox"/> Birth Defects	<input type="checkbox"/> Down Syndrome	<input type="checkbox"/> Muscular Dystrophy
<input type="checkbox"/> Brain/Spinal Defects	<input type="checkbox"/> Fragile X Syndrome	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Tay-Sachs Disease
<input type="checkbox"/> Cystic Fibrosis	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Thalassemia
<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Thyroid Disease

Father's Family

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

Age (or age at death): _____

If deceased, cause of death: _____

Health problems and age when diagnosed: _____

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.	_____	_____	_____	_____	_____

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. _____	_____	_____	_____	_____

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. _____	_____	_____	_____	_____

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

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:** _____

Donor# _____

DONOR APPLICATION & MEDICAL /GENETIC HISTORY

To: Prospective Egg Donor

Thank you for your interest in becoming an egg donor for Piedmont Reproductive Endocrinology Group (PREG). 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
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Donor Application Number (Clinic will complete): _____

Reviewed by John F. Payne, M.D.	Date
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Reviewed by Stephanie Biggerstaff, RN, Egg Donor Program Coordinator	Date
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Risk Factor Questionnaire

Printed Patient Name: _____ **Date:** _____ **Donor #:** _____

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

	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?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> 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?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> 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?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
4. Have you ever had sex in exchange for money or drugs in past the 5 years?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> 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?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> 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?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> 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?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> 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?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> 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?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
10. Have you undergone ear or body piercing or tattooing within the past 12 months?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> 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?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> 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?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
13. Have you received the Small Pox Vaccination (vaccinia virus) within the past 8 weeks?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> 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?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> 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?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
17. Have you been diagnosed or treated for Syphilis or any other sexually transmitted disease within the last 12 months?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
18. Have you been diagnosed or treated for Neisseria Gonorrhoea or Chlamydia trachomatis infection or any other sexually transmitted disease in the preceding 12 months?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> 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?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> 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	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart

Risk Factor Questionnaire

Printed Patient Name: _____ **Date:** _____ **Donor #:** _____

21. Have ever you received Human Pituitary Growth Hormone or received a dura mater (brain covering) graft?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> 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?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> 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?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
25. Have you visited, lived, or spent 5 years or more cumulatively in Europe since 1980?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
26. Have you received a transfusion of blood or blood components in the United Kingdom or France since 1980?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> 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?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> 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?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> 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)	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> 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?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
31. Have you ever had a prior positive or reactive screening test for HIV?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> 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?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
33. Have you ever had unexplained jaundice, hepatomegaly (enlarged liver), elevated or abnormal liver function tests/labs?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> 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?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> 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?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> 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)?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> 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?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
38. Have you received a rabies shot in the past 12 months?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
39. Have you ever used/been injected with Bovine (beef) insulin?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
40. Have you been diagnosed with Hepatitis A or received gamma globulin shot for Hepatitis A exposure?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart

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?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> 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?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
43. Have you traveled to or resided in areas affected by SARS within the previous 14 days? (review current listing)	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> See flowchart
44. Are you feeling well today and feel that you are generally in good health?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ineligible <input type="checkbox"/> 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:** _____