Global Fertility Services

Date Received: _____

CONFIDENTIAL

OVUM DONOR PROGRAM APPLICATION FORM

Please fill out as truthfully as possible and use an extra sheet of paper if necessary. Include pictures with your completed application. These applications are often saved by the families for the children conceived from ovum donation. Please type or print as legibly as possible with dark ink. You may not have all of the information you need to complete this application today. Please keep a copy so that you may update the application as you obtain the information from memory, family members or records; then please send us the completed form for our records. No identifying information will be made available to recipients without your permission.

PLEASE COMPLETE WITH A BLACK INK PEN

Date of Application: _____

PERSONAL INFORMATION

_____ _____ _____
Last name First name Middle name
Address:_____
City: _____ State: _____Zip:_____
Phone: Home (____) _____-_____ Leave Message Yes___ No____
Cell (____) _____-_____ eave Message Yes___ No____
Work (____) _____-_____ Leave Message Yes___ No____
E-mail Address: _____
Age: _____ Date of birth_____
Marital Status: Married Single Separated Divorced Widowed
Spouse Name: _____

Medical Insurance: _____ _____
Name I.D. number
S.S. Number: _____ Driver's License No:_____ State:_____
Do you have a car? _____
Occupation: _____
Employer: _____
Employer's Address:_____
(Street) (City, State) (Zip)
Person to be notified in case of emergency: _____
Address: _____Phone:_____
Are you registered as a Donor anywhere else? ____Yes _____No
If so, what is the name of the Center? _____

1 (925) 953-4089 | marilyn@globalfertilityservices.com
133 East de la Guerra # 193 Santa Barbara. Ca. 19103

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Dear Donor,

Thank you for contacting the Global Fertility Services. I am pleased that you wish to be a part of our Ovum Donor Program. Your interest in helping an infertile couple achieve their dream of having a child is extremely important and you are to be congratulated. It is important to evaluate the appropriateness of your participation in the Ovum Donor Program before you make a commitment.

Enclosed is an extensive questionnaire for you to complete. This questionnaire along with **your original photos (current head-and-shoulders, and one full-length color photo of you now, as well photos of you growing up. Please try to send photos that have only you in the picture)** will form your application. Please fill it out carefully and truthfully. Prospective parents will make their choices based on the information they see within these pages. The people looking at these applications will receive no identifying information about you other than your first name. Please complete the enclosed authorization for release of information and return it with your application. We also require that a copy of your **driver's license or birth certificate** be submitted along with your application. Please keep a copy of the application for yourself, so you can call us with updated information.

Intended parents also like to have childhood photos of you, as well as family photos of other members of your family (any generation). Please send in original photos. We treat these photos with great care. We will make color copies for our files and safely return these treasured photos soon after we receive them. Please do not send color copies.

Many recipients will keep your application to share with their children when they are older. Please consider these children when you write your application. Be as descriptive as possible. Think of the information that you would like to have made available to you if you were 18 years of age and conceived with the help of an ovum donor.

With warm personal regards,
M'lyn

Marilyn G. Butterfield, RN, MS, Clinical Director Director
Mark S. Butterfield, B.A CFO

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***Please only sign up with one agency!!! We will work hard to try and find a match for you.**

Date:_____ **Applicants First Name:**_____
Applicant's Age: _____

FERTILITY HISTORY

Number of pregnancies: _____ Dates of pregnancies: _____
Number of miscarriages: _____ Dates of miscarriages: _____
Number of abortions: _____ Dates of abortions: _____
Number of stillbirths: _____ Dates of each stillbirth: _____

Number of children:_____

First name	Age	Sex	Birth date	Health/Problems
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Are your menstrual periods regular: Yes No
How long is your monthly cycle: _____ days
Interval between periods_____
Age of onset of menses _____
Have you ever donated eggs before: Yes No
If yes; when: _____ Where:
_____

Birth control method used:
_____

Is there any history of fertility problems in your family?
(Difficulty conceiving or miscarriages): Yes No
If yes explain:
_____
_____
__

Did your parents have difficulty conceiving: ___ Yes ___ No
Do any of your siblings have fertility problems: ___ Yes ___ No
Does anyone in your family have fertility problems: ___ Yes ___ No

Did your mother take diethylstilbestrol (DES) or any prescription drug while she was pregnant with you or any of your siblings: Yes No

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If yes explain:

_____
_____
_____
___

PERSONAL CHARACTERISTICS

Height:_____ Dress Size:_____ Eye color:_____ Hair color:_____

(If recently pregnant: pre-pregnancy dress size: _____)

Hair: Curly Wavy Straight

Complexion: Fair Medium Dark

Body type/bone structure: Small Medium Large

Ethnic origin/ ancestry: Mother_____
Father_____
Religion born into:_____Race:_____
Sexual Orientation: Heterosexual_____ Homosexual_____ Bisexual_____
Education: **(check one & list year you are currently completing)**
___ completed grade school
___ completed high school
___ Currently in college pursuing degree in _____
Where?_____

___Completed college degree in_____
Where? _____

___Currently pursuing advance degree in_____
Where?_____

___Advance degree in_____
Where? _____

Please list your Test Scores:
SAT Verbal____ Math____ Total____

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GRE Verbal____ Quantitative____ Analytical____ Total (V+Q)_____
LSAT_____ MCAT_____ ACT_____
Other_____

Marriages: _____ _____
Date _____City, County, State_____

Date _____City, County, State_____

PERSONAL AND MOTIVATIONAL

In your own words, describe your personality and character:

_____
_____
_____
_____

ACADEMIC HISTORY_____

Please describe academic strengths and weaknesses during school years:
Elementary School:

_____

_____

_____

_____

High School:

_____

_____

_____

_____

___
College:

_____

_____

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_____

_____

Special talents, skills, hobbies, etc.
(Examples: music, art, athletics, medicine, law, cabinet maker, handcrafts, writing, reading, ability to do games, crossword puzzles etc)

Yourself_____

_____

_____

_____

MUSICAL

ABILITY_____

_____

ARTISTIC ABILITY

_____

_____

_____

FOREIGN LANGUAGE

ABILITY_____

_____

FAVORITE

BOOKS_____

_____

RECENTLY READ

BOOKS_____

_____

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Do you like pets? If so, what type of pets are you favorite?

_____

Please describe any special **talents, skills, hobbies, careers, etc. in your family**. (Examples: music, art, athletics, medicine, law, cabinet maker, handcrafts, writing, reading, ability to do games, crossword puzzles etc)

Mother (Please include highest level of

education)_____

_____

_____

_____

Father (Please include highest level of education)

_____

_____

_____

_____

Siblings_____

_____

_____

Grandparents_____

_____

_____

_____

_____

_____

Please describe your childhood:

_____

_____

_____

_____

_____

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_____
_____
_____
_____
_____
_____
_____

What is your ultimate ambition or goal in life?

_____
_____
_____
_____
_____
_____

Imagine yourself five years from today watching from a distance the child born with your egg donation, playing in a playground. What do you imagine yourself feeling and thinking?

_____
_____
_____
_____
_____
_____

PERSONAL HEALTH HISTORY

Have you ever had surgery: Yes_____ No_____
If yes, please explain: _____

Have you ever had hospitalization not already mentioned: Yes_____ No_____
If yes, please explain:_____

Have you ever had major radiation or X-ray exposure: Yes_____ No_____
If yes, please explain: _____

Do you currently have any allergies: Yes_____ No_____

If yes, are they to: Food Drugs Environment Other

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Please list below specific substances and reaction(s) produced:

Substance	Reaction
_____	_____
_____	_____
_____	_____

As per above, please describe any childhood allergies you have outgrown:

_____

_____

How is your vision (without glasses): Poor Fair Good Excellent

Do you wear glasses or contacts: Yes No If yes, since what age? _____
Your vision is about: 20/_____
Are you: Nearsighted Farsighted Other_____

Do you have normal hearing: Yes No

What is the condition of your teeth: Poor Fair Good

Blood type: _____

PERSONAL HEALTH : WORK HISTORY/EXPOSURE

What is your current or most recent occupation:

_____

_____

_____

In the past six months have you been exposed to any of the following in your living environment, or while involved in hobbies or extra curriculum activities? If yes, please check the appropriate item below and give dates and how often you have been exposed. Please, consider each carefully.

Exposed to:	WHEN	HOW OFTEN
Toxic chemicals	_____	_____
Sprays	_____	_____
Fumes/Exhaust	_____	_____
Radiation	_____	_____
Flea powers/sprays	_____	_____

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Lead/lead products _____ _____
Asbestos/asbestos products_____ _____

Please list all jobs you have had in the past five years and your possible exposure to chemicals, drugs, and gases. Please consider carefully.

Jobs/Duties	Year Began	Year Ended	Exposed to which (drugs, chemicals, gases)

FAMILY HEALTH HISTORY

Please describe your family members by the following physical characteristics:

	Eye color	Hair color	Complexion	Height	Body type	Vision
Mother	_____	_____	_____	_____	_____	_____
Father	_____	_____	_____	_____	_____	_____
Grandfather (Paternal)	_____	_____	_____	_____	_____	_____
Grandmother (Paternal)	_____	_____	_____	_____	_____	_____
Grandmother (Maternal)	_____	_____	_____	_____	_____	_____
Grandfather (Maternal)	_____	_____	_____	_____	_____	_____
Genetic Siblings	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____	_____

How many genetic siblings are in your immediate family (including yourself): ___
Have twins or multiple births occurred in your family: Yes No
If yes, what relation to you: _____

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Please list below at what age members of your family died and what the cause of their death. Please be as specific as possible.

	Age (if living)	Age at time	Cause of death
Grandfather(paternal)	_____	_____	_____
Grandmother(paternal)	_____	_____	_____
Grandfather(maternal)	_____	_____	_____
Grandmother(maternal)	_____	_____	_____
Father	_____	_____	_____
Mother	_____	_____	_____
Brothers	_____	_____	_____
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
Sisters	_____	_____	_____
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

ALCOHOL USE

Please indicate current alcohol use by each family member:

DRINKS PER WEEK

	None	1-2	3-5	6-10	over 10
Self					
Grandfather (paternal)					
Grandmother (paternal					
Grandfather (maternal)					
Grandmother (maternal)					
Father					
Mother					
Brothers					

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1
2
3

Sisters

1
2
3

Has any member of your family, including yourself and your children, had a problem or defect at birth of any of the following body systems:

Bones, muscles, joints, limbs		Yes	No	
Gastrointestinal system	Yes	No		
Nervous system, brain, spinal cord		Yes	No	
Ears, eyes	Yes	No		
Blood circulation	Yes	No		
Respiratory system	Yes	No		
Organ (heart, lungs, kidney, etc.)	Yes	No		
Genital/urinary	Yes	No		
Metabolic (hormones, enzymes,etc)		Yes	No	
Other Birth Defect	Yes	No		

If yes to any of the above, please explain the specific defect in each case.

Birth defect	Who	How did it happen	Circumstances
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have any brothers or sisters who died in infancy or childhood? Yes No

If yes, please explain what was the cause:

_____
_____
_____
__

Are there any known genetic diseases or conditions that run in your family?

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Yes No

If yes, please explain what they are:_____
_____
_____
__

Has anyone in your family, including yourself, experienced recurring and/or chronic physical symptoms that have not been evaluated by a physician? (Please include those symptoms that you may not consider serious). Yes No
If yes, please explain them:
_____
_____
_____
__

Look through the following list of medical problems and indicate which ones you or one of your relatives have had. Please consider each condition carefully for each family member. Check (√) all that apply.

CONDITION:

HEART	Self	Mother	Father	Siblings	Maternal Grandparents	Paternal Grandparents	Child	Aunts/Uncles Cousins
Stroke								
Heart Attack								
Heart disease from birth								
Heart disease other								
Hardening of arteries								
High blood pressure								

If you answered yes to any of the above conditions, please explain:
Please describe any circumstances, (i.e., diet, smoking) and indicate the date of onset of condition.

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_____
_____
__

BLOOD	Self	Mother	Father	Siblings	Maternal Grand Parent	Paternal Grandparents	Child	Aunts/Uncles Cousins
Anemia								
Sickle cell								
Hemophilia								
Leukemia								
Immune Deficiency								
Other Blood Disorders								

If you answered yes to any of the above conditions, please explain:
Please describe any circumstances, (i.e., diet, smoking) and indicate the date of onset of condition.

_____
_____
_____
_____
____

RESPIRTORY	Self	Mother	Father	Siblings	Maternal Grand Parents	Paternal Grandparents	Child	Aunts/Uncles Cousins
Hay fever								
Asthma								
Emphysema								
Tuberculosis								
Lung Cancer								
Pneumonia								
Other								

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If you answered yes to any of the above conditions, please explain:
Please describe any circumstances, (i.e., diet, smoking) and indicate the date of onset of condition.

_____
_____
_____
_____
____

GASTRO	Self	Mother	Father	Siblings	Maternal Grandparents	Paternal Grandparents	Child	Aunts/Uncles Cousins
Gastro Intestinal Ulcer								
Gall stones								
Hepatitis A								
Hepatitis B								
Liver disease								
Colon cancer								
Ulcerative colitis								
Crohn's Disease								
Cystic Fibrosis								
Intestinal cancer								
Other:								

If you answered yes to any of the above conditions, please explain:

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Please describe any circumstances, (i.e., diet, smoking) and indicate the date of onset of condition.

_____
_____
_____
_____
____

URINARY	Self	Mother	Father	Siblings	Maternal Grandparents	Paternal Grandparents	Child	Aunts/Uncles Cousins
Kidney Disease								
Rectal Disorder								
Other								

If you answered yes to any of the above conditions, please explain:
Please describe any circumstances, (i.e., diet, smoking) and indicate the date of onset of condition.

_____
_____
_____
_____
____

GENITAL/ REPRODUCTIVE	Self	Mother	Father	Siblings	Maternal Grandparents	Paternal Grandparents	Child	Aunts/Uncles Cousins
Un-descended Testicle								
Hypospadiasis								
Prostate Cancer								
Uterine Fibroids								
Ovarian Cysts								

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Cervical Cancer
Ovarian Cancer

Other

If you answered yes to any of the above conditions, please explain:
Please describe any circumstances, (i.e., diet, smoking) and indicate the date of onset of condition.

_____
_____
_____
_____
____

MENTAL	Self	Mother	Father	Siblings	Maternal Grandparents	Paternal Grandparents	Child	Aunts/Uncles Cousins
Mental Health								
Schizophrenia								
Manic Depressive								
Clinical Depression								
Anxiety								
Learning disabilities								
Mental Retardation								
Other mental illness								

If you answered yes to any of the above conditions, please explain:
Please describe any circumstances, (i.e., diet, smoking) and indicate the date of onset of condition.

_____
_____
_____
___

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MUSCLES / BONES / JOINTS	Self	Mother	Father	Siblings	Maternal Grandparents	Paternal Grandparents	Child	Aunts/Uncles Cousins
Muscular Dystrophy								
Chronic Muscle Disease								
Lupus								
Deformity of Spine								
Dwarfism								
Low back pain								
Gout								
Osteoporosis								
Other:								

If you answered yes to any of the above conditions, please explain:
Please describe any circumstances, (i.e., diet, smoking) and indicate the date of onset of condition.

_____
_____
_____
_____
___

SIGHT / SOUND / SMELL	Self	Mother	Father	Siblings	Maternal Grandparents	Paternal Grandparents	Child	Aunts/Uncles Cousins
Deafness before Age 60								

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Deformity of the ear
Cataracts before age 50
Blindness
Color blindness
Glaucoma
Deviated Septum
Other

If you answered yes to any of the above conditions, please explain:
Please describe any circumstances, (i.e., diet, smoking) and indicate the date of onset of condition.

_____
_____
_____
___

SKIN	Self	Mother	Father	Siblings	Maternal Grandparents	Paternal Grandparents	Child	Aunts/Uncles Cousins
Acne								
Eczema								
Skin cancer								
Pigmentation Disorders								
Other								

If you answered yes to any of the above conditions, please explain:
Please describe any circumstances, (i.e., diet, smoking) and indicate the date of onset of condition.

_____
_____

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_____
___

OTHER	Self	Mother	Father	Siblings	Maternal Grand Parent	Paternal Grandparents	Child	Aunts/Uncles Cousins
Alcoholism								
Drug/substance abuse								
Breast cancer								
Any other Cancer								
Nervous System Disorders								
Seizure Disorder								
Diabetes								
Elevated Cholesterol								
Other								

If you answered yes to any of the above conditions, please explain:
Please describe any circumstances, (i.e., diet, smoking) and indicate the date of onset of condition.

_____
_____
_____
_____

Do you or anyone in your family have a history of any of the following disorders?

		Yes	No
1.	Cleft Lip	____	____
2.	Cleft Palate	____	____
3.	Congenital Hip Dislocation	____	____
4.	Clubfoot	____	____

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5.	Albinism	____		____	
6.	Hemoglobin Disorder		____		____
7.	Hereditary Hypercholesterolemia	____		____	
8.	Neurofibromatosis	____		____	
9.	Juvenile Diabetes Mellitus	____		____	
10.	Epileptic Disorder	____		____	
11.	Rheumatoid Arthritis		____		____
12.	Glucose -6-Phosphate Dehydrogenase	____		____	
	Deficiency	____		____	
13.	thalassemia	____		____	
14.	Sickle Cell Disease	____		____	
15.	Tay Sachs Disease	____		____	
16.	Huntington's Disease		____		____
17.	Retinitis Pigmentosa	____		____	
18.	Marfan Syndrome	____		____	
19.	Retinoblastoma	____		____	
20.	Alport Disease		____		____

Comments If Yes	Self Or Family Member	Comments:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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If you could pass on a message to the recipient(s) of your eggs, what would that message be?

_____
_____
_____
_____
_____
_____
_____
_____

Why do you want to be a donor?

_____
_____
_____
___
_____
_____
__

Are you willing to be an anonymous donor? Yes No

Are you willing to be a semi anonymous donor? Yes No
(meet but no exchange of last name or phone #)

Would you be open to meeting the child if his/her parents
wanted this when the child was eighteen. Yes No

Are you interested in our surrogate mother/gestational carrier program: Yes No

If the recipient(s) of your eggs choose to be anonymous, please list non-identifying questions that you may want to have answered by the recipient couple:

_____
_____
_____
_____
_____
_____
_____

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I, the undersigned, do hereby swear and affirm that the above statements are true and correct to the best of my knowledge.

Signature:_____ **Date**:_____

AUTHORIZATION FOR RELEASE OF INFORMATION
(Civil Code section 56.10)

TO: ANY PHYSICIAN, MEDICAL FACILITY, PSYCHIATRIST, PSYCHOLOGIST, OR OTHER HEALTH CARE OR MENTAL HEALTH PROFESSIONAL:

YOU ARE HEREBY AUTHORIZED to release to **GLOBAL FERTILITY SERVICES** any and all medical, psychological, psychiatric, or health information pertaining to me, which is now or in the future may be in your possession or under your control.

GLOBAL FERTILITY SERVICES is expressly authorized hereby to copy, or receive copies of, any records or documents pertaining to me or the information specified above, and to distribute said copies to _____
(Prospective Parents) or to any other Prospective Parents and to any other interested physician, psychiatrist, psychologist or health care or mental health professional who requires the information for purposes of medical or psychological assessment or treatment.

The information may be used in, or in connection with, the ovum donor program agreement I entered into with the Prospective Parents identified above or with other Prospective Parents.

This authorization shall remain valid for two years from the date hereof.

I have been advised of my right to receive a copy of this Authorization.

Dated:_____ _____
OVUM DONOR

msw/ovdauth

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AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Global Fertility Services to disclose the information contained in this Ovum Donor Application to anyone interested in using my ovum/ova in order to conceive a child, and for review by appropriate medical and psychological professionals and their staffs. I understand, and expressly condition this authorization upon such understanding, that my last name will only be disclosed to the appropriate health care professionals involved in my ovum donor process. I give my consent to the release of my photo(s) on the GFS website to Intended Parents who have authorization from GFS staff.

DATED: _____ _____

SIGNATURE

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HUSBAND/PARTNER INFORMATION FORM

I am _____, the husband/partner of _____. I cannot attend the intake interview that you have scheduled for my wife/partner on _____.

_ I am supportive of my wife's/partner's decision to donate her ovum (a) to help an infertile couple have a child.

_ I am not supportive of my wife's/partner's decision to donate her ovum (a) to help an infertile couple have a child.

The reasons for my decision are as follows (in no order of importance):

1.

2.

3.

4.

5.

(continue on back if necessary)

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_____ _____

Date Signature

APPLICANT REFERENCES

When calling references we simply state that you are applying for a voluntary position working with the public. We do not mention anything related to Ovum Donation or the Global Fertility Services.

Please provide the names of 3 (three) acquaintances, friends, or co-workers, that have known you for more than 5 years; DO NOT include relatives or in-laws. If you have an employment history, please include one person who was your supervisor.

Applicant's Name_____ **Date:**_____

Name:_____ Relationship:_____

Phone No: (__ __ __) __ __ __ - __ __ __ __

Name:_____ Relationship:_____

Phone No: (__ __ __) __ __ __ - __ __ __ __

Name:_____ Relationship:_____

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Phone No: (__ __ __) __ __ __ - __ __ __ __

****** PLEASE ATTACH A RECENT PHOTOGRAPH OF YOURSELF AND ******
****** YOUR CHILDREN ******

How did you become aware of the **Global Fertility Services?**

Newspaper advertisement – Name of publication_____
Newspaper/magazine article – Name of publication_____
Friend/acquaintance
Other _____

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PERSONAL HEALTH HISTORY FOR IVF PHYSICIAN AND GFS

Do you drink alcohol: Yes_____ No_____ If yes, how many:_____
Have you ever abused alcohol: Yes_____ No _____
If yes, when & how much:_____
Do you smoke cigarettes Yes_____ No_____
Are you using marijuana now: Yes_____ No_____ If yes, how often_____
Have you ever used illegal or unprescribed drugs: Yes_____ No_____
If yes, what drugs and how often:_____
Are you using illegal or unprescribed drugs now: Yes_____ No_____
If yes, what drugs and how often:_____

Have you had any therapy with a psychiatrist or any other mental health professional:
Yes_____ No_____
If yes, when and why: _____
_____

Have you ever had any psychiatric hospitalization: Yes_____ No_____
If yes, please be as specific as possible:_____

Have you ever been treated for Syphilis: Yes_____ No____ If yes, when:_____

How many times:_____ When was the last time:_____

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Have you ever been treated for Chlamydia: Yes_____ No____ If yes, when:_____

How many times:_____ When was the last time:_____

Have you ever been treated for Gonorrhea: Yes___ No___ If yes, when:_____

How many times:_____ When was the last time:_____

Have you or any of your sexual partners had:

			Myself	*Partner*	*When*
NSU(non-specific urethritis)	Yes	No	___	____	____
Chlamydia	Yes	No	___	____	____
Venereal warts	Yes	No	___	____	____
Herpes	Yes	No	___	____	____
Other sexually transmissible diseases	Yes	No	___	____	____

Have you ever tested positive for Hepatitis B, Hepatitis C, or HIV: Yes____ No____

Have you ever had any problems with the law: Yes_____ No_____
Please list any arrests, convictions, sentences, etc:
_____
_____

RISK FACTOR QUESTIONNAIRE

FDA regulations require that an eligibility determination be performed for ovum and sperm donors, based on testing and screening for relevant communicable diseases. This is for the protection of possible recipients of the tissue, and as well as those people who may handle or come in contact with the tissue. Please read and answer the following questions truthfully and to the best of your knowledge. We recognize that some of the questions are of a sensitive nature, and thank you for providing the most accurate information. Please describe any YES answers on the bottom of this form.

Group 1	YES	NO
1. Have you or a family member had Creutsfeldt-Jakob (“Mad Cow”) disease or Variant Creutzfeldt-Jakob disease or risk for it?		
2. Were you a member of the US military, a civilian military employee, or a dependant of a member of the US military who spent a total of 6 months on or associated with a military base stationed in Belgium, Netherlands, or Germany between 1980-1990, and/or Spain, Portugal, Turkey, Italy, or Greece between 1980-1996?		

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3. Have you visited or lived in the United Kingdom (UK) for three (3) or more months between 1980-1996? (UK includes: England, Scotland, Wales, Northern Ireland, Isle of Man, Channel Islands, Gibraltar, Falkland Islands)		
4. Have you had a blood transfusion in the United Kingdom (UK), or France between 1980 to present?		
5. Have you traveled or lived a cumulative time of 5 years or more since 1980 to present in any combination of countries in Europe?		
6. Have you received Human Pituitary Growth Hormone (used until 1985) or dura matter (brain covering) graft?		
7. Have you injected Bovine (beef) insulin (used to treat diabetes) since 1980?		
8. Do you have biologic relative who has been diagnosed with CJD? Biologic relative in this setting means a mother, father, sibling, grandparent, aunt, uncle, or children		
9. Have you been diagnosed with dementia or any degenerative or demyelinating disease of the central nervous system?		
Group 2		
10. Have you ever had prior reactive (positive) screening for HIV?		
11. Have you had sex with someone who has been diagnose with HIV?		
12. Have you used needles to take injectible drugs for non-medical use, including steroids, or anything not prescribed by a doctor (including intravenous, intramuscular, and subcutaneous injections) within the past five (5) years?		
13. Have you engaged in sex in exchange for money or drugs in previous 5 years?		
14. Have you received human-derived clotting factor concentrates for a bleeding disorder such as hemophilia or related blood clotting disorder within the past 12 months?		
15. Have you ever had sexual contact or participated in sexual activity with someone of the same sex in previous 5 years?		
16. Have you had sexual contact in the past 12 months with anyone described in questions 12-15?		
17. Were you or sexual partner born or have you or your sexual partner lived in certain countries in Africa after 1977? (Cameroon, Central African republic, Chad, Congo, Equatorial Guinea, Gabon, Niger or Nigeria)		
18. Have you received a blood transfusion or any medical treatment that involved blood in the countries listed above in question 17 after 1977?		
	YES	NO
Group 3		
19. Do you have unexplained weight loss (10 pounds or more in less than 2 months), night sweats, or swollen lymph nodes (lumps in your neck, arm pits, or groin) for longer than one month?		
20. Have you had an unexplained temperature of more than 100.5 F for 10 or more days?		
21. Have you had unexplained white spots or unusual blemishes in mouth?		
22. Do you have blue/purple spots under skin or mucous membranes?		
23. Do you have unexplained cough, shortness of breath, persistent diarrhea or other infection?		
Group 4		
24. Have you ever had prior reactive (positive) screening for HTLV?		
25. Have you ever tested positive for Adult T-Cell Leukemia?		
26. Have you ever experienced weakness in your lower extremities (Paraparesis)?		
Group 5		

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27. Have you ever had prior reactive (positive) screening for Hepatitis B or C virus?		
28. Have you had unexplained jaundice (yellow skin) or enlarged liver?		
29. Have you been diagnosed with clinical, symptomatic viral Hepatitis after age 11? If yes, at the time of illness, was it documented as Hepatitis A?		
30. Have you ever received a tattoo or body piercing with in the past 12 months under sterile conditions? If so, when was the last tattoo or body piercing_____?		
31. Have you received a blood transfusion in the last 12 months (excluding your own "autologous" blood)?		
32. Have you been exposed in the preceding 12 months to known or suspected HIV, HBV, or HCV-infected blood through needle stick or through contact with an open wound, non-intact skin, or mucous membrane?		
33. Have you had close contact within 12 months with another person having clinically active hepatitis B or hepatitis C infection (i.e. living in the same household, where sharing of kitchen and bathroom facilities occurs regularly)?		
34. Have you ever been incarcerated (jailed) for more than 72 hours during the past 12 months?		
Group 6 Within past 12 months:		
35. Have you had sex with any person known or suspected to have clinically active Hepatitis B infections, or Hepatitis C infection?		
Group 7 (only to be used when person-to person transmission of SARS-CoV occurring in the world (Check CDC site)		
36. Do you currently have/or within past 7 days had a moderate respiratory illness, fever, cough, and shortness of breath or difficulty breathing?		
37. Do you have a recent X-ray showing evidence of pneumonia within past 12 months?		
38. Have you recently been diagnosed with respiratory Distress Syndrom?		
39. Have you had recent contact (within 14 days) with any person suspected with SARS?		
40. Have you recently traveled to or resided in an area (within 14 days) affected by SARS?		
41. In the past 28 days have you been exposed to, treated for, or do you have SARS?		
Group 8		
42. Have you had an unexplained fever, fast heart rate and fast respiratory rate within past 7 days?		
43. Have you been diagnosed with or treated for Sepsis or have elevated white blood cell count or positive blood cultures associated with the condition described above within the last 7 days?		
44. Do you currently have severe signs and symptoms of Sepsis; unexplained low oxygen in the blood, very low urine output, altered mental functioning, low blood pressure?		
Group 9	YES	NO
45. Have you been treated for Syphilis in the past 12 months?		
46. Have you been treated for Gonorrhea in the past 12 months?		
47. Have you contracted Chlamydia, venereal warts (HPV), or genital herpes in the past 12 months?		
Group 10		
48. Have you had a Smallpox vaccination in the past 21 days? If yes, did the scab separate spontaneously?		

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49. If yes, did you develop any complications (i.e: skin rashes/sores beyond the vaccination site, infection of the cornea, or general illness related to the vaccination)?		
50. Have you developed skin rashes/sores since close contact with someone who received a Small Pox vaccination?		
Group 11		
51. Have you had a medical diagnosis of WNV (including diagnosis based on symptoms and laboratory results, or confirmed WNV viremia)?		
WITH IN PAST 7 DAYS:		
52. Have you had fever or headache, body aches, or eye pain?		
53. Have you had swollen Lymph nodes?		
54. Have you had a skin rash on the trunk of your body?		
55. Have you had a severe illness; encephalitis, meningitis, paralysis?		
56. Have you had severe illness with headache, high fever, neck stiffness, disorientation, coma or tremors?		
57. Have you experienced convulsions, muscle weakness, or paralysis?		
Group 12		
58. Are you a recipient or have you had intimate contact of a xenotransplantation product recipient? (Surgical transfer of cells, tissues, or especially whole organs from on species to another) If yes or this person is in your household, have you been exposed to blood, saliva, or other body fluids from this person?		

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 the IVF center 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 Cryopreserved 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 affect.

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I agree to indemnify, defend and hold harmless GFS, its associated IFV centers, their 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.

Name: _____
(Please Print)

Signature:_____

Date:_____

Please describe any “Yes” answers below:

_____
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