ARIZONA CENTER FOR FERTILITY STUDIES
Jay S. Nemiro, M.D. / Shane T. Lipskind, M.D.
8997 E. Desert Cove Ave., Floor 2 Scottsdale,
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Ph: 480-860-4792 / Fax: 480-860-6819
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ARIZONA CENTER FOR

FERTILITY STUDIES

Thank you for your interest in our donor egg program. The program involves a comprehensive screening process. If you are selected, you will be seen by a psychologist and genetic counselor. You will have a physical exam and various tests for sexually transmitted diseases. These involve blood tests and cervical cultures. Other tests are ordered as necessary to insure that you are in good health.

You will be seen by a nurse at our center for an initial interview. Also, you will be seen by Dr. Nemiro or Dr. Lipskind, who will review your medical history and answer any questions you may have regarding the program.

The process involves taking medication for an average of 6-8 weeks. You will have a transvaginal retrieval of eggs. ACFS donors receive $4,500 in compensation upon completion of each egg retrieval. All procedures, tests and medications, as well as risks and side effects, will be explained at the initial interview with the nurse.

The donor egg program demands some flexibility in your schedule since some visits must occur at precise times.

Women who have donated eggs have found it to be a very rewarding experience. They have felt a great satisfaction in giving childless couples the opportunity to have a child of their own.

I have included forms to be filled out completely and returned to me. I would also like a few professional looking photographs of you. Please include a good head shot and a good body shot, as well as pictures of any children you have. Once I have reviewed these forms, I will call you to set up an initial interview. I look forward to working with you.

If you have any questions that you would like answered before sending back the packet, please feel free to contact me at 480-860-4792.

Sincerely,

Gina Caiazza, RNFA, CNOR

Donor#_____

Scottsdale, AZ 85260
(480) 860-4792

Name _____ Date ___/___/___

Age _____ Date of Birth ___/___/___

Social Security #_____

Address _____

_____

Email Address _____

Phone Home # _____

Work # _____ Cell # _____

In case of emergency notify _____

Home #_____

Work #_____

Do you drive a car? ☐ YES NO

Do you have automobile insurance? ☐ YES ☐ NO

Do you have a valid driver's license? ☐ YES ☐ NO

If yes, please give state and #_____

Where did you hear about our program? _____

I hereby declare the above information to be true and correct. Any false statements will result in termination of my participation the donor egg program.

_____ ____/____/____

Print name Date

_____

Signed name

Please attach a recent professional head shot and body shot of yourself and children or email photos to Gina.Caiazza@gmail.com Egg Donor Profile

Date___/___/___

Donor#_____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Physical Characteristics

Date of Birth ___/___/_____ Age ____ Height ____ Weight (current)_____lbs

Has your weight fluctuated more than 20 lbs in the last 5 years? ☐ YES NO
(If yes, explain)_____

Eye color _____ Natural hair color _____ Circle one in each of the following:

Hair	Hair	Complexion	Bone Structure
☐ Thin	☐ Curly	Fair	Small
☐ Average	☐ Wavy	Medium	Medium
☐ Thick	☐ Straight	Dark	Large

Ethnic Origin/Ancestry

1. Primary: _____2. Secondary: _____ 2. Additional: _____

Do you have any Jewish ancestors? ☐ YES ☐ NO ☐ UNKNOWN
If yes, have you been tested as a carrier of Tay Sachs, Cystic Fibrosis or Gaucher's disease?
☐ YES NO If yes, results_____

Do you have any African ancestors? ☐ YES ☐ NO ☐ UNKNOWN

If yes, have you been tested as a carrier of sickle cell disease? ☐ YES ☐ NO
If yes, results _____

Do you have any Mediterranean (Greek or Italian) ancestors? ☐ YES NO UNKNOWN

If yes, have you been tested as a carrier of Thalassemia? ☐ YES ☐ NO
If yes, results _____

Do you have any Asian ancestors? ☐ YES NO UNKNOWN

If yes, have you been tested as a carrier of Thalassemia? ☐ YES ☐ NO
If yes, results _____

Education/Occupation History

Complete all that apply:

☐ Completed High School

Donor#_____

☐ High School Grade Point Average _____ SAT score _____ ACT score _____

☐ Completed College Degree in _____ GPA _____

☐ Completed Advanced Degree in _____ GPA _____

☐ Completed Trade School in _____ GPA _____

☐ Currently Attending College for _____ Current GPA _____

☐ Currently Attending Trade School for _____ Current GPA _____

☐ Currently Pursuing Advanced Degree in _____ Current GPA _____

Current Occupation: _____

Did you participate in any honors programs or specialty courses or training at any time in your educational background? YES NO

If yes, explain: _____
_____ Please describe your mother's occupation/career: _____
_____ What is your mother's level of educational training? _____
_____

Please describe your father's occupation/career: _____
_____

What is your father's level of educational training? _____

Fertility History

Have you ever been pregnant? ☐ YES ☐ NO
Number of pregnancies _____ Number of miscarriages _____
Number of abortions _____
Number of children born alive _____ # of Males _____ # of Females _____
Caesarean births _____
Stillbirth's _____

Complications ☐ YES ☐ NO Explain_____
_____ Is there any history of fertility problems in your family? ☐ YES NO

If yes, please explain: _____
_____ Have you previously donated eggs? ☐ YES ☐ NO When? _____

Donor#_____
Where? _____ How many births resulted? _____

Have you ever had a fertility evaluation? ☐ YES NO

Results _____

Did your parents have difficulty conceiving? ☐ YES ☐ NO

Do any of your sisters have fertility problems? YES ☐ NO

Do any of your aunts have fertility problems? ☐ YES ☐ NO

What was the first day of your last menstrual period? ___/___/____
How old were you when you first noticed breast development? _____
How old were you when you first noticed pubic hair growth? _____
How old were you when you had your first menstrual period? _____
How old were you when you began to have regular periods? _____
How many days from the first day of your cycle to the next cycle? _____
How many total days of menstrual flow do you have? _____

List any forms of contraception you have used, and the dates used.

_____

_____

When was your last pap smear? ___/___/____ Results _____

When was your last mammogram? ___/___/____ Results _____

List any past infections of your pelvic organs: _____

_____

Health History

Were you adopted? YES NO

Do you have any allergies? ☐ YES NO If yes, list substance and action:_____

_____

Have you ever served in the military? ☐ YES ☐ NO
If yes, when and where _____

How much exercise do you get? NONE ☐ OCCASIONAL REGULAR
What type of exercise? _____

Have you ever had surgery? ☐ YES ☐ NO

Type of Surgery	Date
_____	___/___/_____
_____	___/___/_____

Have you had any hospitalization(s) not already mentioned? YES NO

Type of Problem	Date
_____	____/___/_____

Donor#_____

_____ ____/___/_____

Do you know your blood type? ☐ YES ☐ NO If yes, please list type _____

Have you had any breast problems or surgery (including cosmetic surgery) YES NO
If yes, when and type of surgery _____

_____

Have you ever been treated for syphilis, chlamydia, and/or gonorrhea? YES NO

Do you have any current chronic medical problems or conditions? ☐ YES ☐ NO
If yes, please explain _____

_____

Please list any medications you are currently taking (including birth control pills)

_____

Do you drink alcoholic beverages? ☐ YES ☐ NO
How many drinks per day or week? _____ Day(s) _____Week

Do you use tobacco? ☐ YES ☐ NO
If you previously used tobacco, how long ago did you quit? _____ Have you ever or do you currently use any of the following drugs?

	Frequency	**How used?**
☐ Marijuana	_____	_____
☐ Cocaine	_____	_____
☐ Barbiturates	_____	_____
☐ Narcotics/Opiates (heroin, codeine, (methadone, morphine, opium, oxycodone)	_____	_____
☐ Amphetamines	_____	_____
☐ Hallucinogens	_____	_____
☐ Tranquilizers	_____	_____
☐ PCP	_____	_____
☐ Inhalants (amyl nitrate, aerosol propellants)	_____	_____
☐ Over the counter drugs ☐	_____	

Other: Poor Fair Good Excellent

How is your vision without glasses? ☐

Are you? ☐ Nearsighted Farsighted Other specify: _____

Do you have normal hearing? ☐ YES ☐ NO

Condition of teeth: ☐ Poor ☐ Fair Good

Donor#_____

Have you worn braces? ☐ YES ☐ NO Is your

diet: ☐ Vegetarian Non-Vegetarian

Is your diet: ☐ Poor Average Excellent

Special Abilities and Talents

In general are you? (check all that apply)

1. ☐ Somewhat Shy ☐ Introspective ☐ Sociable ☐ Extrovert Extremely Outgoing
2. Very Outgoing Un-phased ☐ Somewhat Demanding Perfectionist
3. ☐ Very Cautious ☐ PlannerTake-it-as-it-Comes Risk-Taker **Do you have any special abilities or talents that seem to come naturally?**

Check all that apply and provide *detailed* information:

ABILITY	NONE	SOME	VERY	EXPERT	EXPLAIN
English / Writing i.e. journaling, essays, reading, published material	☐	☐	☐	☐	
Foreign Languages i.e. French, Italian, German, Japanese, Hindi, Sign, Spanish	☐	☐	☐	☐	
Mathematics i.e. calculus, statistics, geometry, accounting, engineering	☐	☐	☐	☐	
Physics, Chemistry & Geology i.e. biology, anatomy	☐	☐	☐	☐	
Business i.e. management, entrepreneur, retail, customer service	☐	☐	☐	☐	
Organization i.e. detail oriented, neat, particular, perfectionist	☐	☐	☐		
Intuition i.e. research, thinking ahead, gut feeling, sense about people	☐	☐	☐	☐	
Music & Singing i.e. dance, ballet, play instruments, choir, compose, theater	☐	☐	☐	☐	
Athletic i.e. sports, swim, state honors, hiking, bicycling, marathons,	☐	☐	☐	☐	

horseback riding		
Artistic i.e. design, acting, photography, draw, paint, sculpt, scrapbooking, design, crafts	☐ ☐ ☐ ☐	
Other: i.e. church, awards, computers/IT, pageants, volunteering, honors, blood donations	☐ ☐ ☐ ☐	

Donor#_____

Do you have any specific interests or hobbies? (i.e. reading, travel, musical instrument, sewing, clubs, scrap booking, cooking, baking, passions, painting, drawing, theater, etc.)

_____

_____

_

What is your favorite book, movie/show, musical band, or favorite activities?

_____

What were your motivations for becoming an egg donor?

_____

_____

How would someone close to you describe your character and personality?

_____

_____

What is the one thing about you that everyone should know?

_____

What reassurance can we provide the couple receiving your eggs, that you will not change your mind?

_____

_____

What message would you like to pass on to the recipients of your eggs?

_____

_____

What are your overall career and or personal goals in life?

_____

_____

What is one of the brightest or proudest moments of your life and why?

_____

_____

What is your religious background?

_____

What are your favorite foods?

_____

What is your favorite animal and why?

_____

Where would you like to travel and why?

_____

What makes you laugh?

_____

Donor#_____

Family Health History

Are you a twin? ☐ YES ☐ NO

Are there any known genetic diseases or conditions that run in your family? ☐ YES ☐ NO

If yes, please explain: _____

_____

Educational level

	Years of High School	Years of College	Degree Obtained
Mother	_____	_____	_____
Father	_____	_____	_____
Brother	_____	_____	_____
Brother	_____	_____	_____
Brother	_____	_____	_____
Sister	_____	_____	_____
Sister	_____	_____	_____
Sister	_____	_____	_____

	Age	Eye Color	Hair Color	Complexion	Height	Weight	Body Type
Mother							
Father							
Maternal Grandmother							
Maternal Grandfather							
Paternal Grandmother							
Paternal Grandfather							
Brother							
Brother							
Brother							
Sister							

Sister							
Sister							

Donor#_____

Family Characteristics

Family history includes grandparents, parents, brothers, sisters, aunts, uncles, cousins, children, nieces and nephews. Does any of your family have any of the following ailments?

	NO	YES	RELATIONSHIP	AGE AT DEATH
1. Heart Disease			_____	_____
2. High Blood Pressure			_____	_____
3. Heart Attack or Stroke before age 50			_____	_____
4. Kidney Disease			_____	_____
5. Liver Disease			_____	_____
6. Lung Disease			_____	_____
7. Gastrointestinal Disease			_____	_____
8. Diabetes			_____	_____
9. Neurological Disease			_____	_____
10. Seizure Disorder			_____	_____
11. Mental Retardation			_____	_____
12. Schizophrenia			_____	_____

	_____	_____
13. Manic Depressive Disorder ☐	_____	_____
14. Mental Illness, Other	_____	_____
15. Breast Cancer	_____	_____
16. Colon Cancer	_____	_____
17. Ovarian Cancer	_____	_____
18. Other Cancers	_____	_____
19. Alcoholism	_____	_____
20. Substance Abuse	_____	_____
21. Learning Disabilities	_____	_____
22. Genetic/Inherited Disease ☐ (MS, Cystic Fibrosis, etc.)	_____	_____
23. Congenital/Birth Defects	_____	_____

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DONOR MEDICAL HISTORY ASSESSMENT

Donor Name: _____ Date: _____/_____/_____
Donor ID Number: _____ Donor ID Check: _____ Procedure
or Accession Number: _____ Date of last assessment: _____/_____/_____
Date of Birth: _____/_____/_____ Cells /Tissue Donated: _____

Donation Type: □ Anonymous Directed □ Autologous / Intimate Partner

Recovery Method: □ Transvaginal Aspiration of Oocytes □ Laparoscopic Aspiration of Oocytes
□ Ejaculation □ Biopsy /Aspiration Retrograde / Electro Ejaculation

Please answer the following questions by checking YES or NO:

YES NO

1. (Men only) Have you had sex with another man in the past 5 years?
2. Have you injected drugs for a non-medical reason in the past 5 years?
3. Do you have hemophilia? If so, have you received human-derived clotting factor concentrates in the past 5 years?
4. Have you had sex in exchange for money or drugs in the past 5 years?
5. Have you had sex in the past 12 months with any person described in the items above or with any person suspected of having HIV (including a positive or reactive test for HIV), Hepatitis B infection, or active (symptomatic) Hepatitis C infection?
6. Have you been exposed in the past 12 months to known or suspected HIV, Hep B, and/or Hep C infected blood through percutaneous inoculation (e.g. needle stick) or through contact with an open wound, non-intact skin, or mucous membrane?
7. Have you been in juvenile detention, lock up, jail or prison for more than 72 hours in the past 12 months?
8. Have you had close contact (e.g. living in the same household) with another person who has Hep B or clinically active Hep C in the past 12 months?
9. Have you undergone tattooing, ear or body piercing, or acupuncture in the past 12 months in which sterile items (instruments and/or ink) were not used or shared instruments not sterilized between uses were used?

Risk Assessment Conducted by: _____ Date: _____/_____/_____

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YES NO

10. Have you had a past diagnosis of clinical, symptomatic viral hepatitis after age 11, unless evidence from the time of illness documents that the hepatitis was identified as being caused by Hep A, Epstein-Barr Virus (EBV), or CMV?

11. Have you had a smallpox vaccination in the past 8 weeks? During this time, was the scab at the injection site separated by some other means than spontaneously?

12. Have you acquired a clinically recognizable vaccinia virus infection contracted by close contact with someone who received the smallpox vaccine?

13. Have you had a medical diagnosis or suspicion of West Nile Virus based on symptoms and/or lab results, or confirmed WNV viremia?

14. Have you had both a fever and a headache (simultaneously) during the 7 days prior to donation? **If "yes", then defer donation for 28 days.**

15. Have you been treated for or had Syphilis, Chlamydia Trachomatis, or Neisseria Gonorrhea infection in the past 12 months?

16. Have you had a transfusion or received blood products in the last 48 hours?

17. Have you been diagnosed with vCJD or any form of CJD?

18. Have you been diagnosed with dementia or any degenerative or demyelinating disease of the central nervous system or other neurological disease of unknown etioloty?

19. Do you have a family history of transmissible spongiform encephalopathy (TSE) such as Creutzfeldt-Jakob Disease (CJD); a history of changes in cognition, speech, or gait; or exposure to tissues (e.g. dura mater grafts, corneal transplants) suspected to harbor TSE's?

20. Are you at increased risk for CJD or have a history of CJD in a blood relative?

21. Have you spent 3 or more months cumulatively in the United Kingdom between 1980 and 1996?

22. Are you a current or former U.S. Military member, civilian military employee, or dependent of a military member or civilian employee who resided at U.S. Military bases in Northern Europe (Germany, Belgium, and the Netherlands) for 6 months or more cumulatively from 1980 through 1990, or elsewhere in Europe (Greece, Turkey, Spain, Portugal, and Italy) for 6 months or more cumulatively from 1980 through 1996?

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Donor ID#: _____ Donor Name: _____ Date: _____/_____/_____

Risk Assessment Conducted by: _____ Date: _____/_____/_____

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YES NO

23. Have you spent 5 years or more cumulatively in Europe from 1980 until the present? This includes time spent in the U.K. from 1980-1996?

24. Have you received any transfusion of blood or blood components in the U.K. or France between 1980 and the present?

25. Have you lived cumulatively for 5 years or more in Europe from 1980 until the present (note this criterion includes time spent in the U.K. from 1980 through 1986?

26. Have you received a transfusion of blood or blood components in the U.K. between 1980 and the present?

27. Are you a xenotransplantation product recipient or intimate contacts of a xenotransplantation product recipient?

28. Have you injected bovine Insulin since 1980, unless you can confirm that the product was not manufactured after 1980 from cattle in the U.K.?

The following questions apply to all sperm, oocyte and embryo donors to rule out potential transmission of the ZIKV to a recipient of HCT/Ps.

29. Have you or a partner traveled to or resided in an area with active ZIKV transmission within the last 6 months? This question includes the following countries and regions:

    Cape Verde, Mexico, Aruba, Barbados, Bonaire, Cuba Curacao, Dominica, Dominican Republic, Guadeloupe, Haiti, Jamaica, Martinique, The Commonwealth of Puerto Rico, St Martin, St Vincent and The Grenadines, St Maarten, Trinidad and Tobago, The US Virgin Islands, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, Panama, American Samoa, Marshall Islands, New Caledonia, Samoa, Tonga, Bolivia, Brazil, Colombia, Ecuador, French Guiana, Guyana, Paraguay, Suriname, or Venezuela.

Donor ID#: _____ Name: _____ Date: _____/_____/_____

Risk Assessment Conducted by: _____ Date: _____/_____/_____

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YES NO

31. Have you or a partner had a medical diagnosis of the ZIKV in the past 6 months?

32. Have you had sex within the past 6 months with a male or female who is known to have either of the risk factors listed in questions 29 or 30?

33. Have you experienced any of the following symptoms 2-12 days after being bitten by a mosquito?

34. Have you experienced a low-grade fever, arthralgia, myalgia, headache, retro-ocular headaches, no-purulent conjunctivitis, and cutaneous maculopapular rash?

35. Have you experienced or been diagnosed within the last 6 months with neurologic manifestations of muscle weakness or temporary paralysis, including a diagnosis of GillainBarre' Syndrome?

    If this is a repeat donation within the 6 months of your last full medical history interview have the answers to the above questions changed?

36. The following questions need only to be answered if there is a SARS outbreak in the world. Contact the CDC website9http://www.cdc.gov/ncidod/sars/index.htm) or call CDC (888246-2675) to obtain up to date information concerning areas affected by SARS. If there are cases of SARS, ask the following questions, otherwise note N/A.

37. Have you traveled to or resided in the areas affected in the last 14 days?

38. Have you had close contact with someone who has traveled to or resided in the affected areas in the last 14 days?

39. Have you been treated for SARS or suspected you had SARS in the last 28 days?

40. Have you had close contact within the previous 14 days with persons with SARS or suspected SARS?

Donor ID#: _____ Donor Name: _____ Date: _____/_____/_____

Risk Assessment Conducted by: _____ Date: _____/_____/_____