

**DOMINION FERTILITY AND ENDOCRINOLOGY**

**DONOR INFORMATION AND MEDICAL HISTORY**

Name: \_\_\_\_\_

Soc. Sec.#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Home Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_

Address: \_\_\_\_\_

Work Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_

\_\_\_\_\_

AD # \_\_\_\_\_ (office use only)



Please think carefully as you answer the following questions. It is essential that your medical history be as accurate and complete as possible.

**FERTILITY:**

Have you ever been pregnant before?  yes  no

Number of abortions\_\_\_\_\_ Number of miscarriages\_\_\_\_\_ Number of children\_\_\_\_\_

If you have children, do they have any health problems?  yes  no

If yes, please specify: \_\_\_\_\_

Have you ever donated eggs before?  yes  no

If yes, when and where? \_\_\_\_\_

**PERSONAL HEALTH:**

Vision (uncorrected):  poor  fair  good  excellent  
Do you wear glasses/contact lenses?  yes  no  
Are you:  near sighted  farsighted  
 other ( please specify) \_\_\_\_\_

Hearing: Normal?  yes  no If no, please specify \_\_\_\_\_

Have you ever had surgery?  yes  no If yes, please explain \_\_\_\_\_

Have you been hospitalized for other reasons?  yes  no If yes, please explain: \_\_\_\_\_

Have you ever had any major illnesses  yes  no If yes, please specify: \_\_\_\_\_

Are you currently taking any medications?  yes  no If yes, please list: \_\_\_\_\_

Do you currently use any of the following? (this information is strictly confidential):  
 marijuana  amphetamines  frequently  
 cocaine  hallucinogens  
 barbiturates  tranquilizers  
 narcotics (heroin, methadone)  
Do you drink alcohol?  never  occasionally  
Do you smoke cigarettes?  yes  no  
If yes, how much? \_\_\_\_\_

Have you had any of the following?

- blood transfusion
- major radiation or x-ray exposure
- syphilis
- gonorrhea
- non-specific urethritis
- venereal warts
- herpes
- chlamydia
- other sexually transmitted diseases

In the past six months have you been exposed to:

- toxic chemicals\_\_\_\_\_
- sprays\_\_\_\_\_
- fumes/exhaust\_\_\_\_\_
- radiation\_\_\_\_\_
- flea powders/sprays
- lead or lead products
- asbestos/asbestos products
- other toxic products (please specify)\_\_\_\_\_

Are your family members generally:

- taller than average
- shorter than average
- of average height

Have any of your relatives had more than one miscarriage, any stillbirths or early childhood deaths?

- yes     no    If yes, please explain that person's relationship to you, the cause(s) of their child(ren)'s death(s) and the child(ren)'s age(s) at death.

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Have any of your family members had one or more children with serious birth defects?

- yes            If yes, please specify \_\_\_\_\_
- no                \_\_\_\_\_



**FAMILY HISTORY**

Look through the list of medical problems and indicate which ones you or your relatives have had:

Medical Problem	You	Mother	Father	Sibling	Grand- parents	Aunts/ Uncles	Cousins
Stroke							
Heart Disease							
Hardening of the Arteries							
High Blood Pressure							
Anemia							
Hemophilia/Bleeding Problem							
Leukemia							
Immune Deficiency Disorder							
Thalassemia							
Tay-Sachs							
Sickle Cell							
Hay Fever							
Asthma							
Emphysema							
Tuberculosis							
Lung Cancer							
Other Lung Disease							
Ulcer of Duodenum or Stomach							
Gallstones							
Hepatitis							
Pyloric Stenosis							
Liver Disease							
Ulcerative Colitis							
Crohn's Disease							
Intestinal Cancer							
Other Cancer of Digestive System							
Other Digestive Disease							
Diabetes							
Thyroid Disease							
Other Endocrine Disease							
Cleft lip or palate							
Club foot							
Congenital Heart Disease							
Other Birth Defects							
Kidney Disease							
Other Urinary Tract Disease							

**FAMILY HISTORY (Continued)**

Look through the list of medical problems and indicate which ones you or your relatives have had:

Medical Problem	You	Mother	Father	Sibling	Grand- parents	Aunts/ Uncles	Cousins
Undescended Testicle							
Hypospadiasis							
Prostate Cancer							
Uterine Fibroids							
Cancer of Cervix, Ovaries, or Uterus							
Mental Retardation							
Down's Syndrome							
Senility Before Age 50							
Mental Disorder (Hospitalization)							
Crippling Disorders							
Schizophrenia							
Manic Depressive Disorder							
Other Mental Disorder (Hospitalized)							
Multiple Sclerosis							
Epilepsy							
Hydrocephalus (Water on the Brain)							
Spinal Cord Disorders							
Huntington's Chorea							
Other Nervous System Disorders							
Deafness Before Age 50							
Cataracts Before Age 50							
Blindness							
Glaucoma							
Muscular Dystrophy							
Other Chronic Muscle Diseases							
Spina Bifida/Other Spinal Deformity							
Arthritis							
Hereditary Low Back Disease							
Eczema							
Skin Cancer							
Breast Cancer							
Other Cancer Not Mentioned Above							
Alcohol Related Problem							
Other (please list below):							