



Fertility & Surgical Associates of California

Thank you for your interest in the Egg Donor/ Surrogate program at Fertility & Surgical Associates of California (FSAC). Many infertile couples/individuals can now become parents because of the generosity and commitment of women such as you. FSAC takes pride in the care we give to egg donors, surrogates, as well as recipients, and will generously compensate you for your time and effort.

Please take a few minutes to fill out the enclosed form. Please be sure to attach 2-3 recent photos (front and full body shot) to the front of the form. Return your completed form to us as soon as possible. You will be contacted when a recipient couple has chosen you for further screening and information.

If you have any questions, please do not hesitate to contact our office.

Thank you.

Sincerely,

Arlene Rees, R.N.
Third Party Coordinator

DONOR / SURROGATE INFORMATION:

First Name: _____ **MI:** _____ **Last:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Birth date: _____ **Age:** _____

Home Phone: _____

Cell Phone Number: _____

Male **Female**

Marital Status: **Single** **Married** **Divorced**
 Widow **Widower**

Email Address: _____

Do we have permission to leave messages on home phone, cell or email: **Yes** **No**

How did you hear about us?

Signature: _____ **Date:** _____

**DONOR PROFILE
FEMALE**

Date Completed: _____ **Age/Date of Birth:** _____

Race: Caucasian: _____ **African-American:** _____ **Asian:** _____ **Other** _____

Ancestry: Mother's Family: _____ **Father's Family:** _____

Place of Birth: _____

Marital Status: _____

Education: High school _____ **College/Univ.** _____

Post-graduate Degrees obtained: _____

Occupation: _____

Interests and Hobbies: _____

Personal Characteristics: **Height** _____ **Weight** _____
Eyes _____ **Hair** _____
Skin tone _____ **Blood Type** _____

SURROGATE PROFILE

Date Completed: _____ Age/Date of Birth: _____

Race: Caucasian: _____ African-American: _____ Asian: _____ Other _____

Ancestry: Mother's Family: _____ Father's Family: _____

Place of Birth: _____

Marital Status: _____

Education: High school _____ College/Univ. _____

Post-graduate Degrees obtained: _____

Occupation: _____

Interests and Hobbies: _____

Personal Characteristics: Height _____ Weight _____
Eyes _____ Hair _____
Skin tone _____ Blood Type _____

PERSONAL & FAMILY HISTORY

Are your menstrual cycles regular: Yes _____ No _____

Interval between periods: _____ days

Duration of bleeding: _____

Last menstrual period start date: _____

Have you ever been pregnant: Yes _____ No _____ How many times: _____

Do you have any living children: Yes _____ No _____ How many: _____

Any birth defects or problems: _____

Do you have twins or triplets: Yes _____ Explain: _____

Have you had miscarriages: Yes _____ No _____ How many: _____

Do you have or were you ever treated for endometriosis: Yes _____ No _____

Allergies: _____

Do you take any medications: _____

Contraceptive Practices

	Yes	No	Dates
Intrauterine device (IUD)	_____	_____	_____
Oral contraceptives	_____	_____	_____
Other _____	_____	_____	_____

When was your last pap smear: _____ When was your last mammogram: _____

Any abnormal Pap smears: _____ Any procedures on your cervix: _____

Toxicant Exposure:

	Yes	No	Dates
Alcohol	_____	_____	_____
None	_____	_____	_____
Weekend	_____	_____	_____
Daily	_____	_____	_____
Smoking	_____	_____	_____
Pesticides	_____	_____	_____
Radiation	_____	_____	_____
Coffee/caffeine	_____	_____	_____ (amount)
Other chemicals	_____	_____	_____
Drugs	_____	_____	_____

PERSONAL & FAMILY HISTORY

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Interval between periods: _____ days

Duration of bleeding: _____

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Have you ever been pregnant: Yes _____ No _____ How many times: _____

Do you have any living children: Yes _____ No _____ How many: _____

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Do you take any medications: _____

Contraceptive Practices

	Yes	No	Dates
Intrauterine device (IUD)	_____	_____	_____
Oral contraceptives	_____	_____	_____
Other _____	_____	_____	_____

When was your last pap smear: _____ When was your last mammogram: _____

Any abnormal Pap smears: _____ Any procedures on your cervix: _____

Toxicant Exposure:

	Yes	No	Dates
Alcohol	_____	_____	_____
None	_____	_____	_____
Weekend	_____	_____	_____
Daily	_____	_____	_____
Smoking	_____	_____	_____
Pesticides	_____	_____	_____
Radiation	_____	_____	_____
Coffee/caffeine	_____	_____	_____ (amount)
Other chemicals	_____	_____	_____
Drugs	_____	_____	_____

Do you have or have you ever had (check ALL that apply):

Infectious Diseases:	Gynecologic Problems:	Medical Problems:
Chicken pox (varicella)	Abnormal mammogram	Bleeding disorders
Hepatitis A, B, or C	Abnormal pap smear	Blood clots
German Measles-Rubella	Blocked fallopian tubes	Blood transfusion
Rheumatic fever	Pelvic Adhesions	Appendicitis
Chronic bronchitis	Endometriosis	Mitral valve prolapse
Chlamydia	Cervical stenosis	Uterine anomalies
Gonorrhea	DES exposure	Kidney disease
Syphilis	Breast discharge	Kidney infection
Pelvic infection (PID)	Hot flashes or night sweats	Liver problems
Mycoplasma/Ureaplasma		Kidney disease
Chlamydia	Immunizations:	Recurrent urinary infections
Condyloma-Venereal warts	Chicken pox vaccine	Rh sensitized
Herpes: Genital	German Measles-Rubella	Lost >15 lbs last year
Other (explain):	Rubella	Gained >15 lbs last year

Comments _____

List all surgeries you have had (including cervix, uterus, ovarian cysts, tubes, endometriosis, appendix, etc):

(Type of surgery) (Date)

List all other serious illnesses for which you have been under the care of a physician:

(Illness) (Date)

Special dietary habits _____

How much do you exercise? _____

Number of Siblings
 Number of Aunts
 Number of Uncles
 Number of Maternal Cousins
 Number of Paternal Cousins

Male _____ Female _____
 Paternal _____ Maternal _____
 Paternal _____ Maternal _____
 Male _____ Female _____
 Male _____ Female _____

Medical Problems	You	Moth	Fath	Siblings		Grandparents				Aunt		Uncle		M-Cousins		P-Cousins		No Or	
				F	M	MGM	MGF	PGM	PGF	Mat	Pat	Mat	Pat	F	M	F	M		
1. Heart																			
A. Heart disease/defect																			
1. from birth																			
2. other																			
B. Heart attack																			
C. Hardening of arteries																			
D. High blood pressure																			
2. Blood																			
A. Anemia																			
B. Sickle cell anemia																			
C. Hemophilia																			
D. Leukemia																			
E. Immune deficiency																			
F. Clotting disorders																			
3. Respiratory																			
A. Hay fever																			
B. Asthma																			
C. Emphysema																			
D. Tuberculosis																			
E. Lung cancer																			
F. Pneumonia																			
G. Other lung diseases																			
4. Skin																			
A. Severe acne																			
B. Eczema																			
C. Skin cancer																			
D. Pigmentation																			
E. Melanoma																			
F. Other																			

COMMENTS _____

Medical Problems	You	Moth	Fath	Siblings		Grandparents				Aunt		Uncle		M-Cousins		P-Cousins		No One	
				F	M	MGM	MGF	PGM	PGF	Mat	Pat	Mat	Pat	F	M	F	M		
5. Gastrointestinal																			
A. Ulcer of stomach																			
B. Gallstones																			
C. Hepatitis A																			
D. Hepatitis B																			
E. Other liver diseases																			
F. Colon cancer																			
G. Ulcerative colitis																			
H. Crohn's disease																			
I. Cystic fibrosis																			
J. Intestinal cancer																			
K. Other diseases																			
6. Reproductive																			
A. Testicular disease																			
B. Hypospadias																			
C. Uterine fibroids																			
D. Ovarian cysts																			
E. Ovarian cancer																			
F. Uterine cancer																			
G. Cervical cancer																			
7. Musculoskeletal																			
A. Muscular dystrophy																			
B. Lupus																			
C. Osteoporosis																			
D. Gout																			
E. Arthritis																			
F. Dwarfism																			
G. Club feet																			
H. Congenital hip disease																			

COMMENTS _____

Medical Problems	You	Moth	Fath	Siblings		Grandparents				Aunt		Uncle		M-Cousins		P-Cousins		No One	
				F	M	MGM	MGF	PGM	PGF	Mat	Pat	Mat	Pat	F	M	F	M		
8. Metabolic																			
A. Diabetes mellitus																			
B. Hypoglycemia																			
C. Thyroid disease																			
D. Goiter																			
E. Thyroid cancer																			
F. Adrenal disease																			
G. Tay-Sachs disease																			
H. Other																			
9. Neurologic																			
A. Migraines																			
B. Mental retardation																			
C. Senility before 50																			
D. Alzheimer's disease																			
E. Multiple sclerosis																			
F. Cerebral palsy																			
G. Epilepsy or seizures																			
H. Hydrocephalus																			
I. Spinal cord disease																			
J. Spina bifida																			
K. Huntington's dis.																			
L. Gaucher's disease																			
M. Wilson's disease																			
N. other																			
10. Urinary																			
A. Kidney disease																			
B. Bladder cancer																			
C. Prostate cancer																			

COMMENTS _____

Medical Problems	You	Moth	Fath	Siblings		Grandparents				Aunt		Uncle		M-Cousins		P-Cousins		No On	
				F	M	MGM	MGF	PGM	PGF	Mat	Pat	Mat	Pat	F	M	F	M		
11. Ear, Eye, Face																			
A. Deafness before 60																			
B. Ear deformity																			
C. Cataracts before 50																			
D. Blindness																			
E. Color Blindness																			
F. Glaucoma																			
G. Cleft lip or palate																			
12. Mental Health																			
A. Schizophrenia																			
B. Manic/Depression																			
C. Severe depression																			
D. Other disorders																			
13. Other Disease																			
A. Alcoholism																			
B. Drug abuse																			
C. Breast cancer																			
D. Other cancers not mentioned above																			
E. Any other condition not mentioned above																			
F. Down's syndrome																			
G. Other birth defects																			
H. Two or more miscarriages																			
I. Other																			

COMMENTS _____