

# Fertility & Surgical Associates of California

Thank you for your interest in donating your residual cryopreserved embryos to another couple or individual at Fertility & Surgical Associates of California. Many infertile couples/individuals can now become parents because of your compassion and generosity.

Please take a few minutes to fill out the enclosed questionnaire. Please be sure to attach 2-3 recent photos (front and full body shot) to the front of the form. If available, please also include a picture of your child(ren). Return your completed forms to us as soon as possible. You will be contacted when a couple/individual has chosen your embryos. The couple/individual will pay for a legal contract. You may have to have extra lab testing performed which will be paid for by the couple/individual adopting the embryos.

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

Thank you,

Sincerely,



Arlene Rees, RN.  
Third party Coordinator

325 Rolling Oaks Drive, Suite 110  
Thousand Oaks, California 91361  
Tel (805) 778-1122 • (818) 361-1833  
(800) 961-1801 • Fax (805) 778-1199

**COUPLE DONATING EMBRYOS:**

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

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 \_\_\_\_\_

## 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	_____	_____	_____



Number of Siblings

Number of Aunts

Number of Uncles

Number of Maternal Cousins

Number of Paternal Cousins

Male \_\_\_\_\_

Paternal \_\_\_\_\_

Paternal \_\_\_\_\_

Male \_\_\_\_\_

Male \_\_\_\_\_

Female \_\_\_\_\_

Maternal \_\_\_\_\_

Maternal \_\_\_\_\_

Female \_\_\_\_\_

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		
<b>1. Heart</b>																			
A. Heart disease/defect																			
1. from birth																			
2. other																			
B. Heart attack																			
C. Hardening of arteries																			
D. High blood pressure																			
<b>2. Blood</b>																			
A. Anemia																			
B. Sickle cell anemia																			
C. Hemophilia																			
D. Leukemia																			
E. Immune deficiency																			
F. Clotting disorders																			
<b>3. Respiratory</b>																			
A. Hay fever																			
B. Asthma																			
C. Emphysema																			
D. Tuberculosis																			
E. Lung cancer																			
F. Pneumonia																			
G. Other lung diseases																			
<b>4. Skin</b>																			
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 Order	
				F	M	MGM	MGF	PGM	PGF	Mat	Pat	Mat	Pat	F	M	F	M		
<b>8. Metabolic</b>																			
A. Diabetes mellitus																			
B. Hypoglycemia																			
C. Thyroid disease																			
D. Goiter																			
E. Thyroid cancer																			
F. Adrenal disease																			
G. Tay-Sachs disease																			
H. Other																			
<b>9. Neurologic</b>																			
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																			
<b>10. Urinary</b>																			
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		
<b>11. Ear, Eye, Face</b>																			
A. Deafness before 60																			
B. Ear deformity																			
C. Cataracts before 50																			
D. Blindness																			
E. Color Blindness																			
F. Glaucoma																			
G. Cleft lip or palate																			
<b>12. Mental Health</b>																			
A. Schizophrenia																			
B. Manic/Depression																			
C. Severe depression																			
D. Other disorders																			
<b>13. Other Disease</b>																			
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 \_\_\_\_\_