



## 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  
MALE**

**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**

Allergies: \_\_\_\_\_

Do you take any medications: \_\_\_\_\_

<b>Toxicant Exposure:</b>	<b>Yes</b>	<b>No</b>	<b>Dates</b>
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):**

<b>Infectious Diseases:</b>	<b>Immunizations:</b>	<b>Medical Problems:</b>
Chicken pox (varicella)	Chicken pox vaccine	Bleeding disorders
Hepatitis A, B, or C	German Measles-Rubella	Blood clots
German Measles-Rubella	Rubella	Blood transfusion
Rheumatic fever		Appendicitis
Chronic bronchitis		Mitral valve prolapse
Chlamydia		Uterine anomalies
Gonorrhea		Kidney disease
Syphilis		Kidney infection
Pelvic infection (PID)		Liver problems
Mycoplasma/Ureaplasma		Kidney disease
Chlamydia		Recurrent urinary infections
Condyloma-Venereal warts		Rh sensitized
Herpes: Genital		Lost >15 lbs last year
Other (explain):		Gained >15 lbs last year

Comments \_\_\_\_\_  
 \_\_\_\_\_

**List all surgeries you have had:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 (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 \_\_\_\_\_

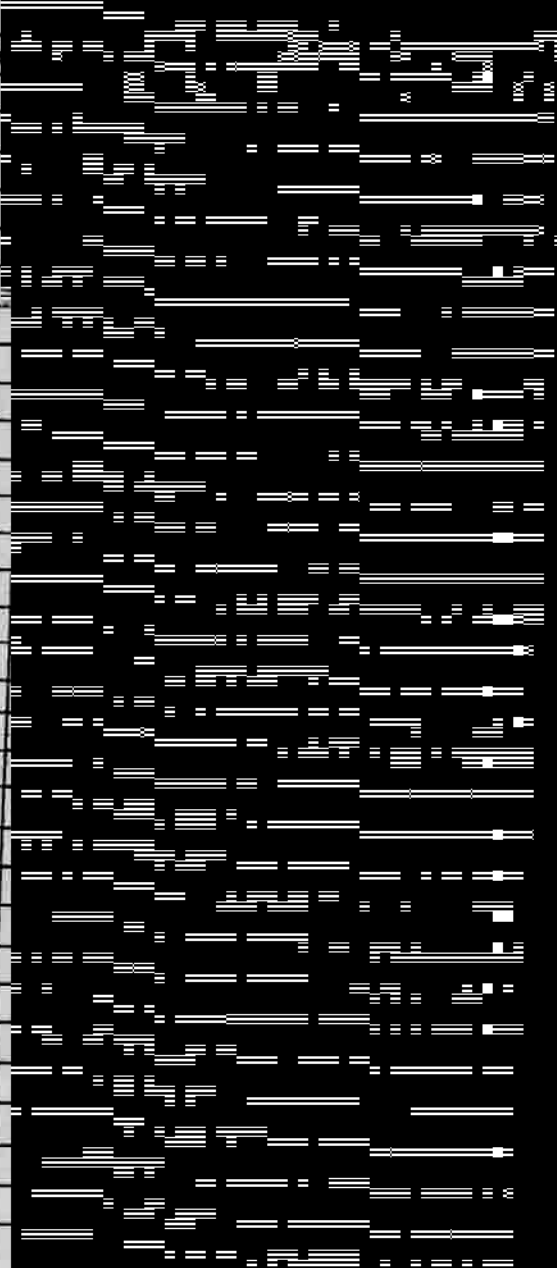
How much do you exercise? \_\_\_\_\_





Medical Problems	You	Moth	Fath	Siblings		Grandparents				Mat	
				F	M	MGM	MGF	PGM	PGF		
<b>B. 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>B. 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>1. 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 \_\_\_\_\_