

North Carolina Center for Reproductive Medicine Egg Recipient Application

Please print and fill out. Return to NCCRM 400 Ashville Ave #200 Cary NC 27518 Phone (919) 233-1680 Fax (919)233-1685

Step 1: Confidential Medical History / Egg Recipient Form

How did you learn about our egg donor program?	
Were you referred by anyone?	
Female Partner Information	
Name:	
Date of Birth:	
Home Street Address:	
City:State:	Zip code
Home Phone:()	
Work Phone: ()	
Cell Phone: ()	
Email Address:	
What is your preferred method of contact:	
Social Security #:	
Employer or school:	
Occupation or Majors/Minors:	
Years of Education/Degrees:	

List the country, state and county of origin of most of your ancestors and yourself:
Country:
State:
County:
Male Partner Information
Name:
Date of Birth:
Home Street Address:
City State: Zip code:
Home Phone: ()
Work Phone: ()
Cell Phone: ()
Email Address:
What is your preferred method of contact:
Social Security#:
Employer or school:
Occupation or Majors/Minors:
Years of Education/Degrees:
List the country, state and county of origin of most of your ancestors and yourself:
Country:
State:

County:
Are there any known genetic or birth defects in your family?YesNo
If yes, please explain:
Have you ever been tested as a carrier of:
Tay Sach's disease: Carrier Not Carrier Don't Know
Sickle Cell disease: Carrier Not Carrier Don't Know
Do you have any Jewish relatives?
Do you have any black relatives?
Do you have any health problems? Yes No
If yes, please explain and give age of diagnosis:
Were you born you born with any birth defects? (heart defect, cleft lip or palate, club feet) Yes No
If yes, please explain and give age of diagnosis:
How much alcohol do you consumer a week?
Have you shared needles or used intravenous (street) drugs? Yes No
Have you ever had a blood transfusion? Yes No
Have you ever had a sexually transmitted disease (STD)? Yes No
If yes, what and when?

Hospitalization?	Yes No	
If yes please give da	tes and for what reason(s):	
ii yes, pieuse give uu	tes and for what reason(s).	
Male Partner's Fath	ner's Family	
Race and Ancestry:		
Did your father have	dimples?	
Did your father have	a cleft lip?	
Skin Tone:	Freckles:	
	Hair Type:	
	Eye Color:	
Father's Year of Birtl	h (if living)	
His health status:		
If deceased, his age a	t death:	
Cause of death?		
Father's FATHER's	Year of Birth:	
His health status?	1 10	
	t death?	
	ear of birth:	
	at dooth?	
	at death?	
Cause of death!		
Aunts and Uncles (Y	Your father's brothers and sisters)	
		TT 141. C4 - 4
Gender Age	If deceased, age and cause of death	Health Status

Male Partner's Mother's Family

Race and Ancestry:
Did your mother have dimples?
Did your mother have a cleft lip?
Skin Tone: Freckles:
Natural Hair Color: Hair Type:
Hair Texture: Eye Color:
Did Your Mother take DES when she was pregnant with you?
Mother's Year of Birth (if living)
Her health status:
If deceased, her age at death:
Cause of death?
Mother's FATHER's Year of Birth:
His health status?
If deceased, his age at death?
Cause of death?
Mother's MOTHER year of birth:
Her health status:
If deceased, her age at death?
Cause of death?
Male Partner's Aunts and Uncles (Mother's Side)
Gender Age If deceased, age and cause of death Health Status
Male Partner's Brothers and Sisters
Gender, year of birth, if deceased, cause of death, health status, eye color, hair type and
natural hair color

Male Partner's Children (If any)

Gender, year of birth, if deceased, cause of death, health status, eye color, hair type and natural hair color	

Medical History of Male Partner and His Family:

Please fill out the following charts to the best of your knowledge. Your effort to be as forthcoming as possible is to your benefit.

The following medical conditions apply to you and your BLOOD RELATIVES ONLY (grandparents, parents, aunts, uncles, cousins, brothers, sisters, yourself and any of your own children). Do not guess at any answer.

Please use an X mark to indicate which medical conditions you or one of your family members has/had. If none, please choose "No One."

	f	Mother	Father	Brothers	Sisters	Daughters	SL	Maternal Aunts	Maternal Uncles	ernal nts	ernal cles	ternal andma	Maternal Grandpa	Paternal Grandma	Paternal Grandpa	No One
Conditions	Self	Мо	Fat	Brc	Sis	Dai	Sons	Ma Aui	Ma Un	Pat Auı	Pai Un	Ma Gra	Ma Gra	Pat Gra	Pat Gra	No
Blood Issues																
Anemia																
Sickle-cell																
Anemia																
Hemophilia																
HIV																
Thalassemia																
Other																
Congenital																
Anomalies																
Cleft lip/palate																
Hip problems																
Club feet																
Cri du chat																
Trisomy 18																
Trisomy 13																
Fragile x																
Gastro-Intestinal																
Ulcers of stomach																
Gall stones																
Hepatitis A (infectious)																
Hepatitis B																
(serum)																
Development disorders																
of stomach and																
intestine																
Pyloric Stenosis																
Rectal disorder																
Any other cancer or																
problem																
Genital																
Reproductive																

	H.	Mother	Father	Brothers	Sisters	Daughters	ns	Maternal Aunts	ternal cles	ternal nts	ternal cles	ternal andma	ternal andpa	Paternal Grandma	Paternal Grandpa	No One
Conditions	Self	Mc	Fа	Brc	Sis	Da	So	Ma Au	Ma Un	Pa Au	Pa Un	Ma Gr	Ma Gr	Pa Gr	Pa Gr	N N
Undescended testicle																
Hermaphrodi- tism/Ambiguous																
genitals																
Hypospadias																
Lumps or cysts in breasts																
Breast surgery																
Two or more																
miscarriages																
Stillborn																
Death of newborn infant																
Neonatal jaundice																
HEART																
Stroke																
Heart attack																
Heart disease																
Hardening of arteries																
High blood pressure																
High cholesterol																
Other																
Mental Health																
Schizophrenia																
Manic depression or																
bipolar disorder																
Anxiety or panic																
attacks																
Mild depression																
Metabolic/																
Endocrine																
Diabetes – Type 1 or 2																
Hypoglycemia																
Thyroid cancer																
Thyroid disease																
Goiter																
Adrenal dysfunction																
Hyperactivity																
Other																
Muscle/ Bone/																
Joints																
Muscular dystrophy																
Loss of muscle																
disease																

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		her	er	ner	SIC	ghte	(0	erna	es	rna	rna es	erna ndrr	erne Idp	rna ndr	rna Idp	Jne
Conditions	Self	Mother	Father	Brothers	Sisters	Daughters	sons	Maternal Aunts	Nate Incl	ate	ate Incl	nate Arar	Maternal Grandpa	Paternal Grandma	Paternal Grandpa	No One
Loss of muscle	(7)	2		ш	(J)		()	2 4	2 _	ΠA		20	20	П О	ΕО	
coordination																
Lupus																
Osteoporosis																
Dwarfism																
Arthritis																
Gout																
Myasthenia gravis																
Other																
Neurological																
Migraines																
Mental retardation																
Downs syndrome																
Alzheimer's syndrome																
Senility before age 50																
Multiple sclerosis																
Cerebral palsy																
Epilepsy/																
Seizures																
Hydrocephalus																
Spina bifida/																
Neural tubal defect																
Huntington's disease																
Gauchers disease																
Wilson's disease																
Parkinson's disease																
Paraplegia																
Tourettes syndrome																
Scoliosis																
Tay-Sachs disease																
Other																
Respiratory																
Allergies																
Asthma																
Emphysema																
Tuberculosis																
Pneumonia																
Cystic fibrosis																
Other lung disease																
Sight, smell, sound																
Deafness before age																
60																
Ear deformity																
Cataracts before age																
50																

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		er	je.	Brothers	rs	Daughters		rnal	Maternal Uncles	ınal	mal es	Maternal Grandma	rnal dpa	Paternal Grandma	Paternal Grandpa	ne
Conditions	Self	Mother	Father	roth	Sisters	aug	suo	late unts	late Incle	ater	ater Incle	late iran	late iran	ater	ater iran	No One
Blindness	S	2	ш	В	S		S	≥∢	≥⊃	ВΑ		≥ ∪	≥ 0	В Θ	д Θ	Z
Color blindness																
Glaucoma																
Deviated septum																
Other																
Skin																
Acne																
Eczema																
Pigmentation disorders																
Neurofibro-matosis																
Other																
Chromosomal																
Abnormalities																
Turner syndrome																
Kleinfelter syndrome																
Other																
Urinary																
Kidney disease																
Other																
Other Issues																
Alcoholism																
Drug abuse, misuse or addiction																
Cancers																
Breast																
Leukemia																
Lymphoma																
Myeloma																
Lung																
Stomach																
Colon																
Pancreas																
Liver																
Skin																
Prostate																
Brain																
Testicular																
Ovarian																
Cervical																
Uterine Other Concern																\vdash
Other Cancers											<u> </u>	<u> </u>				

Recipient Couple's Physical Characteristics:

Male Partner	Female Partner
Height	Height
Weight	Weight
Eye Color	Eye Color
Hair Color & Texture	Hair Color & Texture
Race	Race
Blood Type (A,B,O)	Blood Type (A,B,O)
RH (+,-)	RH (+, -)

Please attach a picture of both of you (recipient couple):

Characteristics Recipients Desire of Their Donor:

In order to facilitate matching your egg donor, please indicate the importance of the characteristics below on a scale of 1-5, with 1 being the least important and 5 being the most important.

(Least	impor	tant)		Most i	mportant)	
Eye Color	1	2	3	4	5	
Hair Color	1	2	3	4	5	
Height	1	2	3	4	5	
Weight (<)	1	2	3	4	5	
Education	1	2	3	4	5	
Blood Type	1	2	3	4	5	
Please add comments	on any	of the abov	e or add 1	to your spe	ecifications	S:
Preferences for Donor	's Ance	estry:				
Chinese _		Japane	se	Kore	an	Other
Pacific I	slands .		Native	Americar	ı	_ Alaskan
Middle	Eastern	1	Black		Hispa	anic
Caucasi	an					
Skin Tone:	Fair	·	Mediu	m	Olive	Dark
Preferences for Donor	's Inter	ests:				
Sports		Music		_Science		_Volunteer Work

Signature of Female Partner	Date
r hereby give permission to recently to disclose pertinent info	ormation.
knowledge or the knowledge of my parents, grandparents, etc information. I have had an opportunity to have my questions I hereby give permission to NCCRM to disclose pertinent info	answered to my satisfaction.
The above information concerning my blood relatives and me	•
Sign and Date Form:	
<i></i>	
If yes, please list dates:	