Please complete this form and return it to us by mail together with one passport size photograph. All information provided will be treated as strictly confidential.
Please circle the correct answer. (Example: Are your periods painful? Yes/ (No))

Family Name: _____ First Name: _____

Date of birth: _____ Age: _____
(dd/mm/yyyy)

Place of Birth: _____ Province/Country:_____

Marital status: Single and dating / Single with one partner / Living together / Married / Divorced

Address:

Street: _____ City: _____

Province: _____ Country: _____

Postal Code: _____ E-mail: _____

Tel.(home) _____ Tel.(cellular) _____

Tel.(work) _____ Can we call you at work: Yes / No

Height: _____ Weight: _____

Build: X-Small / Small / Medium / Large / X-Large

Eye Colour: Blue / Black / Brown / Green / Hazel / Other:_____

Natural Hair colour:

Auburn / Ashe Blonde / Strawberry Blonde / Blonde / Light Brown / Dark Brown / Black /Red

Type of Hair : Straight / Wavy / Thick / Fine / Curly / Coarse / Frizzy / Kinky

Do you wear corrective lenses: Yes /No

Are you predominantly: Right Handed / Left Handed

Skin Tone: Fair / Medium / Olive / Dark

Freckles: None / Few / Numerous

Additional Characteristics (check all that apply):

Cleft Chin / Big Eyes / High Cheek Bones / Dimples / Full Lips Other:_____

Race:
Yours: _____ Your Father's: _____

Your Mother's: _____

Ethnicity (check all that apply):

Aborigine / African / Asian / South Asian / Caucasian / Hispanic / Indonesian / Mediterranean / Native American / West Indian Other:_____

Religion:
Yours: _____ Your Father's: _____

Your Mother's: _____

Personal Medical History

Menstrual History:
When did your last menstrual period start? _____

How many days are there usually between the start of 1 cycle and the start of your next? _____

Are your cycles ever irregular? (If yes please explain) Yes/No

How many days of bleeding do you usually have? _____

Are you currently taking the birth control pill: Yes / No

Have you had a Pap Smear within the past 12 months? Yes / No
Was result of your Pap Smear within normal limits? Yes / No

Obstetrical history:

How many times in your life have you been pregnant? _____
If you have children, how many do you have and what was their year of birth?
_____
How many miscarriages have you had? _____
How many abortions have you had? _____

Have you had any pregnancy related complications? (If yes, please describe below) Yes / No

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Have you ever been told in the past, that you have had any of the following? (check all that apply):
Sexually Transmitted Disease
Gonorrhea or Chlamydia
HIV / AIDS
Condyloma (Human Papaloma Virus)
Ureaplasma/Mycoplasma
Auto-immune Disorders
Hypertension
Multiple Sclerosis
Tuberculosis
Herpes Simplex Virus I or II
Hepatitis B / C or Syphillis
Bleeding disorders
Endometriosis
Fibroids
Pelvic Inflammatory Disease
Diabetes
Alzheimer's Disease
Abnormal Pap Smear
Endocrine disorder (like Thyroid)
If yes, please give more details:

Have you ever had any other serious illness? If yes, please list:

_____

_____

Do you take any prescription or over the counter medications on a regular or continual basis? Yes / No
If yes, please list what medication you are currently taking:

_____

_____

Have you had any surgeries in the past? Yes/ No
If yes, please indicate what surgeries you have had:

_____

_____

Have you ever been hospitalized for anything other than the above listed surgeries? Yes / No
If yes, please tell us why you were hospitalized:

_____

_____

Do you have any allergies that you are aware of? Yes / No
If yes, please list your allergies:

_____

_____

Do you have an occupation with risk of exposure to radiation or other chemicals
that could be harmful to your health? Yes / No
If yes, please explain what chemicals you are or have been exposed to:

_____

_____

Have you received a blood transfusion within the past six months? Yes / No

Have you acquired a tattoo within the last year? Yes / No

Have you ever been excluded from blood donation? Yes / No
If yes, please explain when and why:

_____

_____

Do you have any dietary restrictions? Yes / No
If yes, what are your dietary restrictions, and for what reason?

_____

_____

Do you exercise regularly? Yes / No

Psychological History:

Have you ever sought counselling for depression or emotional problems? Yes / No

Have you ever taken antidepressants for more than three months at a time? Yes / No

Have you ever been diagnosed as having any of the following (please check all that apply)
Depression
Schizophrenia
Manic Depression
Obsessive-Compulsive Disorder
Mania
Anorexia or Bulimia
Self Mutilation

Family Medical History

	Mother	Father	Own Child	Own Child
Alive	Yes / No	Yes / No	Yes / No	Yes / No
Age				
Country of Birth				
Does he/she have any medical problems (please give details below)	Yes / No	Yes / No	Yes / No	Yes / No

	Brother/Sister	Brother/Sister	Brother/Sister	Brother/Sister
Alive	Yes / No	Yes / No	Yes / No	Yes / No
Age				
Country of Birth				
Does he/she have any medical problems (please give details below)	Yes / No	Yes / No	Yes / No	Yes / No

	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Alive	Yes / No	Yes / No	Yes / No	Yes / No
Age				
Country of Birth				
Does he/she have any medical problems (please give details below)	Yes / No	Yes / No	Yes / No	Yes / No

If there is any medical problem in the family, please give more details:
_____
_____
_____
_____

Please tell us if you or any member of your family has any of the conditions listed below. Check all that apply and indicate who in your family has the condition.

Condition	Self	Family	Who in the Family?
Cleft Palate	Yes / No	Yes / No	_____
Spina Bifida	Yes / No	Yes / No	_____
Thyroid Disease	Yes / No	Yes / No	_____
Clubfoot	Yes / No	Yes / No	_____
Mental Retardation	Yes / No	Yes / No	_____
Down's Syndrome	Yes / No	Yes / No	_____
Cystic Fibrosis	Yes / No	Yes / No	_____
Marfan Syndrome	Yes / No	Yes / No	_____
Albinism	Yes / No	Yes / No	_____
Muscular Dystrophy	Yes / No	Yes / No	_____
Cancer (indicate type)	Yes / No	Yes / No	_____
Schizophrenia	Yes / No	Yes / No	_____
Clinical Depression	Yes / No	Yes / No	_____
Obsessive-Compulsive Disorder	Yes / No	Yes / No	_____
Mania	Yes / No	Yes / No	_____
Tay Sachs Disease	Yes / No	Yes / No	_____
Canavan's Disease	Yes / No	Yes / No	_____
Hemolytic Anemia	Yes / No	Yes / No	_____
Blindness	Yes / No	Yes / No	_____
Hearing Impairment	Yes / No	Yes / No	_____
Color Blindness	Yes / No	Yes / No	_____
Heart Disease	Yes / No	Yes / No	_____
Parkison's Disease	Yes / No	Yes / No	_____
Hemochromotosis	Yes / No	Yes / No	_____
High Cholesterol	Yes / No	Yes / No	_____
Sickle Cell Anemia	Yes / No	Yes / No	_____
Hemophilia	Yes / No	Yes / No	_____
Huntington's Disease	Yes / No	Yes / No	_____
Diabetes	Yes / No	Yes / No	_____
Multiple Sclerosis	Yes / No	Yes / No	_____
Alzheimer's Disease	Yes / No	Yes / No	_____
Infertility	Yes / No	Yes / No	_____
Recurrent Miscarriage	Yes / No	Yes / No	_____
Liver Disease	Yes / No	Yes / No	_____
High Blood Pressure	Yes / No	Yes / No	_____
Asthma	Yes / No	Yes / No	_____
Epilepsy	Yes / No	Yes / No	_____
Tourette's Syndrome	Yes / No	Yes / No	_____
Attention Deficit Syndrome	Yes / No	Yes / No	_____
Still Born Babies	Yes / No	Yes / No	_____
Sudden Infant Death	Yes / No	Yes / No	_____
Hermaphrodism	Yes / No	Yes / No	_____
Death before age 40	Yes / No	Yes / No	_____
Addiction (indicate type)	Yes / No	Yes / No	_____
Clinical Osteoporosis	Yes / No	Yes / No	_____

Social behaviour:

How many cigarettes are you smoking per day (enter 0 if non-smoker) ? : ____

If you are ex-smoker, when did you stop ? ____

How many glasses of alcohol do you drink per week ? ____

Drug usage:
I have never used illegal drugs / I have tried illegal drugs at least once in the past
I used to do drugs regularly but don't anymore / I am currently using one or more of the following:
_____

Have you ever used injectable drugs? Yes / No

Sexual Activity/History:
(please answer the following questions about your sexual history)

How many sexual partners have you had intercourse with in the past year? ____

Have you been with a sexual partner that is a known user of drugs? Yes / No

Have you had intercourse with a bisexual or homosexual partner? Yes / No

Have any of your past or present sexual partners shown evidence of having HIV infection? Yes / No

Have you ever been with a sexual partner who tested positive for a sexually transmitted disease? Yes / No

Sexual Behaviour (check all that apply):

I have worked as a prostitute in the past
I have engaged in homosexual activities
I have engaged in heterosexual activity with a prostitute within the previous six months
I engage in sexual activities with more than one partner on regular basis
I consider myself to be bisexual
I consider myself to be homosexual
I consider myself to be heterosexual

The Law (check all that apply):

I have never had any legal trouble
I have had legal trouble in the past

If yes, explain the type of legal trouble you have had:
_____
_____

Crimes:
I have never been convicted of a crime
I have been convicted of a crime
I have spent time in prison

What was the crime you were convicted of perpetrating?
_____
_____

Educational Background (check all that apply):

Some High School / High School Graduate / CEGEP / Trade School / Some University / University graduate

Bachelor's Degree:
Degree Achieved (year): _____ Major Area of Study: _____

Associate's Degree
Degree Achieved (year): _____ Major Area of Study: _____

Graduate Study:
Graduate Degree: Masters / MBA / Ph.D. / D.O. / M.D. / Law Other: _____
Degree Achieved (year): _____

Post Graduate Study: Major Area of Study: _____

Work/Interests

Work/Occupation History
Present occupation: _____

Work at home / A full-time student / Unemployed / Work part time / Work full-time

What kind of work have you done in the past? _____
_____
_____

What kind of work is most appealing to you? _____
_____
_____

(check at an appropriate place on the scale between 0 and 10):

	Poor Average Excellent
Athletic Abilities	0—--1—--2—--3—--4—--5—--6—--7—--8—--9----10
Musical Ability:	0—--1—--2—--3—--4—--5—--6—--7—--8—--9----10
Artistic Talents:	0—--1—--2—--3—--4—--5—--6—--7—--8—--9----10
Mechanical skills	0—--1—--2—--3—--4—--5—--6—--7—--8—--9----10
Abilities in Mathematics:	0—--1—--2—--3—--4—--5—--6—--7—--8—--9----10
Writing Skills:	0—--1—--2—--3—--4—--5—--6—--7—--8—--9----10
Research Ability:	0—--1—--2—--3—--4—--5—--6—--7—--8—--9----10

Describe your talents / hobbies/ interests:
_____
_____

Other than English, what languages do you speak? _____

How would you describe your personality?

_____
_____

What is your ultimate ambition in life?

_____
_____

I am interested in becoming an egg donor because:

_____
_____

Have you ever donated your eggs before? Yes / No
If yes, when did you donate?

_____
_____

How many eggs were retrieved? _____

I would like my oocyte recipient to know these things about my characteristics/personality and/or areas of talent:

_____
_____

Do you certify that your answers and explanations were voluntarily given? Yes / No

Do you certify that your answers which were voluntarily given,
are correct to the best of your knowledge? Yes / No

Are you aware of any other health problems in your self,
family or previous sexual partners that you have not already disclosed? Yes / No
If yes, please indicate those problems :

_____
_____

I hereby certify that my answers and explanations, which were voluntarily given in this questionnaire, are correct. I am not aware of any problems in myself, my family, or my current or previous sexual partners that were not answered in the above questions.

Name (block capitals): _____

Signature: _____ Date: _____
dd/mm/yyyy