

**Palm Beach Fertility Center**  
**Mark Denker, M.D.**  
[www.palmbeacfertility.com](http://www.palmbeacfertility.com)

**Egg Donor Profile Information Form**

Date:\_\_\_\_\_ Age:\_\_\_\_\_ Height:\_\_\_\_\_ Weight:\_\_\_\_\_ Year of Birth: 19\_\_

Do you smoke? Y N Do you know your Biological Parents' Medical History? Y N

Racial Group: \_\_\_Caucasian \_\_\_Black \_\_\_Asian \_\_\_Other\_\_\_\_\_

Ethnic Origin/Ancestry: Mother\_\_\_\_\_ Father\_\_\_\_\_

Religion Born Into: Donor\_\_\_\_\_ Mother\_\_\_\_\_ Father\_\_\_\_\_

If Jewish: \_\_\_Ashkenazi \_\_\_Sephardic \_\_\_Oriental

Eye Color:\_\_\_\_\_ Blood Type:\_\_\_\_\_

Hair Color:\_\_\_\_\_ Hair Type: (check one) Corrective Lenses:  
 \_\_\_Curly \_\_\_No  
 \_\_\_Wavy \_\_\_Yes  
 \_\_\_Straight

Bone Structure: \_\_\_Small \_\_\_Medium \_\_\_Large\_\_\_Very Large

Are you predominantly: \_\_\_Right-handed \_\_\_Left-handed \_\_\_Ambidextrous

Other distinguishing features (dimples, cleft chin, roman nose, etc):  
 \_\_\_\_\_

**Skin Characteristics:**

\_\_\_Freckles: \_\_\_None \_\_\_Few \_\_\_Numerous  
 \_\_\_Very fair (little to no ability to tan on sun exposure)  
 \_\_\_Fair (skin will tan lightly on sun exposure)  
 \_\_\_Medium (light color but will tan moderate to dark)  
 \_\_\_Olive (pigmentation of unexposed skin): \_\_\_Light \_\_\_Moderate \_\_\_Dark  
 \_\_\_Dark (pigmentation of unexposed skin): \_\_\_Light Tan \_\_\_Dark Tan \_\_\_Brown \_\_\_Black

**Educational Background**  
 (circle highest level attained)

High School	1	2	3	4		
College/University	1	2	3	4	B.A._____	B.S._____
Major Area of Study:	_____					
Post Graduate	1	2	3	4	5+	Major:_____
Degrees Attained:	M.A.	M.S.	Ph.D.	M.D.	J.D.	D.D.S. Other:_____

**Personal Characteristics**  
(Please describe in some detail)

Why do you want to be a donor? \_\_\_\_\_  
\_\_\_\_\_

What is your ultimate ambition or goal in life? \_\_\_\_\_  
\_\_\_\_\_

Math Skills \_\_\_\_\_

Mechanical Skills \_\_\_\_\_

Athletic Skills \_\_\_\_\_

Music Skills \_\_\_\_\_

Artistic Abilities \_\_\_\_\_

Favorite Sport \_\_\_\_\_

What languages do you speak? \_\_\_\_\_

Hobbies \_\_\_\_\_

Special Talents \_\_\_\_\_

Favorite Foods \_\_\_\_\_

Favorite Color \_\_\_\_\_

Describe your personality \_\_\_\_\_  
\_\_\_\_\_

Do you have any children?       Yes       No

If yes, please give their age and any health problems they might have:

Age	Health Problems
_____	_____
_____	_____
_____	_____

Have you ever been refused as a blood donor?       Yes       No

If yes, explain: \_\_\_\_\_

Has anyone in your family had difficulty achieving a pregnancy? \_\_\_\_\_

### Work / Occupational History

Please list all the jobs you have had in the past five years, starting with your present position. Include all exposures to drugs, chemicals and toxins.

Job / Duties (Do not name employer)	Start Date	End Date	Drugs, Chemicals and Toxins exposed to
1.			
2.			
3.			
4.			
5.			

### Personal Health History

Menstrual History:                      Regular Periods  Yes  No  
 Birth Control  Yes  No    What Brand \_\_\_\_\_

Allergies: Item	Reaction
1. _____	_____
2. _____	_____
3. _____	_____

Do you wear corrective lenses?     Yes             No

Vision uncorrected:    \_\_\_\_\_ / 20

Describe your diet: \_\_\_\_\_

Do you Exercise regularly?     Yes             No

Type of exercise: \_\_\_\_\_

List all Surgeries:

1. _____	Date: _____
2. _____	Date: _____
3. _____	Date: _____

Have you ever been hospitalized? \_\_\_\_\_

Have you had major x-ray or other radiation exposure? \_\_\_\_\_

Have you ever been treated for sexually transmitted disease?     \_\_\_ Yes     \_\_\_ No

If yes, please explain:     What type? \_\_\_\_\_

When? \_\_\_\_\_     Details: \_\_\_\_\_

When were you last treated? \_\_\_\_\_

Have you or your sexual partners ever had:

			Myself / Partner	When
Chlamydia	___ No	___ Yes	_____	_____
Venereal warts	___ No	___ Yes	_____	_____
Herpes	___ No	___ Yes	_____	_____
Other Sexually Transmitted Diseases	___ No	___ Yes	_____	_____
Type: _____				

Do you have any chronic medical problems or conditions?     If yes, please describe:

1. \_\_\_\_\_     Date: \_\_\_\_\_

2. \_\_\_\_\_     Date: \_\_\_\_\_

3. \_\_\_\_\_     Date: \_\_\_\_\_

Please list all prescription and non prescription drugs you have used or are currently using.

Name of Drug	Date started	Date ended	Frequency of use	How used?
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____

**Family History**  
Please fill in completely

Medical Problem	You	Mother	Father	Sib ling	Sib ling	Sib ling	Sib ling	MGM	MGF	PGM	PGF
Heart Disease											
Heart Attack											
High Blood Pressure											
Anemia											
Hemophilia											
Sickle Cell Disease											
Leukemia											
Immune Deficiency											
Asthma											
Lung Cancer											
Skin Cancer											
Stomach Ulcer											
Gallstones											
Hepatitis											
Ulcerative Colitis											
Chron's Disease											
Cystic Fibrosis											
Colon Cancer											
Kidney Disease											
Undescended Testicle											
Hypospadias											
Prostate Cancer											
Cancer of Ovary, Uterus, Cervix											
Diabetes											
Thyroid Cancer											
Mental Retardation											
Alzheimer's Disease											
Multiple Sclerosis											
Epilepsy or Seizures											
Disorders of Spinal Cord											
Huntington's Disease											
Gaucher's Disease											
Wilson's Disease											
Schizophrenia											
Other Psychiatric											
Muscular Dystrophy											
Lupus											
Arthritis											
Gout											
Deafness											
Blindness											
Cataracts before age 50											
Color Blindness											
Breast Cancer											
Other Cancer											
Any other condition											

Please explain any checkmarks in the family history form boxes:

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_
- 6. \_\_\_\_\_
- 7. \_\_\_\_\_
- 8. \_\_\_\_\_
- 9. \_\_\_\_\_
- 10. \_\_\_\_\_

PLEASE ENCLOSE A RECENT PICTURE OF YOURSELF. THIS WILL BE MAINTAINED FOR OUR PRIVATE OFFICE RECORDS FOR IDENTIFICATION PURPOSES ONLY AND WILL NOT BE AVAILABLE FOR VIEWING BY POTENTIAL EGG RECIPIENTS.

PLEASE ENCLOSE A PICTURE OF YOURSELF AS A CHILD IF AVAILABLE, OR IF YOU HAVE CHILDREN, YOU MAY ENCLOSE PICTURES OF THEM. THESE PICTURES WILL BE ATTACHED TO YOUR PROFILE FOR VIEWING BY PROSPECTIVE RECIPIENTS.

Please return this completed form to:

**Palm Beach Fertility Center  
9291 Glades Road Suite 202  
Boca Raton, FL 33434  
Fax: 561 477-7035**

**Once your application has been reviewed, we will contact you for an initial screening interview with our Nurse. After this interview, your profile will be placed in our donor book for selection by prospective recipients.**

Egg Donation Program\Donor\Donor Profile