



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? _____ Yes _____ No

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 dates and for what reason(s): _____

Male Partner's Father's Family

Race and Ancestry: _____

Did your father have dimples? _____

Did your father have a cleft lip? _____

Skin Tone: _____ Freckles: _____

Natural Hair Color: _____ Hair Type: _____

Hair Texture: _____ Eye Color: _____

Father's Year of Birth (if living) _____

His health status: _____

If deceased, his age at death: _____

Cause of death? _____

Father's FATHER's Year of Birth: _____

His health status? _____

If deceased, his age at death? _____

Cause of death? _____

Father's MOTHER year of birth: _____

Her health status: _____

If deceased, her age at death? _____

Cause of death? _____

Aunts and Uncles (Your father's brothers and sisters)

| 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

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 important) | | | Most important) | |
|-----------------|-------------------|---|---|-----------------|---|
| 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 above or add to your specifications:

Preferences for Donor's Ancestry:

_____ Chinese _____ Japanese _____ Korean _____ Other

_____ Pacific Islands _____ Native American _____ Alaskan

_____ Middle Eastern _____ Black _____ Hispanic

_____ Caucasian

Skin Tone: _____ Fair _____ Medium _____ Olive _____ Dark

Preferences for Donor's Interests:

_____ Sports _____ Music _____ Science _____ Volunteer Work

Are there any times that you would not be available for embryo transfer? _____

If yes, please list dates: _____

Sign and Date Form:

The above information concerning my blood relatives and me is all correct based on my knowledge or the knowledge of my parents, grandparents, etc. and includes all relevant information. I have had an opportunity to have my questions answered to my satisfaction. I hereby give permission to NCCRM to disclose pertinent information.

Signature of Female Partner

Date

Signature of Male Partner

Date