Egg Donor Screening Package
DONOR INTAKE FORM

Donor Identification

RAMQ
First Name
Last Name
Date of Birth (YYYY/MM/DD)
Hospital Card Number

1. Donor Intake Form

Donor Details

Surname: ____________________

Given name: ____________________

Date of birth (Y/M/D): ____________________

Occupation: ____________________

Relationship status:

☐ **Single**

☐ **Married/Common law**

☐ **Divorced**

Ethnic origin / background:

Mother ____________________

Father ____________________

Medical / Surgical History

Please check off the answer that applies to you. If you are unable to answer any of the questions, please leave them blank and you can discuss them with your physician.

History Of Illnesses			
Major illnesses	**Yes**	**No**	**Notes**
Asthma			
Pneumonia			
Heart problems			
High blood pressure			
Stroke			
Blood clots in lungs or legs			
Thyroid issues			
Diabetes			
Depression / anxiety			
Eating disorders			
Migraine headaches			
Cancer			
Anemia			
HIV/AIDS			

History Of Illnesses			
Major illnesses	**Yes**	**No**	**Notes**
Seizures/ epilepsy			
Hepatitis/jaundice/ liver disease			
Blood transfusions			
Bleeding disorders			
Psychiatric disorders			

Are you currently under a physician's care for any reason? ☐ Yes ☐ No

If yes, please explain:

____

____

____

____

Have you ever had any surgery? ☐ Yes ☐ No

If yes, please explain and provide dates:

____

____

____

____

Reproductive / Gynecological / Obstetrical History

Age of first menstrual period ___________

Date of most recent menstrual cycle (1st day) ____________

Are your periods regular? ☐ Yes ☐ No

Period frequency ____________ (e.g., 28-35 days)

Amount of flow:

- ☐ Light
- ☐ Mod
- ☐ Heavy

Do you have painful periods? ☐ Yes ☐ No

If yes, do you take medication for the pain? ☐ Yes ☐ No

If sexually active, are you using any methods of contraception? ☐ Yes ☐ No

Methods of contraception used:

- ☐ Birth control pills
- ☐ Condoms
- ☐ Diaphragm
- ☐ IUD
- ☐ Withdrawal
- ☐ None

Date of last Pap smear _______________ Result _____________

Have you ever had an abnormal pap smear? ☐ Yes ☐ No

History of sexually transmitted diseases		
	Yes	No
Chlamydia		
Gonorrhea		
Genital Herpes		
Syphilis		
HPV/genital warts		
Other STD		

If answered yes, please list dates, diagnosis and treatment:

____

____

____

____

Have you been pregnant before? ☐ Yes ☐ No

If yes:

Total number of pregnancies ___________

Number of living children ____________ Full term births _________

Premature ______ Miscarriages ______

Abortions / terminations _________

If you have children, please indicate if there were any medical problems with any of the children:

____

____

____

____

____

List any medications you are currently taking or have taken within the last 12 months:

____

____

____

____

____

Do you have any medication or food allergies? ☐ Yes ☐ No
If yes, please indicate the reactions if known:

Allergy	Type of Reaction

Have you ever donated eggs before? ☐ Yes ☐ No
If yes, please provide the past donation history and information:

____

____

____

____

____

Social History

Do you smoke? ☐ Yes ☐ No If yes, how many cigarettes per day: _______ per week: _______ How long have you been smoking: _______
If you are currently smoking, are you ready to quit? ☐ Yes ☐ No Please specify:
Have you ever used recreational drugs? ☐ Yes ☐ No If yes, please specify which drugs and how often:
Do you consume alcohol? ☐ Yes ☐ No If yes, how many drinks per day: _______ per week: _______
In the past year, have you had any unsterile body piercings? ☐ Yes ☐ No Please specify:
In the past year, have you received unsterile tattoo(s)? ☐ Yes ☐ No Please specify:
In the past year, have you received any blood products or transfusions? ☐ Yes ☐ No Please specify:
Have you recently travelled outside the country (internationally) in the past 3 months? ☐ Yes ☐ No Please specify:
Have you ever been evaluated, diagnosed or treated for the West Nile Virus? ☐ Yes ☐ No Please specify:

2. Genetic Screening

Please describe the following characteristics of your family members:

Genetic / Family History					
Relation	**Ethnic Origin**	**Age if living**	**Age at Death**	**Health**	**Cause of death**
Father				☐ Good ☐ Fair ☐ Poor	
Mother				☐ Good ☐ Fair ☐ Poor	
Paternal Grandmother				☐ Good ☐ Fair ☐ Poor	
Paternal Grandfather				☐ Good ☐ Fair ☐ Poor	
Maternal Grandmother				☐ Good ☐ Fair ☐ Poor	
Maternal Grandfather				☐ Good ☐ Fair ☐ Poor	

Has anyone in your family had any of the following conditions?
Please check (✓) the applicable boxes to the best of your knowledge:

	Personal	**Mother**	**Father**	**Grand-parents**
Downs Syndrome				
Intellectual disability				
Still births				
Serious birth defects				
Cystic Fibrosis				
Sudden death				
Cleft Lip and / or cleft palate				
Club feet				
Congenital Heart Defects (cardiac diseases)				
Congenital hip disease				
Hemophilia				
Anemia				
Spinal muscular atrophy				
Rheumatoid Arthritis				
Spina Bifida				
Any psychiatric illness				
Deafness				
Malignancy (cancer)				

Please check (✓) the applicable boxes that apply to your ethnic background:

Southeast Asian, Mediterranean, African descent:	**Personal**	**Mother**	**Father**	**Grand-parents**
Sickle cell				
Thalassemia				

Ashkenazi Jewish descent:	**Personal**	**Mother**	**Father**	**Grand-parents**
Tay-Sachs disease				
Canavan disease				
Familial dysautonomia				
Gaucher disease				
Niemann pick disease				
Fanconi anemia, type C				
Bloom syndrome				
Mucolipidiosis (Type IV)				
Glycogen storage disease, type 1a				
Familial hyperinsulinism				
Maple syrup urine disease, type 1b				
Dihydrolipoamide hydrogenase deficiency				
Usher syndrome				
Joubert syndrome				
Nemaline myopathy				
Walker-Warburg syndrome				

Saguenay-Lac Saint-Jean / Charlevoix region:	**Personal**	**Mother**	**Father**	**Grand-parents**
Tyrosinemia type I				
Congenital lactic acidosis Saguenay-Lac-Saint-Jean type				
Spastic ataxia, Charlevoix-Saguenay type				
Agenesis of the corpus callosum with peripheral neuropathy				

Bas-St-Laurent (Rimouski) and Gaspésie regions in Quebec, and adjoining New Brunswick territories:	**Personal**	**Mother**	**Father**	**Grand-parents**
Tay-Sachs disease				

Cree ancestry:	**Personal**	**Mother**	**Father**	**Grand-parents**
Cree encephalitis (Aicardi-Goutières syndrome				
Cree leukoencephalopathy				

Indigenous Manitoba populations:	**Personal**	**Mother**	**Father**	**Grand-parents**
Cerebro-oculo-facio-skeletal syndrome				

Newfoundland region:	**Personal**	**Mother**	**Father**	**Grand-parents**
Bardet-Biedl syndrome				
Neuronal ceroid lipofuscinosis				

DISCLAIMER BY DONOR

I hereby confirm and acknowledge that the above information is true and complete.

______________________	______________________	______________________	______________________
Patient Name (Print)	*Signature*	*Place (City)*	*Date (YYYY/MM/DD)*