Centre universitaire de santé McGill | McGill University Health Centre

Initial Screening Form

I am interested in being:

☐ Egg Donor

☐ Sperm Donor

☐ Surrogate

Identification

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

General information and Social History

1. Country of birth__________________
2. Are you adopted? ☐ Yes ☐ No ☐ Unsure
3. Do you have any allergies? If so, please indicate:

   ______________ ______________ ______________ ______________

4. Do you have a partner? ☐ Yes ☐ No

5. Are you currently under a physician's care for medical reasons other than routine checkups? ☐ Yes ☐ No
   If yes, please explain:

   ____

   ____

6. Do you take medication? ☐ Yes ☐ No

   If yes, list any medications you are currently taking or have taken within the last 12 months: ______________ _____________ _____________ _____________

7. Do you take any supplements or vitamins? ☐ Yes ☐ No

   If yes, list any supplements/vitamins you are currently taking or have taken within the last 12 months: ______________ _____________ _____________ _____________

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8. Have you ever had any surgery? ☐ Yes ☐ No
   If yes, indicate which ones and provide dates:

   ______________________________ date:______________

   ______________________________ date:______________

   ______________________________ date:______________

9. Do you smoke? ☐ Yes ☐ No

   If yes, how many cigarettes per day: _____ per week _____

10. Do you vape? ☐ Yes ☐ No

    If yes, how many times per day: _____ per week _____

11. Have you ever used recreational/ illicit drugs? ☐ Yes ☐ No If yes, please specify which drugs and how often:

    ____

    ____

    ____

    ____

    ____

    ____

12. Do you consume alcohol? ☐ Yes ☐ No

    If yes, how many drinks per day: _____ per week:_____

Please note that the following questions of this **Initial Screening Form** may be repeated in the **Pre-Donation Screening Form** necessary before the start of your treatment.

Medical History

	Do **you** have or have **you** been diagnosed with the following diseases/disorders? Please check (✓) the applicable boxes and add comments as needed.	**Yes**	**No**	**Comments**
13.	Alcoholism			
14.	Anemia			
15.	Anxiety			
16.	Asthma			
16.1	Autism /Autism spectrum disorder			
17.	Bipolar Disorder/ manic depressive disorder			
18.	Bleeding or clotting disorders			
19.	Blood clots in lungs or legs			
20.	Cancer			
21.	Depression			
22.	Diabetes			
23.	Illicit Drug abuse			
24.	Eating disorder (e.g. anorexia, bulimia)			
25.	Haemophilia A and B			
26.	Heart attack			
27.	Heart disease			
28.	Hernia			
29.	High blood pressure			
30.	Kidney disease			

		Yes	No	Comments
31.	Liver disease			
32.	Lung disease			
33.	Lupus			
34.	Migraines /headaches			
35.	Neurological disease/ seizures			
36.	Other psychiatric disorders (e.g. schizophrenia)			
37.	Stroke			
38.	Thyroid disease			
39.1	**For Egg donor and Surrogate:** Undiagnosed breast lump			
39.2	**For Sperm donor:** Undescended testicle (cryptorchidism) as a child			
40.	Other major systemic diseases (e.g. Crohn's disease, fibromyalgia, chronic fatigue syndrome…)			
41.	Other:			
42.	Other:			
43.	Other:			

Genetic Medical History

	Conditions Please check (✓) the applicable boxes that apply to you, your family and add comments at the end of this table when applicable. *If you, your children, parents, siblings and grand-parents are not affected, choose 'No one in my family'.	You	Your Children	Mother	Father	Siblings	Grand-Parents	*No one in my family
44.	22q11.2 deletion syndrome (DiGeorge Syndrome)							
44.1	Autism /Autism spectrum disorder							
45.	Bipolar Disorder/ manic depressive disorder							
46.	Bleeding / clotting disorder							
47.	Blindness / eye problems							
48.	Cancer							
49.	Cleft Lip / Palate							
50.	Club feet							
51.	Congenital cataracts							
52.	Congenital Heart Defects							
53.	Congenital hip disease							
54.	Cystic fibrosis							
55.	Deafness genetic							
56.	Depression							
57.	Diabetes							
58.	Downs syndrome							
59.	Dwarfism							
60.	Ehler's-Danlos Syndrome							

	Conditions	You	Children	Mother	Father	Siblings	Grand-Parents	*None in my family
61.	Fragile-X syndrome							
62.	Gilbert's syndrome							
63.	Haemophilia A or B							
64.	Heart disease							
65.	High blood pressure							
66.	Huntington's disease							
67.	Marfan's syndrome							
68.	Mental retardation/ intellectual disability							
69.	Muscular dystrophy (e.g. Duchenne/Becker Muscular dystrophy)							
70.	Neurofibromatosis							
71.	Neurological disease/ seizures							
72.	Polycystic kidney disease							
73.	Premature menopause							
74.	Psychiatric disorders (others) e.g. schizophrenia							
75.	Rheumatoid Arthritis							
76.	Serious birth defect							
77.	Sickle cell anemia							
78.	Spinal muscular atrophy							
79.	Still birth							
80.	Substance abuse							
81.	Sudden death	n/a						
82.	Other genetic disease :							

	Please check (✓) the applicable boxes that apply to your **ethnic background:**	You	Children	Mother	Father	Siblings	Grand-Parents	*None in my family
	Southeast Asian, Mediterranean, African descent? ☐ Applicable ☐ Not applicable							
83.	Sickle cell							
84.	Thalassemia							
	Ashkenazi Jewish descent: ☐ Applicable ☐ Not applicable							
85.	Tay-Sachs disease							
86.	Canavan disease							
87.	Familial dysautonomia							
88.	Gaucher disease							
89.	Niemann pick disease							
90.	Fanconi anemia, type C							
91.	Bloom syndrome							
92.	Mucolipidosis (Type IV)							
93.	Glycogen storage disease, type 1a							
94.	Familial hyperinsulinism							
95.	Maple syrup urine disease, type 1b							
96.	Dihydrolipoamide dehydrogenase deficiency							
97.	Usher syndrome							
98.	Joubert syndrome							
99.	Nemaline myopathy							
100.	Walker-Warburg syndrome							

	Saguenay-Lac Saint-Jean / Charlevoix region: ☐ Applicable ☐ Not applicable	You	Children	Mother	Father	Siblings	Grand-Parents	*None in my family
101.	Tyrosinemia type I							
102.	Congenital lactic acidosis Saguenay-Lac-Saint-Jean type;							
103.	Spastic ataxia, Charlevoix-Saguenay type;							
104.	Agenesis of the corpus callosum with peripheral neuropathy							
105.	Mucolipidosis							
106.	Zellweger Syndrome							
	Bas-St-Laurent (Rimouski) and Gaspésie regions in Quebec, and adjoining New Brunswick territories: ☐ Applicable ☐ Not applicable							
107.	Tay-Sachs disease							
	Cree ancestry: ☐ Applicable ☐ Not applicable							
108.	Cree encephalitis (Aicardi-Goutières syndrome)							
109.	Cree leukoencephalopathy							
	Indigenous Manitoba populations: ☐ Applicable ☐ Not applicable							
110.	Cerebro-oculo-facio-skeletal syndrome							
	Newfoundland region: ☐ Applicable ☐ Not applicable							
111.	Bardet-Biedl syndrome							
112.	Neuronal ceroid lipofuscinosis							

Please indicate comments for each check (✓) done in above table

Question #	Comments

Family information

113.	Family information				
Relation	**Ethnic Origin**	**Age (if living)**	**Health**	**Age at Death**	**Reason of Death**
Father			☐ Good ☐ Fair ☐ Poor		
Mother			☐ Good ☐ Fair ☐ Poor		
Siblings			☐ Good ☐ Fair ☐ Poor		
Paternal Grandmother			☐ Good ☐ Fair ☐ Poor		
Paternal Grandfather			☐ Good ☐ Fair ☐ Poor		
Maternal Grandmother			☐ Good ☐ Fair ☐ Poor		
Maternal Grandfather			☐ Good ☐ Fair ☐ Poor		

Infectious Disease Screening

	Do **you** have, or have **you** been diagnosed in the past with the following **Infectious diseases?**	Yes	No	Comments /Dates
114.	Chlamydia			
115.	Gonorrhea			
116.	Genital Herpes			
117.	Syphilis			
118.	HIV			
119.	Hepatitis B			
120.	Hepatitis C			
121.	HTLV-1, HTLV-2			
122.	Genital warts, genital ulcers, urethral discharge			
123.	Other Sexually Transmitted Infections (STIs)			
124.	Transmissible Spongiform encephalopathy / prion-related diseases, like Creutzfeldt-Jakob Disease (disease related to Mad Cow Disease). And /or Do you have any family member who was diagnosed with prion-related diseases (Creutzfeldt-Jakob Disease)?			
125.	Active encephalitis or meningitis			
126.	Dementia, degenerative or demyelinating disease of the central nervous system or other neurological disease of unknown cause			

	Infectious Diseases	Yes	No	Comments/dates
127.	Long Covid-19			
128.	Other significant infectious disease requiring hospitalization			
	Other questions related to infectious diseases:	**Yes**	**No**	**Comments/dates**
129.	Have you been a recipient of blood product, or have you received a blood transfusion in the past?			
130.	Have you been a recipient of human growth hormone?			
131.	Have you been a recipient of dura mater (brain/vertebral column tissue)?			

	Indications of high risk for HIV, Hepatitis B, Hepatitis C and HTLV diseases	Yes	No	Comments/dates
132.	In the last five (5) years, have you used **nonmedical** intravenous, intramuscular, or subcutaneous injection of drugs?			
133.	In the last twelve (12) months, have you had sex with any person who used **nonmedical** intravenous, intramuscular, or subcutaneous injection of drugs?			
134.	In the last twelve (12) months, have you engaged in sex in exchange for money or drugs?			
135.	In the last twelve (12) months, have you had sex with any person who has engaged in sex in exchange for money or drugs?			
136.	In the last four (4) months, have you taken any medications to prevent HIV infection, such as pre-exposure prophylaxis or post-exposure prophylaxis?			
137.	In the last (12) months, have you had sex with a person known to have taken any medications to prevent HIV infection (see item 135.), have HIV, clinically active Hepatitis B or clinically active Hepatitis C?			

		Yes	No	Comments/Dates
138.	In the last three (3) months, have you had anal sex with a new sexual partner? **(Sperm Donor Only)**			
139.	In the last three (3) months have you had multiple sexual partners and have you had anal sex with one of those partners during that time. **(Sperm Donor Only)**			
140.	In the last twelve (12) months, have you been exposed to known or suspected HIV-, Hepatitis B-, and/or Hepatitis C-infected blood through percutaneous inoculation or through contact with an open wound, non-intact skin, or mucous membrane? (mouth, eye, nose, penis, anus).			
141.	In the last twelve (12) months, have you been in a correctional facility, jail or prison for more than 72 consecutive hours?			
142.	In the last twelve (12) months, have you undergone tattooing, ear piercing, or body piercing in which sterile procedures were not used?			
143.	In the last twelve (12) months, have you had close contact (for example, living in same household, caring for) with another person having clinically active Hepatitis B or clinically active Hepatitis C infection?			
144.	Do you have a history of infection with HIV-1, HIV-2, HTLV-1, HTLV-2, clinically active Hepatitis B or clinically active Hepatitis C?			
145.	In the last twelve (12) months, have you or your sexual partner(s) received, blood, blood components, blood products, or other human tissues that are known to be possible sources of blood-borne infection?			
146.	In the last six (6) months, have you used cocaine intranasally?			

	Indication of high risk of Zika or West Nile Virus Infection	Yes	No	Comments/Dates
147.	In the past three (3) months, have you ever been evaluated, diagnosed or treated for the Zika Virus?			
148.	In the past three (3) months, have you lived in or travelled outside of Canada?			Name of country:
149.	In the past three (3) months, have you had unprotected sex with a person who is known to have either of the risk factors for Zika infection listed in 147. and 148. above?			
150.	Have you had a diagnosis or suspicion of West Nile Virus infection (based on symptoms and/or laboratory results or confirmed West Nile Virus infection) in the last 120 days following diagnosis or onset of illness, whichever is later?			

- **Section 2 - Egg Donor:**
  Complete and sign this section if you are an egg donor.
- **Section 3 - Sperm Donor**:
  Complete and sign this section if you are a sperm donor.
- **Section 4 – Surrogate**:
  Complete and sign this section if you are a surrogate.

Egg Donors, Sperm Donors and Surrogates must complete the form titled Profile Information on the last page.

SECTION 2 - EGG DONOR

Reproductive / Gynecological / Obstetrical History

1. Age of first menstrual period __________

   Are your periods regular? ☐ Yes ☐ No

   Period frequency ________ (e.g. cycle of 28 days or 35 days)

2. Do you have painful periods? ☐ Yes ☐ No

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

   If yes, what is the medication(s):__________________________

3. Are you sexually active? ☐ Yes ☐ No

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

   If yes, which method(s) of contraception are you using?

   ☐ Birth control pills
   ☐ NuvaRing / Evra patch
   ☐ Condoms
   ☐ Diaphragm
   ☐ Copper IUD
   ☐ IUD with hormones / Nexplanon Implant
   ☐ Withdrawal and/or Calendar method

5. Have you ever had a PAP test? ☐ Yes ☐ No

   If yes, indicate date of latest PAP and result:

   Date_____________________ Result _______________

6. Have you ever had an abnormal PAP test? ☐ Yes ☐ No

7. Have you ever had a colposcopy with / without a cervical biopsy? ☐ Yes ☐ No

8. Have you been pregnant before? ☐ Yes ☐ No If yes, indicate:

   Total number of pregnancies _____

   Number of miscarriage(s) _____

   Number of abortion(s)/ termination(s) _____

   Number of living children _____

SECTION 2 - EGG DONOR (con't)

	Sex	Year child was born	Weeks of pregnancy at delivery	Medical issues/ problems with the child?
First Child				
Second Child				
Third Child				
Fourth Child				

9. Have you donated eggs before? ☐ Yes ☐ No If yes, how many times? ____

Month/year	Name of clinic	Number of eggs retrieved	Any pregnancies?
Cycle 1			
Cycle 2			
Cycle 3			

10. During your cycles or previous egg retrievals, did you have any complications?

____

____

DISCLAIMER BY EGG DONOR

As per Quebec's law on the *Right to know one's origins in assisted procreation involving a third person*, I understand that the MUHC Reproductive Centre must transmit certain information concerning the profile of a person who has contributed to the procreation of a child to the Minister of Employment and Social Solidarity for entry in the Register of Origin.

I hereby confirm and acknowledge that the above information **in Sections 1 and 2** is true and complete.

I confirm that I know the intended recipient to whom I have consented to donate my eggs.

I recognize that the information contained in this document will also be shared with the recipient as part of the egg donation process.

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

SECTION 3 - SPERM DONOR

Reproductive / Uro-Genital History

1. Are you sexually active? ☐ Yes ☐ No
2. Do you use condoms? ☐ Yes ☐ No
3. Have you fathered a child? ☐ Yes ☐ No

   If yes, please complete the table below:

	Sex	Year child was born	Weeks of pregnancy at delivery	Medical issues/ problems with the child?
1st Child				
2nd Child				
3rd Child				
4th Child				

4. Have you donated sperm before? ☐ Yes ☐ No

   If yes, how many times? ________

Month/year	Name of clinic	Home insemination	Any pregnancies?
First Donation:			
Second Donation:			
Third Donation:			

SECTION 3 – SPERM DONOR (con't)

DISCLAIMER BY SPERM DONOR

As per Quebec's law on the *Right to know one's origins in assisted procreation involving a third person*, I understand that the MUHC Reproductive Centre must transmit certain information concerning the profile of a person who has contributed to the procreation of a child to the Minister of Employment and Social Solidarity for entry in the Register of Origin.

I hereby confirm and acknowledge that the above information **in Sections 1 and 3** is true and complete.

I confirm that I know the intended recipient to whom I have consented to donate my sperm.

I recognize that the information contained in this document will also be shared with the recipient as part of the sperm donation process.

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

SECTION 4 – SURROGATE

Reproductive / Gynecological / Obstetrical History

1. Age of first menstrual period ___________

   Are your periods regular? ☐ Yes ☐ No

   Period frequency _________ (e.g. cycle of 28 days or 35 days)

2. Do you have painful periods? ☐ Yes ☐ No

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

   If yes, what is the medication(s):____________________________

3. Are you sexually active? ☐ Yes ☐ No

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

   If yes, which method(s) of contraception are you using?

   - ☐ Birth control pills
   - ☐ NuvaRing / Evra patch
   - ☐ Condoms
   - ☐ Diaphragm
   - ☐ Copper IUD
   - ☐ IUD with hormones / Nexplanon Implant
   - ☐ Withdrawal and/or Calendar method

5. Have you ever had a PAP test? ☐ Yes ☐ No

   If yes, indicate date of latest PAP and result:

   Date_______________________ Result ________________

6. Have you ever had an abnormal PAP test? ☐ Yes ☐ No

7. Have you ever had a colposcopy with / without a cervical biopsy? ☐ Yes ☐ No

8. Have you been pregnant before? ☐ Yes ☐ No If yes, indicate:

   Total number of pregnancies _____

   Number of miscarriage(s) _____

   Number of abortion(s)/ termination(s) _____

   Number of living children _____

SECTION 4 – SURROGATE (con't)

	Sex	Year child was born	Weeks of pregnancy at delivery	Medical issues/ problems with the child?
First Child				
Second Child				
Third Child				
Fourth Child				

9. Have you been a surrogate before? ☐ Yes ☐ No If yes, how many times? ____

	Month/year of embryo transfer	Name of clinic	Number of embryo(s) transferred	Outcome	Weeks of pregnancy at delivery	Medical issues/ problems with the child?	Breastfeeding
1							
2							
3							
4							

10. During your previous embryo transfers or pregnancies, did you have any issues or complications?

____

____

SECTION 4 – SURROGATE (con't)

DISCLAIMER BY SURROGATE

As per Quebec's law on the *Right to know one's origins in assisted procreation involving a third person*, I understand that the MUHC Reproductive Centre must transmit certain information concerning the profile of a person who has contributed to the procreation of a child to the Minister of Employment and Social Solidarity for entry in the Register of Origin.

I hereby confirm and acknowledge that the above information in **Sections 1 and 4** is true and complete.

I confirm that I know the intended parent(s) to whom I have consented to carry their child.

I recognize that the information contained in this document will also be shared with the intended parent(s) as part of the surrogacy process.

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

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Profile Information

Identification		
First Name:	Address:	
Last Name:	City:	Postal code:
Date of Birth:	Province:	Country:
RAMQ:	Phone number:	
Hospital Card:	Email:	

General information

Age ____________________

Ethnic Origin ____________________

Civil status _________________

Level of education, diplomas, field of study:

____

____

Profession(s):____

____

Physical and Other Characteristics

Height: ____________________

Weight: ____________________

Skin color: ____________________

Eye color: ____________________

Natural hair color and texture: ____

Personality traits:____

Special skills:____

Preferences and Hobbies:

____

____

_

As per Quebec's law and the *Regulation respecting information on the profile of the person who has contributed to the creation of a child in the context of a parental project (OC 106 – 2024*, I understand that the MUHC Reproductive Centre must transmit certain information concerning the profile of a person who has contributed to the procreation of a child to the Minister of Employment and Social Solidarity for entry in the Register of Origin.

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

_____________________ _____________________ _____________________

Patient's signature Place Date