



Woman to Woman
FERTILITY CENTER

OVUM DONOR PROGRAM
CONFIDENTIAL APPLICATION FORM

Please print clearly in blue or black ink. Fill out completely, thoroughly, and truthfully, potential recipients will be reading this application (identifying information will be masked). Use extra paper if necessary.

Date of application: ____/____/____
Month Day Year

Application No _____
(W.W.F.C. information)

PERSONAL INFORMATION

Last name First name Middle name

Maiden name : _____ Age: _____ Date of birth: _____

Partner's name : _____ Age: _____ Date of birth: _____

Present address: _____
(Street) (City, State) (Zip)

Phone: Home (____) _____ - _____ Work (____) _____ - _____

U.S. Citizen: Yes No Email Address: _____

Marital Status : Married: Single: Separated: Divorced: Widowed:

S. S. Number: _____ - _____ - _____ Driver's License No: _____ State: _____

Occupation: _____

Employer: _____

Employer's Address: _____
(Street) (City, State) (Zip)

Partner's occupation: _____ Business Phone No: (____) _____ - _____

Partner's employer: _____

Employer's Address: _____
(Street) (City, State) (Zip)

In case of emergency: Name: _____ Phone: (____) _____ - _____

Dates of all marriages: _____

Dates of all divorces: _____

City, County, and State of all marriages: _____

Medical insurance: Yes No

Insurance company: _____ Policy Number: _____

Present or past Physician : _____

Address: _____
(Street) (City, State) (Zip)

PERSONAL CHARACTERISTICS

Height: _____ Ft _____ In Weight: _____ Lbs Eye color: _____ Hair color: _____

Hair:		Complexion:		Body Type	
Curly	<input type="checkbox"/>	Fair	<input type="checkbox"/>	Small	<input type="checkbox"/>
Wavy	<input type="checkbox"/>	Medium	<input type="checkbox"/>	Medium	<input type="checkbox"/>
Straight	<input type="checkbox"/>	Dark	<input type="checkbox"/>	Large	<input type="checkbox"/>

Ethnic background Maternal: _____ Paternal _____

Religion born into: _____ Race : _____

Education: (check one)

Completed grade school Completed high school

Currently in college pursuing degree in _____

Completed college degree in _____

Name of College or University? _____

Currently pursuing advance degree in _____

Advance degree in _____

Name of College or University? _____

FERTILITY HISTORY

Number of pregnancies : _____ Dates of pregnancies : _____

Number of miscarriages : _____ Dates of miscarriages : _____

Number of abortions : _____ Dates of abortions : _____

Number of stillbirths : _____ Dates of each stillbirth : _____

Number of children : _____

First name	Age	Sex	Birthdate	Health / Problems
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Are your menstrual periods regular : Yes No

How long is your monthly cycle : _____ days How many days does your period usually last : _____ days

How old were you when you first started your period ? _____

Have you ever donated eggs before : Yes No

If yes; when : _____ Name of IVF Clinic : _____

Was pregnancy achieved as a result of your donation ? Yes No Don't Know

Have you ever been told you were infertile : Yes No

If yes; when : _____ On what basis: _____

Birth control method used: _____

Is there any history of fertility problems in your family (conceiving or miscarriages) : Yes No

If yes, please explain : _____

Did your mother take diethylstilbestrol (DES) or any prescription drug while she was pregnant with you or any of your siblings : Yes No

If yes, please explain : _____

PERSONAL HEALTH HISTORY

Do you smoke cigarettes : Yes No If yes, how many : _____

Do you drink alcohol : Yes No If yes, how much : _____

Are you using marijuana now : Yes No If yes, how often: _____

Have you ever used illegal or unprescribed drugs : Yes No

If yes, what drugs and how often : _____

Are you using illegal or unprescribed drugs now: Yes No

If yes, what drugs and how often : _____

Have you ever had any problems with the law : Yes No

Please list any arrests, convictions, sentences, etc. : _____

Have you ever had an eating disorder : _____

Have you had any therapy with a psychiatrist or any other mental health professional : Yes No

If yes, when and why : _____

Have you ever had any psychiatric hospitalization : Yes No

If yes, please be specific : _____

Have you ever had any problems with drug or alcohol abuse : Yes No

If yes, please explain : _____

Do you currently have any allergies : Yes No

If yes, are they to: Food Drugs Environment Other _____

Please list below specific substances and reaction(s) produced:

Substance	Reaction
_____	_____
_____	_____
_____	_____

As per above, please describe any childhood allergies you have outgrown :

How is your vision (without glasses) : Poor Fair Good Excellent

Do you wear glasses : Yes No Your vision is about: 20 / _____

Are you : Nearsighted Farsighted Other : _____

Do you have normal hearing : Yes No Blood type : _____

What is the condition of your teeth : Poor Fair Good

Your diet is : Vegetarian Non - vegetarian

How would you describe your diet : Poor Average Excellent

How much exercise do you do : None Occasionally Regularly Athlete

What type of exercise : _____

Have you ever had surgery : Yes No

If yes, please explain : _____

Have you ever had any hospitalization not already mentioned : Yes No

If yes, please explain : _____

Have you ever had major radiation or X-ray exposure : Yes No

If yes, please explain : _____

Have you ever been treated for syphilis : Yes No If yes, when _____

How many times : _____ When was the last time : _____

Have you ever been treated for gonorrhoea : Yes No If yes, when _____

How many times : _____ When was the last time : _____

Have you or any of your sexual partners had:

	<u>Myself</u>		<u>Partner</u>		<u>When</u>
NSU (non-specific urethritis)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Chlamydia	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Venereal warts	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Herpes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Other sexually transmissible diseases	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____

Have you ever had any major illnesses such as amoebic dysentery, hepatitis, pneumonia, mononucleosis, etc.:

Yes No If yes, please explain
: _____

Any current chronic medical problems / conditions : Yes No

If yes, please explain : _____

PERSONAL HEALTH : WORK HISTORY / EXPOSURE

What is your current or most recent occupation : _____

Please list all jobs you have had in the past five years and your possible exposure to chemicals, drugs, and gases. Please consider carefully.

Jobs / Duties	Dates of employment		Exposed to which drugs, chemicals, gases.
	Began	Ended	

In the past six months have you been exposed to any of the following in your living environment, or while involved in hobbies or extra curricular activities. If yes, please check the appropriate item below and give dates and how often you have been exposed. Please, consider each carefully.

Exposed to	When (dates)	How often (daily, weekly, monthly)
Toxic chemicals		
Sprays		
Fumes / Exhaust		
Radiation		
Flea powders / sprays		
Lead / lead products		
Asbestos / asbestos products		

FAMILY'S EDUCATIONAL INFORMATION

	Completed High School	Completed College	Major
Father			
Mother			
Sibling			
Sibling			
Sibling			

Profession of Father: _____

Profession of Mother: _____

Profession of Siblings: _____

Profession of Siblings: _____

Profession of Siblings: _____

FAMILY HEALTH HISTORY

Please describe your family members by the following physical characteristics:

	Eye color	Hair color	Complexion	Height	Body type	Vision
Mother						
Father						
M.G.M.						
M.G.F.						
P.G.M.						
P.G.F.						

How many blood siblings are in your immediate family : (including yourself): _____

Have twins or multiple births occurred in your family : Yes No

If yes, what relation to you : _____

Please list below at what age members of your family died and the cause of their death.

	Age (if living)	Age (at time of death)	Cause of death
Grandfather (paternal)			
Grandmother (paternal)			
Grandfather (maternal)			
Grandmother (maternal)			
Father			
Mother			
Brothers 1.			
2.			
3.			
Sisters 1.			
2.			
3.			

Has any member of your family, including yourself, had a problem or defect at birth of any of the following body systems:

- | | | | | | |
|-------------------------------------|------------------------------|-----------------------------|--------------------|------------------------------|-----------------------------|
| Bones, muscles, joints, limbs | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Blood circulation | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Gastrointestinal system | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Diabetes | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Nervous system, brain, spinal cord | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Respiratory system | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Organ (heart, lungs, kidney, etc.) | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Genital / urinary | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Metabolic (hormones, enzymes, etc.) | Yes <input type="checkbox"/> | No <input type="checkbox"/> | | | |

If yes to any of the above, please explain the specific defect in each case.

Birth defect	Who	How did it happen	Circumstances
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have any brothers or sisters who died in infancy or childhood. Yes No

If yes, please explain what was the cause : _____

Are there any known genetic diseases or conditions that run in your family. Yes No

If yes, please explain what are they : _____

Has anyone in your family, including yourself, experienced recurring and/or chronic physical symptoms that have not been evaluated by a physician. (Please include those symptoms that you may not consider serious).

Yes No

If yes, please explain them : _____

Look through the following list of medical problems and indicate which ones you or one of your relatives have had. Please consider each condition carefully for each family member.

Check (√) all that apply.

Condition.

Heart	You	Mother	Father	Sibling	Grandparents	Aunt/Uncle	Cousins
Stroke							
Heart attack							
Heart disease							
from birth							
other: _____							
Hardening of arteries							
High blood pressure							
Congenital Heart Malformation							
Other: _____							

Blood	You	Mother	Father	Sibling	Grandparents	Aunt/Uncle	Cousins
Anemia							
Sickle cell							
Hemophilia							
Leukemia							
Immune deficiency							
A- or B-Thalassemia							
Tay-Sachs							
Hemoglobin disorder							
Hereditary hypercholesterolemia							
Other: _____							

Respiratory	You	Mother	Father	Sibling	Grandparents	Aunt/Uncle	Cousins
Hay fever							
Asthma							
Emphysema							
Tuberculosis							
Lung cancer							
Pneumonia							
Other: _____							

Condition.

Gastro intestinal	You	Mother	Father	Sibling	Grandparents	Aunt/Uncle	Cousins
Ulcer							
Gall stones							
Hepatitis A							
Hepatitis B							
Liver disease							
Colon cancer							
Ulcerative colitis							
Crohn's disease							
Cystic fibrosis							
Intestinal cancer							
Multiple Polyposis of colon							
Other: _____							

Endocrine/Glandular	You	Mother	Father	Sibling	Grandparents	Aunt/Uncle	Cousins
Juvenile Diabetes Mellitus							
Cystic Fibrosis							
Other: _____							

Urinary	You	Mother	Father	Sibling	Grandparents	Aunt/Uncle	Cousins
Kidney disease							
Rectal disorder							
Other: _____							

Genital / Reproductive	You	Mother	Father	Sibling	Grandparents	Aunt/Uncle	Cousins
Undescended testicle							
Hypospadiasis							
Prostate cancer							
Uterine fibroids							
Ovarian cysts							
Cancer of cervix							
Cancer of ovaries							
Other: _____							

Mental health	You	Mother	Father	Sibling	Grandparents	Aunt/Uncle	Cousins
Schizophrenia							
Manic depressive							
Psychosis							
Other: _____							

Condition

Muscles/Bones/Joints	You	Mother	Father	Sibling	Grandparents	Aunt/Uncle	Cousins
Muscular dystrophy							
Marfan's Syndrome							
Multiple Sclerosis							
Chronic muscledisease							
Rheumatoid Arthritis							
Lupus							
Deformity of spine							
Spina bifida							
Congenital hip dislocation							
Osteoporosis							
Dwarfism							
Low back pain							
Club foot							
Gout							
Other: _____							

Sight/Sound/Smell/Mouth	You	Mother	Father	Sibling	Grandparents	Aunt/Uncle	Cousins
Cleft lip or palette							
Deafness before age of 60							
Deformity of the ear							
Cataracts before age of 50							
Blindness							
Retinoblastoma							
Retinitis Pigmentosa							
Color blindness							
Glaucoma							
Deviated septum							
Other: _____							

Skin	You	Mother	Father	Sibling	Grandparents	Aunt/Uncle	Cousins
Acne							
Eczema							
Skin cancer							
Albinism							
Pigmentation disorders							
Other: _____							

Nervous System	You	Mother	Father	Sibling	Grandparents	Aunt/Uncle	Cousins
Neuro fibromatosis							
Epilepsy							
Huntington's disease							
Other: _____							

Condition

Other	You	Mother	Father	Sibling	Grandparents	Aunt/Uncle	Cousins
Alcoholism							
Drug abuse							
Breast cancer							
Other condition: _____							

PERSONAL AND MOTIVATIONAL

In your own words, describe your personality and character: _____

What are your hobbies, interests, and talents: _____

Do you plan on having any (more) children? _____

If you could pass on a message to the recipient(s) of your eggs, what would that message be:

Why do you want to be a donor : _____

Please state your fee _____ What will your fee be used for ? _____

Are you willing to be an anonymous donor : Yes No

Are you willing to meet the recipient: Yes No

Are you willing to work with a single woman? Yes No

Are you willing to work with a single man? Yes No

Would you like to know the outcome of your donation : Yes No

How do you feel about meeting the child(ren) born of this donation (if it is successful) after they are adults

What was your personality like as a child? _____

What were your best subjects in school? _____

Do you plan to further your education? _____

What are your goals in life? _____

What do you like to do in your spare time? _____

Name two of your favorite books and two of your favorite movies: _____

Please describe your children's (if any) interests and personality : _____

If offsprings of your donation is / are born with a genetic defect, would you be willing to come forward for further testing (at no cost to you). Yes No

Will you be interested in the surrogate parenting program : Yes No

How did you become aware of the Woman to Woman Fertility Center :

- Newspaper advertisement Specify: _____
- Newspaper / magazine article Specify: _____
- Friend / acquaintance Name: _____
- Other _____

I verify that the statements made and information provided in this Application are true and correct.

This Application is executed under penalty of perjury under the laws of the State of California.

Signature: _____ Date: _____

Include pictures of yourself and children (if applicable) and a copy of your Drivers License and Social Security Card with your completed application.

Please mail, email or Fax completed Application to:

Woman to Woman Fertility Center, Inc.
383 Diablo Road, Suite 100
Danville, CA 94526
Phone (925) 820-9495 Fax (925) 820-3885
Email: wwfc@compuserve.com

AUTHORIZATION FOR RELEASE OF INFORMATION

(Civil Code section 56.10)

TO: ANY PHYSICIAN, MEDICAL FACILITY, PSYCHIATRIST, PSYCHOLOGIST, OR OTHER HEALTH CARE OR MENTAL HEALTH PROFESSIONAL:

YOU ARE HEREBY AUTHORIZED to release to Woman to Woman Fertility Center any and all medical, psychological, psychiatric, or health information pertaining to me, which is now or in the future may be in your possession or under your control.

Woman to Woman Fertility Center is expressly authorized hereby to copy, or receive copies of, any records or documents pertaining to me or the information specified above, and to distribute said copies to _____ (Prospective Parents) or to any other Prospective Parents and to any other interested physician, psychiatrist, psychologist or health care or mental health professional who requires the information for purposes of medical or psychological assessment or treatment.

The information may be used in, or in connection with, the ovum donor program agreement I entered into with the Prospective Parents identified above or with other Prospective Parents.

This authorization shall remain valid for two years from the date hereof.

I have been advised of my right to receive a copy of this Authorization.

I have received a copy of this Authorization. ___ yes ___ no

Dated: _____

Ovum Donor

HUSBAND/PARTNER SUPPORT FORM

I am _____, the husband/partner of
_____. I can /cannot attend the initial interview that you
have
scheduled for my wife/partner on _____.

- I am supportive of my wife's/partner's decision to donate her ovum(a) to help an infertile couple have a child.
- I am not supportive of my wife's/partner's decision to donate her ovum(a) to help an infertile couple have a child.
- I am willing to have an HIV test.**

The reasons for my decision are as follows (in no order of importance):

1. _____

2. _____

3. _____

4. _____

Dated: _____

Husband / Partner

**Authorization for Publication of Confidential Donor Information
on Woman to Woman Fertility Center, Inc.'s Website**

I, _____, have been advised by Woman to Woman Fertility Center, Inc. (WWFC) that if I am "approved" to be an egg donor in WWFC's egg donation program, I agree to the following.

I have been advised by WWFC that WWFC "publishes" information about WWFC's "approved" egg donors on WWFC's website for the viewing of WWFC's potential and actual Intended Parent client(s) ("IP Clients") who are seeking an egg donor. I have been advised by WWFC that as an "approved" egg donor, a photograph of my face (as provided by me); my first name; my age, height and weight; my national ancestry; and my educational background (all as provided by me), will preliminarily be provided to IP Clients on WWFC's website. I have been further advised by WWFC that if such IP Clients want to know more about me, they can view my complete profile (as provided by me) on WWFC's website as managed by WWFC. (All of the above information pertaining to me shall be identified as "Donor's Confidential Information." Such Donor's Confidential Information expressly shall NOT include my personal identity.)

I hereby authorize the "publication" on WWFC's website (as identified above) of my Donor's Confidential Information, for WWFC's IP Clients' on-line review.

I understand that I have the right to revoke this authorization for "publication" of my Donor's Confidential Information at any time, by written notice to WWFC (who shall cease publication of my Donor's Confidential Information within 2 (two) business days after receipt of my such written notice).

I have received (made) a copy of this Authorization for Publication of Confidential Donor Information.

Dated: _____

Ovum Donor