Dear Egg Donor Applicant:

Thank you for requesting a profile on our web site. After you have completely filled in this application form, please email it to ED-CM@gen5fertility.com

Note: Please read the following carefully as we must receive *all* of the required items to complete your application.

1) **Scan a few photos for us.**

   You may scan more than one photo on a page, but each scanned page must be emailed *separately* and must be in JPEG, PDF, BMP or GIF format. Other people may be included in the photos as we can easily edit the pictures.

   We need a full-length photo plus a front and profile close-up. Photos including your siblings, family members, and children would be very much appreciated as it means a lot to Intended Parents to see what their child may look like over time.

2) **Submit a copy of your driver's license, student ID and college transcripts (if applicable.)**

   If you are not a U.S. citizen, we would need a copy of your green card, student visa, etc.

3) **We will also need verification of your SAT score or ACT score, if applicable.**

3420 Carmel Mountain Road, Suite 200, San Diego, CA 92121
Phone: 858.267.4365 Fax: 858.225.3535
www.gen5fertility.com

General Information:

Name:_____

Street Address: _____

City, State and Zip Code: _____

Social Security #: _____

E-mail Address: _____

Phone Number: _____

GEN 5 FERTILITY

EGG DONATION PROFILE

Race:_____

Maternal Ethnic Ancestry: _____

Paternal Ethnic Ancestry: _____

Citizenship:_____

Native Tongue: _____

Age:_____

Birth date: _____

Height:_____

Weight:_____

Eye Color: _____

Natural Hair Color: _____

Natural Hair Texture: _____

Complexion:_____

Physical Build: _____

Predominant Hand: _____

Teeth:_____

Braces:_____ If yes, at what age? _____

Vision:_____

Do you wear corrective/contact lenses? _____

How old were you when diagnosed? _____

Hearing:_____

Religion:_____ Practicing:_____

Blood Type: _____

Sexual Orientation: _____

Marital Status: _____

Smoker:_____ How many per day? _____

Education

Name of college/university you are now attending: _____

Name of any other college/university attended: _____

When: _____

College/Graduate Degrees (please provide proof , if applicable): _____

High School Grade Point Average: _____

College Grade Point Average: _____

College Major: _____

Highest Grade in which subject: _____

SAT Score: _____

ACT Score: _____

Learning Disabilities: _____ If yes, please explain: _____

Have you taken an I.Q. test? _____

Date of test and score: _____

Are you willing to take an I.Q. test? _____

Additional Educational Information: _____

Early Childhood Development Facts: _____

_____

Personal Profile

Have you ever been arrested and/or convicted of a crime/felony? _____
If yes, please explain: _____

_____

_____

_____

Have you, or any family member, ever been under the care of a psychiatrist? (i.e. Hospitalization, medication, on-going therapy?) _____
If yes, please explain: _____

_____

_____

_____

Have you, or any family member, ever received treatment for drug and/or alcohol abuse? _____
If yes, please explain when and which type of treatment was received: _____

_____

_____

_____

Do you drink alcohol? _____
If yes, when and how often: _____
_____
_____

Do you take any **non-prescription** drugs? _____
If yes, please indicate which ones and the reason: _____
_____
_____

Your diet (Check one) ☐ Vegetarian ☐ Non-vegetarian

Your appetite (Check one) ☐ Poor ☐ Average ☐ Excellent

How much do you exercise? (Check one)
☐ None ☐ Some ☐ Regularly

What type of exercise do you enjoy? : _____
Are you willing to have drug screening? _____

Please list if you use or have used any of the following.

Substance **Frequency**
Alcohol: _____
Marijuana: _____
Cocaine: _____
Tobacco: _____
Caffeine: _____
Prescription Drugs: _____
Other: _____

Have you ever had (Check one):

Tattoos? ☐ Yes ☐ No
How Many? _____
Where? _____ When? _____

Body Piercings? ☐ Yes ☐ No
How Many? _____
Where? _____ When? _____

Acupuncture? ☐ Yes ☐ No
When? _____

Blood transfusions? ☐ Yes ☐ No
When? _____

*ONCE YOU ARE ACCEPTED AS A POTENTIAL DONOR WITH GEN5 FERTILITY CENTER, PLEASE DO NOT RECEIVE ANY TATTOOS, PIERCINGS, ACUPUNCTURE, DEPO PROVERA INJECTIONS OR APPLY TO BECOME A BLOOD DONOR.

Is your husband/partner aware of their responsibilities in the medical process and willing to be tested for infectious diseases? ☐ Yes ☐ No

Are you willing to have HIV and other infectious disease testing? ☐ Yes ☐ No

Are you willing to take health-related tests at no expense to you? ☐ Yes ☐ No

Do you have health insurance? ☐ Yes ☐ No

If yes, name of Health Insurance Company: _____

Please list any significant illnesses you have had: _____

Please list any hospitalizations, operations or surgeries you have had and the date: _____

_____

Please list any **prescription** drugs you are currently taking and any medical conditions for which you are currently being seen or treated: _____

_____

Were you adopted? _____
If yes, what do you know about your biological medical history? _____

_____

_____

Please describe your character (personality) and any unique aspects about yourself: _____

_____

_____

_____

_____

Please describe any special skills, talents and abilities you have: _____

_____

_____

_____

_____

Please describe your professional aspirations: _____

_____

_____

_____

_____

Please describe any future goals you may have: _____

Favorites (as an adult)	Favorites (as a child)
Food:	
Color:	
Season:	
Book:	
TV Program:	
Music:	
Movies:	

Please describe your favorite memory as a child:

When you were a child, what did you want to be when you grew up?

Please describe what you like to do with your spare time?

What is your current occupation?

How long have you been employed in this occupation?

Please describe your biggest passions in life?

What is the biggest stressor in your life right now?

Have you ever been a surrogate or an ovum donor? _____
If yes, When? _____

Are you registered with any other agency or clinic? If yes, please answer all of the following questions:

A. Which agency (agencies) or clinic(s) have you registered with?

B. How many cycles have you done and when were they completed? Please include any

C. Which medical facility performed the retrieval(s)? We will need a copy of the medical records to forward to the new facility.

D. Which agency or clinic matched you for the cycle(s)?

E. When was your last physical screening done?

F. When was your last psychological screening done?

G. Do you know the amount of eggs retrieved? How many eggs were fertilized? Was there a pregnancy that resulted from your donation? Please list each cycle.

We are not opposed to you choosing to register elsewhere. But we really feel that, out of respect for the Intended Parents who have been struggling in their search for a donor, you need to be absolutely honest with us, and that you notify us immediately of any changes that would affect our Clients' ability to immediately proceed with a cycle should they choose you. It is not Gen5 Fertility Center's policy to set the compensation fees for our donors; however, if you are listed with other agencies, our policy is that your compensation requested through Gen5 Fertility Center, must not be higher than what you would receive as compensation through the other agencies. Any dishonesty associated with this matter will result in immediate removal from our donor database.

Briefly explain your personal reasons for wanting to be an ovum donor:

What would your response be if the prospective parents wanted to meet or speak with you?

What would your response be if the child wanted to meet you?

What would you like the donor recipients to tell their Child about you?

During the ovum donation process, who can you expect to receive emotional support from?

Describe the family for whom you would like to donate.

What do you anticipate your feelings and reactions will be to becoming an egg donor? What difficulties do you anticipate?

At this time, the policy of this program is total anonymity. Should the disclosure policy change, would you like to know if pregnancy occurred?

☐ Yes ☐ No ☐ Uncertain

Would you be willing to travel out of the state to donate? _____
(If you are traveling a long distance, the majority of your travel costs will not be your responsibility.)

At present, participants in this program are strictly anonymous. We would like your opinion on the following questions:

Would you be willing to (Check all that apply):

☐ Participate in annual follow-up for medical update and to explore reactions to ovum donation.

☐ Speak by telephone with the recipients, but not meet in person.

☐ Share non-identifying letters.

☐ Share a current picture of yourself.

☐ Meet in person with the recipients.

☐ Exchange identifying information.

Would you like to meet any children who may result from your egg donation once they reach 18 years of age? (Please check all that apply):

☐ Would definitely not like to meet.

☐ Would like to meet the child(ren).

☐ Would like to share picture with the child(ren).

☐ Would not object if child(ren) wished to meet but would not seek a meeting.

Would you consider donating your eggs on more than one occasion? ☐ Yes ☐ No

Would you consider updating your records with any pertinent medical information that might impact the offspring from your donation?

☐ Yes ☐ No

What would your preference be regarding the disposition of excess frozen eggs and/or embryos? Please check all that apply:

☐ Leave decision up to Intended Parents

☐ Donate to research

☐ Donate to other infertile families

☐ Destroy

☐ Leave Frozen

☐ No preference

Have you been another kind of donor before (not including ovum)? If yes, indicate what type (blood, bone marrow, etc.) _____

Reproductive Health History

Please list any reproductive illnesses or diseases that you have experienced: (Please indicate the date(s), complications, outcome, extenuating circumstances, etc.)?

_____

Which type of birth control are you currently using?

_____

Have you ever been pregnant? ☐ Yes ☐ No

If yes, please answer the following questions:

How many times have you been pregnant?

_____

Please list the approximate dates of your pregnancies:

_____

Please list the age, sex and general health condition of each of your children:

_____

_____

Were all of your children born healthy? ☐ Yes ☐ No
If no, please explain:

_____

_____

Were any of them born at an extremely high or low weight? ☐ Yes ☐ No
If yes, please explain:

_____

_____

Do you have legal and physical custody of all the above children? ☐ Yes ☐ No
If no, please explain:

_____

_____

Have you ever failed to carry a pregnancy to full term? ☐ Yes ☐ No
If yes, please explain: If you have experienced any complications with any of your pregnancies, please explain the circumstances:

_____

_____

Did any of your pregnancies take longer than 6 months to conceive? ☐ Yes ☐ No

Did you need any medical assistance to conceive your children? ☐ Yes ☐ No
If yes, please explain:

_____

_____

Donor Genetic History:

Please describe any known genetic conditions or birth defects in your family:

_____

_____

Please explain if you were born with any birth defects (heart defect, cleft lip, club feet, etc.):

_____

_____

Have you been tested as a carrier of:

Thalassemia? Results: Positive ☐ Negative ☐ Unknown ☐

Tay Sachs? Results: Positive ☐ Negative ☐ Unknown ☐

Sickle Cell? Results: Positive ☐ Negative ☐ Unknown ☐

Cystic Fibrosis? Results: Positive ☐ Negative ☐ Unknown ☐

Family Health History

Mother: Age: _____

Father: Age: _____

Siblings: Ages: _____

If your grandparents have passed away, please note the specific cause and age at time of death:

Maternal Grandmother: Age? ___ Alive? _____ Cause of death? _____

Maternal Grandfather: Age? ___ Alive? _____ Cause of death? _____

Paternal Grandmother: Age? ___ Alive? _____ Cause of death? _____

Paternal Grandfather: Age? ___ Alive? _____ Cause of death? _

Maternal Grandfather:
Year of Birth: _____
Race: _____

Ethnic Ancestry: _____
Height: _____
Weight (approx.): _____
Eye Color: _____
Wears Corrective Lenses? _____
Natural Hair Color: _____
Hair Type: _____
Complexion: _____
Sex and Age of Children: _____
Occupation: _____
Education: _____
Special Skills, Talents, Abilities: _____
General Health: _____
If Deceased, Age and Cause of Death: _____
Type of personality: _____

Maternal Grandmother:
Year of Birth: _____
Race: _____
Ethnic Ancestry: _____
Height: _____
Weight (approx.): _____
Eye Color: _____
Wears Corrective Lenses: _____
Natural Hair Color: _____
Hair Type: _____
Complexion: _____
Sex and Age of Children: _____
Occupation: _____
Education: _____
Special Skills, Talents, Abilities: _____
General Health: _____
If Deceased, Age and Cause of Death: _____
Type of personality: _____

Paternal Grandfather:
Year of Birth: _____
Race: _____
Ethnic Ancestry: _____
Height: _____
Weight (approx.): _____
Eye Color: _____
Wears Corrective Lenses: _____
Natural Hair Color: _____
Hair Type: _____
Complexion: _____
Sex and Age of Children: _____
Occupation: _____
Education: _____
Special Skills, Talents, Abilities: _____
General Health: _____

If Deceased, Age and Cause of Death: _____
Type of personality: _____

Paternal Grandmother:
Year of Birth: _____
Race: _____
Ethnic Ancestry: _____
Height: _____
Weight (approx.): _____
Eye Color: _____
Wears Corrective Lenses: _____
Natural Hair Color: _____
Hair Type: _____
Complexion: _____
Sex and Age of Children: _____
Occupation: _____
Education: _____
Special Skills, Talents, Abilities: _____
General Health: _____
If Deceased, Age and Cause of Death: _____
Type of personality: _____

Father:
Year of Birth: _____
Race: _____
Ethnic Ancestry: _____
Height: _____
Weight (approx.): _____
Eye Color: _____
Wears Corrective Lenses: _____
Natural Hair Color: _____
Hair Type: _____
Complexion: _____
Sex and Age of Children: _____
Occupation: _____
Education: _____
Special Skills, Talents, Abilities: _____
General Health: _____
If Deceased, Age and Cause of Death: _____
Type of personality: _____

Mother:
Year of Birth: _____
Race: _____
Ethnic Ancestry: _____
Height: _____
Weight (approx.): _____
Eye Color: _____

Wears Corrective Lenses: _____
Natural Hair Color: _____
Hair Type: _____
Complexion: _____
Sex and Age of Children: _____
Occupation: _____
Education: _____
Special Skills, Talents, Abilities: _____
General Health: _____
If Deceased, Age and Cause of Death: _____
Type of personality: _____

Sibling:
Year of Birth: _____
Sex: _____
Race: _____
Ethnic Ancestry: _____
Height: _____
Weight (approx.): _____
Eye Color: _____
Wears Corrective Lenses: _____
Natural Hair Color: _____
Hair Type: _____
Complexion: _____
Sex and Age of Children: _____
Occupation: _____
Education: _____
Special Skills, Talents, Abilities: _____
General Health: _____
Type of personality: _____

Sibling:
Year of Birth: _____
Sex: _____
Race: _____
Ethnic Ancestry: _____
Height: _____
Weight (approx.): _____
Eye Color: _____
Wears Corrective Lenses: _____
Natural Hair Color: _____
Hair Type: _____
Complexion: _____
Sex and Age of Children: _____
Occupation: _____
Education: _____
Special Skills, Talents, Abilities: _____
General Health: _____

Type of personality: _____

Sibling:
Year of Birth: _____
Sex: _____
Race: _____
Ethnic Ancestry: _____
Height: _____
Weight (approx.): _____
Eye Color: _____
Wears Corrective Lenses: _____
Natural Hair Color: _____
Hair Type: _____
Complexion: _____
Sex and Age of Children: _____
Occupation: _____
Education: _____
Special Skills, Talents, Abilities: _____
General Health: _____
Type of personality: _____

Sibling:
Year of Birth: _____
Sex: _____
Race: _____
Ethnic Ancestry: _____
Height: _____
Weight (approx.): _____
Eye Color: _____
Wears Corrective Lenses: _____
Natural Hair Color: _____
Hair Type: _____
Complexion: _____
Sex and Age of Children: _____
Occupation: _____
Education: _____
Special Skills, Talents, Abilities: _____
General Health: _____
Type of personality: _____

Please add additional siblings if need be.

PSYCHIATRIC AND COUNSELING HISTORY

1. Have you ever been hospitalized for substance abuse, depression or any another psychological problem? ☐ Yes ☐ No
   If yes, please list dates and diagnosis.

Dates	Diagnosis/Reason
_____	_____
_____	_____
_____	_____
_____	_____

2. Have you ever been in counseling or psychotherapy? ☐ Yes ☐ No
   If yes, please list dates and diagnosis or reason.

Dates	Diagnosis/Reason
_____	_____
_____	_____
_____	_____
_____	_____

3. Have you ever had psychotropic medications (e.g. antidepressants, anxiolytics/anti-anxiety, anti-psychotic, etc.) by any physician? ☐ Yes ☐ No If yes, please explain.

_____
_____

4. Do you have a history of dementia or degenerative neurological disorders of viral or unknown etiology? ☐ Yes ☐ No If yes, please explain.

_____
_____

5. Have you had any personal experience with a traumatic event?

EVENT	**YES/ NO**	**DETAILS**
Accident:		_____
Rape or sexual assault:		_____
Incest, sexual or physical abuse:		_____
Victim of any crime:		_____
Other:		_____

6. Have you ever been arrested or convicted of any crime (other than minor traffic offenses)? ☐ Yes ☐ No

If yes, please explain.

7. Have you ever filed bankruptcy? ☐ Yes ☐ No
   If yes, please explain.

8. Have you ever had children removed from your custody? ☐ Yes ☐ No
   If yes, please explain.

9. Are you currently involved in any lawsuits? ☐ Yes ☐ No
   If yes, please explain.

Should you not meet FDA requirements, would you be willing to be a known donor to the recipient(s)? ☐ Yes ☐ No

As of May 28th 2005, the FDA and State of CA Health Department are requiring all licensed agencies to ask the following infectious disease risk assessment questions. In compliance with these requirements, please answer as completely as possible. Your answers are confidential and will not be disclosed with identifying information without your permission, unless required by law.

Place of birth: City_____ State_____ Country_____

If born outside of the U.S., when did you come to the states? _____

Have you ever been arrested or been an inmate in a correctional facility for more than 72 consecutive hours within the preceding 12 months? ☐ Yes ☐ No
If yes, please explain. _____

In the last five years, have you engaged in sexual activity with a man who has engaged in homosexual or bi-sexual behavior? ☐ Yes ☐ No
Month/year of last activity _____/_____
If yes, please explain.

_____
_____

Have you had **close contact*** with another person having viral hepatitis within 12 months preceding donation? ☐ Yes ☐ No
If yes, please explain.

_____
_____

*** = "Close contact" is defined as sexual contact or contact resulting in exchange of body fluids and includes living in the same household, where sharing kitchen and toilet facilities occurs**

Have you been exposed within the last 12 months to known or suspected HIV, hepatitis B, and/or hepatitis C infected blood through percutaneous inoculation (e.g., needle stick) or through contact with an open wound, non-intact skin, or mucous membrane?

☐ Yes ☐ No If yes, please explain.

_____
_____

Have you had sex in the preceding 12 months with any person described in the 4 items above or any person suspected or having HIV, hepatitis B virus, or hepatitis C virus infection?

☐ Yes ☐ No If yes, please explain.

_____
_____

In the last five years, have you had sex in exchange for money or drugs?

☐ Yes ☐ No If yes, please explain.

_____
_____

In the last five years, have you been sexually involved with anyone who has engaged in prostitution?

☐ Yes ☐ No If yes, please explain.

_____

_____

In the last five years, have you injected drugs in yourself for non-medical reasons (including intravenous, intramuscular, or subcutaneous injections)?

☐ Yes ☐ No If yes, please explain.

_____

_____

In the last five years, have you had a sexual partner who had injectable drugs?

☐ Yes ☐ No If yes, please explain.

_____

_____

Have you ever been sexually involved with anyone known to be HIV positive?

☐ Yes ☐ No If yes, please explain.

_____

_____

Have **you or your partner/spouse** been diagnosed with any of the following:

Hepatitis B:	You? ☐ Yes ☐ No	Your partner? ☐ Yes ☐ No
Hepatitis C:	You? ☐ Yes ☐ No	Your partner? ☐ Yes ☐ No
Herpes:	You? ☐ Yes ☐ No	Your partner? ☐ Yes ☐ No
HIV/AIDS:	You? ☐ Yes ☐ No	Your partner? ☐ Yes ☐ No
Gonorrhea:	You? ☐ Yes ☐ No	Your partner? ☐ Yes ☐ No
Syphilis:	You or Your Partner? ☐ Yes ☐ No	When?

Have you ever donated blood or had a blood component transfused to a patient who later developed evidence of hepatitis, HIV, or HTLV?

☐ Yes ☐ No If yes, please explain.

_____

_____

Have you ever been deferred as a blood donor?

☐ Yes ☐ No If yes, please explain.

_____

_____

Do you presently have any health problems?

☐ Yes ☐ No If yes, please explain.

_____

_____

Have you or a partner of yours ever had a sexually transmitted disease (gonorrhea, syphilis, hepatitis, Chlamydia, herpes, condyloma or trichomoniasis)?

☐ Yes ☐ No Please describe your diagnosis, year and treatment:

_____

_____

Have you ever had any of the following or had sexual relations with anyone with the following symptoms? Please specify:

_____

_____

Unexplained weight loss_____ Kaposi Sarcoma _____

Fever of unknown etiology_____ Pneumocystis Pneumonia _____

Do you have a current or past diagnosis of viral hepatitis (except for a past diagnosis of cytomegalovirus or Epstein-Barr virus hepatitis, documented hepatitis A, or viral hepatitis occurring before the age of 11 years)?

☐ Yes ☐ No

How many sexual partners have you had in your lifetime? _____

In the last year? _____

In the last 6 months? _____

Contraceptives Used:

TYPE	WHEN	HOW LONG	REACTION
The Pill:			
IUD:			
Diaphragm:			
Condom:			
The Patch:			
Depo Provera Shot:			

When was your last pap smear? Month_____ Year_____

If over a year, would you be willing to have it repeated? ☐ Yes ☐ No

Have you ever been told of any gynecological problems (endometriosis, fibroids, ovarian cysts, abnormal Pap smears, etc.)? ☐ Yes ☐ No When? _____

If yes, please explain.

_____

_____

Have you undergone any procedures as a result of an abnormal pap smear? ☐ Yes ☐ No

Colposcopy_____Cryosurgery(freezing)_____Laser treatment _____

Conization_____LEEP procedure_____Other _____

If you answered yes to the question above, have you had a normal pap smear since? ☐ Yes ☐ No
When? _____
If yes, please explain.

_____
_____

Do you have discharge from one or both breasts? ☐ Yes ☐ No
If yes, please explain.

_____
_____

Have you ever had endometriosis? ☐ Yes ☐ No
If yes, please explain.

_____
_____

Have you ever had pelvic inflammatory disease? ☐ Yes ☐ No
If yes, please explain.

_____
_____

In the last 12 months, have you undergone tattooing, acupuncture, ear or body piercing? If so, when? ☐ Yes ☐ No

_____
_____

In the past 14 days, have you had an open sore or infection? ☐ Yes ☐ No
If yes, please explain.

_____
_____

Do you have a diagnosis of Creutzfeldt-Jakob disease (Mad Cow disease) or known family history (blood relative) of a person with Creutzfeldt-Jakob disease? ☐ Yes ☐ No
If yes, when was diagnosis?

_____
_____

Have you ever received injections of human pituitary-derived growth hormone (pit-hGH)? ☐ Yes ☐ No
If yes, please explain.

_____

_____

Have you ever received transplants of human tissue (i.e. bone marrow, kidney, etc.)? ☐ Yes ☐ No
If yes, please explain.

_____

_____

Have you ever received intravenous Factor VIII or Factor IX concentrate, which was not heat-treated or otherwise virally inactivated? ☐ Yes ☐ No
If yes, please explain.

_____

_____

Have you ever been exposed to radiation or toxic chemicals such as lead, mercury and gold? ☐ Yes ☐ No
If yes, please specify. _____

_____

Have you traveled out of the country in the past year? ☐ Yes ☐ No
If yes, please give dates and name the countries.

_____

_____

Have you visited a country known to have SARS within the past 14 days? ☐ Yes ☐ No
If yes, please explain.

_____

_____

Have you had close contact* with persons who have traveled to or resided in areas affected by SARS within the past 14 days? ☐ Yes ☐ No
If yes, please explain.

_____

_____

Have you been suspected of having SARS, been diagnosed with or received treatment for SARS within the last 28 days? ☐ Yes ☐ No
If yes, please explain.

_____

_____

Have you been bitten by an animal suspected of rabies within the last 6 months? ☐ Yes ☐ No
If yes, please explain.

_____

_____

In the past 8 weeks, have you had a smallpox vaccination or have you had contact with the smallpox vaccination site of anyone else? ☐ Yes ☐ No
If yes, please explain.

_____
_____

In the past year, have you visited or lived in an area having malaria, or have you been diagnosed with malaria? ☐ Yes ☐ No If yes, please explain.

_____
_____

In the past year, have you been given immune globulin for infectious disease exposure? ☐ Yes ☐ No
If yes, please explain.

_____
_____

In the past year, have you received shots, vaccinations, including Rh immune globulin? ☐ Yes ☐ No
If yes, for what?

_____
_____

In the past year, have you been diagnosed with West Nile Virus or had flu-like symptoms, fever >100.5 with headache? ☐ Yes ☐ No
If yes, please explain.

_____
_____

Did your mother take DES while she was pregnant with you? ☐ Yes ☐ No
If yes, please explain.

_____
_____

Please list current allergies (food, pollen, bee stings, medications, etc.):

_____
_____

Please describe any childhood allergies you have outgrown:

_____
_____

Please list any allergies to medicine:

_____
_____

I hereby certify that I have answered the above questions honestly and accurately to the best of my ability.

Donor Candidate	Date	Witness	Date