

Prime Genetics, LLC

"Helping Give the Gift of Life"

Egg Donor Application (long form)

First Name:

Last Name:

Address:

City: State: Zip Code:

Phone:

Email Address:

Ethnicity:

Ethnic Origin Maternal:

Ethnic Origin Paternal:

Religious/Spiritual Affiliation:

Date of Birth:

Weight:

Height:

Eye Color:

Natural Hair Color:

Current Hair Color:

Complexion:

Family Background

	AGE	HEIGHT	HAIR COLOR	EYE COLOR
Father:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Mother:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Paternal Grandfather:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Paternal Grandmother:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Maternal Grandfather:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Maternal Grandmother:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Sibling 1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Sibling 2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Sibling 3	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Sibling 4	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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Mother's Occupation:

Mother's Education Level:

Father's Occupation:

Father's Education Level:

Sibling's Occupations:

Education Level:

Children: (If Applicable)

NAME

AGE

EYE COLOR

HAIR COLOR

PERSONALITY

NAME

AGE

EYE COLOR

HAIR COLOR

PERSONALITY

Describe your personality and character:

Hobbies/Talents:

Describe yourself as a child:

Why do you want to become a donor?

What message would you like to pass on to the recipients/intended parents of your eggs?

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Health History

Blood Type: (If known)

General Health Condition:

Do you have any past or current medical problems? Please explain.

Are you currently taking any over the counter or prescription, including vitamin or herbal supplements? Please explain.

Have you had any of the following sexually transmitted or pelvic infection? (Check all that apply)

Chlamydia Gonorrhea Genital Warts Syphilis HIV/AIDS Hepatitis

Other

When was your last PAP Smear? (Month/year) Normal Abnormal

If you have had any abnormal PAP Smears, when was the last one? (Month/year) N/A

Have you undergone any of the following procedures as a result of an abnormal PAP Smear?

Colposcopy Cryosurgery (freezing) Conizaion Laser LEEP

Are you allergic to any foods or medication? Yes No (If yes, please list and describe reaction)

Do you or anyone in your family wear glasses or contacts?

Do you are anyone in your family have a history of drug or alcohol abuse? Please explain.

List deceased family members: (Please include any primary relatives or grandparents)

Name	Relationship	Age at time Of Death	Cause of Death
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Have you or has anyone in your family been on medication for a psychological condition? Please explain.

Do you or anyone in your family have a history or treated for hyperactivity/ADH/ADD?

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Number of Children:

Males Ages

Females Ages

Number of Pregnancies

Has anyone in your family had multiple births (i.e. twins, triplets)? Please explain:

Previous Donor? Yes or No (Circle one)

Did a pregnancy occur? Yes or No (Circle One)

What method of birth control are you currently using?

Lifestyle

Current Occupation:

Previous Occupation:

Career Goals:

Marital Status:

Married Single Divorced Committed Relationship

Do you have a sexual partner? Yes No

Have you ever had a sexual partner that was bi-sexual or a partner that has been sexual with a bisexual?

Yes No

Have you had plastic surgery? Yes No

If yes, explain:

Have you had a body piercing or a tattoo in the past year? Yes No

Have you ever been arrested? Yes No

If yes, what was the charge?

Were you convicted? Yes No

Is there or has there ever been any criminal history in your family? Yes No

If yes, please explain:

My current living situation:

Do you smoke? Yes No

Do you drink alcohol? If so, how many drinks per week? (Specify wine or beer and how many drinks per Week)

Do you use illicit, illegal drugs, e.g. Cocaine, LSD, Methamphetamines, or Marijuana? Yes No

Have you or your sexual partners ever injected illicit drugs? Yes No

Academic Achievement

Education Level:

SAT:

*

GPA:

College GPA/from what College/University?

Major:

Degree:

Please list all colleges, universities, trade schools, business or tech schools or medical schools that you have been enrolled in or presently enrolled in:

*We will need a copy of your SAT/ACT scores and/or your college transcripts.