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Donor Sticker

**Initial Assessment – Egg Donor**

**Personal Information**

Surname……………………………………………………… Forename (s) ………………………..……………..………

Surname at birth (if different)……………………………………… D.O.B……………………………………………

Address………………………………………………………………………………………………………………………………..….….

……………………………………………………………………………………………………………………………..……………..……..

Postcode…………………………………………………… Tel No…………………….…………………………………..….

Mobile………………………………………………………. E mail………………………………..……………………..…….

Town or district of birth……………………………… Country of birth…………………………….……

Occupation ………………………………………………. Religion ………………………………………….…..

NHS number (if known)..………………………..… Ethnic Group ………………………………………

Marital status……………………………………….…… Sexual Orientation………………………..……

Passport number (+ country of issue) ..……………………………………………………………………………….….….

Nationality ……………………………………………….. Parent’s nationality ……………………………

Mothers Ethnic Group ……………………………… Fathers Ethnic Group ……………………………

Do you have your own children: YES / NO No. of girls……...… No. of boys…….…

Height : metres/feet……………………………………. Natural Hair Colour:……………………………….

Eye Colour …………………………………………….. Build/Weight kgs/stone…………………………

Skin Tone…………………………………………………….. Left Handed or Right Handed…………………

How were you recruited …………………………… Reasons for donating …………………….………

Donations at other centres? …………………….. If so what centres? …………………………….….

**Personal / Travel History**

Have you visited any area affected by the Zika virus in the last 3 months…………………..……………………..

Have you visited any area affected by the Ebola virus in the last 6 months………………..………………………

Any history of STDs? ……………………………………………………………..…….……………………………………………………..

Ever had genital warts / herpes? .......................................................................................................

Number of sexual partners where intercourse was unprotected?.....................................................

If had unprotected intercourse, how recently?................................................................................

Do you practice anal sex………………………………………………………………………………………………………………………

Have you ever used recreational drugs, such as cannabis or intravenous drugs, such as heroin or cocaine?.........................................................................................................................................

Have you used recreational drugs in the last year?.............................................................................

Are you on any medication (prescribed or over the counter).................……………………………………………..

**Medical History**

G.P. Name…………………………………………………………………………………………………………………………………..……….

G.P. Address…………………………………………………………………………………………………………………………………..…...

……………………………………………………………………………………………………………………………………………..…………....

**Have you ever suffered from:**

Thrombo-Embolism……………………………………………………………………………………………………………………………

Oestrogen dependent tumour………………………………………………………………………………………………………….

Recent Pelvic Inflammatory Disease………………………………………………………………………………………………….

**Do you or any of your family suffer from (or at higher risk of):**

Diabetes ……………………………………………………………………………………………………………………………….…………

Epilepsy…………………………………………………………………………………………………………………………….…………….

Debilitating Asthma.………………………………………………………………………………………………………………….…….

Rheumatoid arthritis…………………………………………………………………………………………………..…………………….

Severe refractive disorder…………………………………………………………………………………………..….………………..

Sickle cell / Thalassaemia/ glucose-6-phosphate dehydrogenase deificiency ……………….…………………

Tay Sachs…………………………………………………………………………………………………………………………………….……..

Talipes..……………………………………………………………………………………………………………………………………………..

Mental disorders inc psychosis…………………………………………………………………………………………………………

Severe hypertension………………………………………………………………………………………………………………………..

Chromosomal rearrangement………………………………………………………………………………………….………………

Autosomal recessive disease e.g. Cystic Fibrosis ………………………………..…………………………………………..

Autosomal dominant / X-linked disorders e.g. Huntingdon’s………………………………………………..…………

Congenital or inherited abnormalities inc. hip dislocation, heart malformation, cleft lip/palate, neural tube defects inc. spina bifida, club foot, hypospadia …………………………………………………….…………………

Mendelian disorders: albinism, haemophilia, haemoglobin disorders, hereditary hypercholesterolaemia, neurofibromatosis, tuberous sclerosis……………………………………………………….

Transmissible Spongiform Encephalopathies (prion diseases)…………………..………………………………………

Have you had an invasive neurosurgery procedure?.......................................................................

Have you received human pituitary derived growth hormone or cornea or sclera or dura mater?..........................................................................................................................................

|  |  |
| --- | --- |
| AFC Right:  | AFC Left: |

**Clinic use only**

**AFC Appointment**

Total follicles 2-6mm ……………………………………………

TV Scan: Evidence of hydrosalpinges, cysts, fibroids, PCO etc…………………………………................

……………………………………………………………………………………………………………………………………………….

AMH taken [ ] Result………………………………………..

CMV taken [ ]

BMI……………………………………………….…… Blood Pressure………………………………………………..

GP letter signed & sent [ ]

HFEA CD completed [ ]

ID copied [ ]

Hospital notes requested [ ]

Photo taken on IDEAS [ ]

Medical history reviewed at face-to-face by nursing team:

Signed (Clinic staff)…………………………………..……………..… Date………………………………

Assessed by medical practitioner at CRM with GP response and hospital notes (if available)

Signed (Medical Practitioner)……………………………………………. Date……………………………….