JACQUELYNE GORTON, MSN, JD
NURSE ATTORNEY

Dear Ovum Donor Applicant:

Thank you for expressing interest in our agency and ovum donation. For the past seventeen years it has been my pleasure to aid in the creation of hundreds of new families by matching them with caring, selfless donor candidates like you.

To learn about medical aspects of ovum donation procedures, go to our website: www.jackiegortonnurseattorney.com to review Donor *FAQS* or *What to Expect Page*. Of course, you are encouraged to call our office any time, (415) 485-1969; with questions you may have about the process, your qualifications, or how to complete forms.

Please call our office for a phone screening to see if you are eligible if you are still interested in becoming a donor. If you are accepted, we will schedule a personalized interview to be held at our office to confirm your family health history, to explain the medical procedures, and to answer any questions. The following health history form is what you will be bringing to your interview so that we can go over it with you.

Please take your time in filing out the application. The first three pages are for our office use only, but the **Ovum Donor Health History and Background** form will be reviewed by recipients. It is crucial that you answer each question thoroughly. Recipients are looking for donors with similar values and characteristics, for example if a recipient is an artist she will be looking for a donor who has some artistic ability. Please feel free to use extra pages so you can elaborate on descriptions of your interests, talents, and pursuits.

We strive to make the application and screening process as meaningful as possible. We look forward to working with you and matching you with grateful recipients.

Best Wishes,
Jacquelyne Gorton, MSN, JD

****When filling out form below, to save your filled info to disk & continue to edit you must update Acrobat Reader to version XI. Versions X and lower will not allow for saving.** DOWNLOAD FREE READER HERE. **OR fill out form in browser all at once & print. Saving to disk you can print from there too.**

25 Biscayne Ct. San Rafael, CA 94901
(415) 485-1969 Fax (415) 485-1113
E-Mail: info@jackiegortonnurseattorney.com Website: www.jackiegortonnurseattorney.com

JACQUELYNE GORTON, MSN, JD
NURSE ATTORNEY

Donor Contact Information

Please complete form either electronically or handwritten and bring it to your initial appointment with our office.

First Name: Last Name:

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

Email Address: How often do you check your email?

Home Phone: Work: Cell:

May We Leave Detailed Messages: ◯ yes ◯ no

Married? ◯ ***Significant Other?*** ◯ ***Single?*** ◯ ***Divorced?*** ◯

Is your partner currently employed? ◯ yes ◯ no Occupation:

Partner's Employer Name:

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

Partners Employer Phone: How Long?

Is your partner supportive of your decision to become an egg donor, and will to undergo STD testing if the clinic you work with requires it? ◯ Yes ◯ No

Partner's Signature

Employment Information

Are you currently employed? ◯ yes ◯ no

Occupation: How Long? Employer Name:

Employer Address: (**Street**) **City, State**) (**Zip**)

Employer Phone:

Social Security Number: Date of Birth:

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Rev. 3/20/2012

Emergency Contact Name (such as a parent):

Phone: Relationship to you:

Permanent Contact Address:

Street:

City, State, Zip:

Insurance Company: **Policy Number**:

Past or Present Physician:

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

I understand that any significant misrepresentation or omission is grounds for dismissal from the donor program and that I can then be held financially responsible for any lab, medical, or psychological costs involved in furtherance of the proposed donorship. I declare that all of the following information and statements made regarding myself and my family's health history are true and correct. The Following Ovum Donor Health History and Background form has been completed under penalty of perjury under the laws of the State of California.

Signature: Date:

JACQUELYNE GORTON, MSN, JD
NURSE ATTORNEY

Authorization for Use and/or Disclosure of Patient Health Information

I hereby authorize:

Name of Disclosing Party

Address

City State ZIP

To disclose to:

Jackie Gorton
Name of Recipient

25 Biscayne Court
Address

San Rafael CA 94901
City State ZIP

Records and Information Pertaining to:

Patient' Name (List Other Names Used) Medical Record No. Date of Birth

Address Telephone Number

DURATION: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here (date).

REVOCATION: I understand that the recipient may not lawfully further use or disclose health information unless another authorization is obtained from me or unless such use or disclosure is specifically required by law.

SPECIFICY RECORDS: Check the box, initial and/or sign which type of information to be disclosed.

- ☐ **Medical Information** **(initial)**
- ☐ **Psychiatric Information** **(initial)**
- ☐ **Drug/Alcohol Information** **(initial)**
- ☐ **Genetic Records** **(initial)**
- ☐ **Results of an HIV Test** **(initial)**

Specify records to be disclosed:

The recipient may use the health information authorized on this form for the following purposes:

A copy of this authorization is as valid as the original. Member/Patient has a right to a copy of this authorization.

Date Signature if signed by Other than Member/Patient, Indicate Relationship

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Authorization for Publication of Donor Information on Jacquelyne Gorton Nurse Attorney Inc.'s Website

Please complete form either electronically or handwritten and bring it to your initial appointment with our office.

I, _____, have been advised by Jacquelyne Gorton Nurse Attorney, Inc. ("JGNA") that if I am accepted to be an ovum donor in JGNA's ovum donation program, that JGNA Publishes information about JGNA's ovum donors on JGNA's website for potential and actual Intended Parent Clients to view.

I agree to the following:

JGNA may publish information including a photographs of my family and me (as provided by me); my first name ; my age; height and weight; my national/ethnic ancestry; my educational background (all as provided by me) and my complete profile (as provided by me) on JGNA's website as managed by JGNA.

Said information will be provided to Intended Parent Clients on JGNA's website. All of the above information pertaining to me shall be identified as *Ovum Donor Health History and Background and* said health history and background information shall not include any information that would reveal my personal identity.

I hereby authorize the publication on JGNA's website as identified above of my *Ovum Donor Health History and Background* for online viewing.

I understand that I have the right to revoke this authorization for publication of my *Ovum Donor Health History and Background* at any time, by written notice to JGNA (who shall delete all information about me from JGNA's website within two (2) business days after receipt of my written notice.

I have received a copy of this Authorization for Publication of Donor Information

Dated: Name of Ovum Donor

Ovum Donor Health History and Background

Date of Health History and Background: ____ / ____ / ____ /
Month **Day** **Year**

Please complete form either electronically or handwritten and bring it to your initial appointment with our office.

First Name Only

City of Residence

City of Employment

Are you currently employed? ◯ yes ◯ no Occupation: How Long?

Do you own a credit card? ◯ yes ◯ no Name of Card (NOT number)

Are you planning to be out of town within the next 6 months? If so, for how long?

Do you have a car? ◯ yes ◯ no If not, do you have access to a car? ◯ yes ◯ no

If Married or in Committed Relationship:

Is your partner currently employed? ◯ yes ◯ no Occupation:

Health Insurance:

Are you currently covered by a Health Insurance Plan ◯ yes ◯ no?

If yes, Name of Plan:

Physical Characteristics:

Date of Birth: Age: Race: Blood Type:

Height: Weight: Eye Color: Hair Color:

Hair (Check one)
- ☐ curly
- ☐ wavy
- ☐ straight

Complexion (Check one)
- ☐ fair
- ☐ medium
- ☐ dark

Body type/bone structure (Check one)
- ☐ small
- ☐ medium
- ☐ large

Personal Characteristics:

Your Race: Mother's Race: Biological Father's Race:

Ethnic/ National Ancestry (e.g.; Irish, Chinese, etc.): Mother: Father
Religion Born Into: Religion Practiced Now:

Sexual Orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual

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

If not married, are you currently involved in a committed relationship? ☐ yes ☐ no

Which of the following describes you best? (Check all that apply on next page)

Extrovert ☐ Passive ☐ Sensitive ☐ Cheerful ☐ Dependent ☐
Introvert ☐ Aggressive ☐ Assertive ☐ Solemn ☐ Independent ☐

# of Months at your current address? # Months at your previous address?

Education (complete all that apply):

Completed High School / Name: GPA:

Completed 4 Year College / Name: GPA:

Some College: # hours/semesters completed Name: GPA:

Undergraduate Major

Advanced Degree in School's Name: GPA:

Other Licensure / Certifications

Career Goal:

Family Background:

Where were you born?

Where did you spend your childhood?

Parents' Marital Status If separated, your age at separation?

Parents' Place of Residence

	Completed High School	Completed 4 Year College or # of Years	Certifications or other Licenses	Profession
Father				
Mother				
Sibling				
Sibling				
Sibling				

Fertility History:

Have you been pregnant before: ◯ yes ◯ no Number of children born:

Dates of Abortions: Dates of Miscarriages:

For each child born, please write date of birth, sex, and any special health problems:

First Name	Date of Birth	Age	Sex	Special Health Problems

1st day of last menstrual period: How many days does your period last? days

How long is your monthly cycle? days Are your menstrual periods regular? ◯ yes ◯ no

Birth control method used:

Have you ever been an ovum donor before? ◯ yes ◯ no

If so, when? Name of IVF Clinic? Phone number:

# of eggs retrieved? Pregnancy?

Is there any history of fertility problems with you or in your bloodline (difficulty conceiving or miscarriage)? ◯ yes ◯ no

If yes, explain:

Did your mother take diethylstilbestrol (DES) or any other prescription drug while pregnant with you? ◯ yes ◯ no

If yes, please explain:

Personal Health History:

Do you currently have allergies? ◯ yes ◯ no As a Child? ◯ yes ◯ no

If yes, are they due to: ☐ food ☐ drugs ☐ environment ☐ other

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

Substance	Reaction

Are you: ☐ Left Handed ☐ Right Handed ☐ Ambidextrous

How is your vision (without corrective lenses)? ☐ poor ☐ fair ☐ good ☐ excellent

Do you wear glasses or contact lenses? ☐ yes ☐ no

Are you: ☐ nearsighted ☐ farsighted ☐ other

Normal hearing? ☐ yes ☐ no

Condition of your teeth: ☐ poor ☐ fair ☐ good

Did you have braces? no ☐ if yes: ☐ age duration

Your diet is: ☐ vegetarian ☐ non-vegetarian ☐ poor ☐ good ☐ excellent

How much do you exercise? ☐ none ☐ occasional ☐ regular

What type of exercise?

Do you smoke cigarettes? ☐ yes - approx. number/ day: no ☐

Do you drink alcoholic beverages? ☐ yes - type? #/day: #/wk no ☐

List any recreational drugs you have used:

Substance	**Date Last Used**	**Frequency of Use**

Do you drink caffeinated beverages such as coffee, tea, colas? ☐ yes - approx. #cups/day ☐ no

Are you currently taking any medication prescribed by your doctor? ◯ yes ◯ no

If so, please indicate medication, dosage, and condition prescribed for below (include birth control pills):

Medication	Dosage	For Condition

Have you ever had surgery? yes no

If so, please indicate the procedure, reason for surgery, your age at time of surgery, and the year below:

Surgery	Reason	Age	Year

Have you ever been hospitalized? ☐ yes ☐ no

If yes, please explain:

Have you ever had a blood transfusion? ☐ yes ☐ no

If yes, please explain:

In the last year, have you gotten a tattoo, acupuncture, or body piercing of any kind?

☐ yes ☐ no Was sterile technique used? ☐ yes ☐ no Were disposable needles used? ☐ yes ☐ no

When (if ever) did you donate blood? yes ☐ no ☐ date

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 gonorrhea? ☐ yes ☐ no

If yes, when? How many times? When was the last time?

Have you or any of your sexual partners ever had:

NSU (non-specific urethritis)	☐ yes	☐ no	☐ self	☐ partner	when?
Chlamydia	☐ yes	☐ no	☐ self	☐ partner	when?
Venereal Warts	☐ yes	☐ no	☐ self	☐ partner	when?
Herpes	☐ yes	☐ no	☐ self	☐ partner	when?

Other sexually transmittable diseases? yes ☐ no ☐ self ☐ partner ☐

What? When?

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

☐ yes ☐ no If yes, explain:

If you have any current, chronic medical problems or conditions please explain:

Have you ever been involved in any civil or criminal proceedings involving any arrests? ☐ yes ☐ no

If so, list date, type of proceeding, name of court & outcome.

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 gasses. Please consider carefully. List in chronological order with your most recent job on the first line.

Jobs/Duties	Beginning & Ending Employment Dates	Exposed to which drug, chemicals, gases, etc.

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

Exposures		Dates	How often (daily, weekly, monthly)
Toxic chemicals			
Sprays			
Fumes/Exhaust			
Radiation			
Flea Powders / Sprays			
Lead / Lead Products			
Asbestos / Asbestos Products			

Family Health History:

Please describe your family members by the following physical characteristics: For Sibling Circle M or F = male/female
*Use the following abbreviations MGM - Maternal Grandmother PGF - Paternal Grandfather, etc.

	Eye Color	Hair Color	Complexion	Height	Body Type	Vision
Mother						
Father						
Sibling M / F						
Sibling M / F						
Sibling M / F						
MGM						
MGF						
PGM						
PGF						

Have twins/multiple births occurred in your family? ☐ Yes ☐ No

If Yes, what relation to you:

Please chart at what age members of your family died and what was the cause of their death? Please be as specific as possible. Identify full siblings (from the same biological parents) and half siblings (from one of your biological parents) circle appropriate symbol. Also, next to your siblings, list the ages of their children, if any.

	Age, if Living	Offspring	Age at Time of Death	Cause of Death
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Mother				
Father				
Brother				
Brother				
Sister				
Sister				
½ S or B w/ Mo. or w/ Fa				
½ S or B w/ Mo. or w/ Fa				
½ S or B w/ Mo. or w/ Fa				

Has any member of your family, including yourself, had problem or defect at birth of any of the following body systems? If yes, check which body system(s).

Bones, muscles, joints, limbs	☐	Blood circulation	☐	Genital/urinary	☐
Gastrointestinal system	☐	Respiratory system	☐	Metabolic (hormones, enzymes, etc)	☐
Nervous system, brain, spinal chord	☐	Organ (heart, lung, kidney, etc)	☐	Learning Disabilities	☐

If yes, please list below the specific defect in each case.

Birth Defect	Who	When did it happen?	Relevant Circumstances

Do you have any brothers or sisters who died in infancy or childhood? ☐ yes ☐ no
If yes, what was the cause?

Are there any genetic diseases that run in your bloodline? ☐ yes ☐ no. If yes, what are they?

Has anyone in your bloodline, 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:

PLEASE IDENTIFY WHICH BLOOD RELATIVES HAD ANY OF THE MEDICAL PROBLEMS CHARTED BELOW. FOR EXAMPLE, IF YOUR MOTHER'S SISTER HAD A STROKE, YOU WOULD WRITE "MA" (MATERNAL AUNT) UNDER THE COLUMN LABELED *AUNT/UNCLE* AND ACROSS FROM THE "STROKE COLUMN."
MA=Maternal Aunt / MU=Maternal Uncle / PA=Paternal Aunt / PU=Paternal Uncle / MC=Maternal Cousin / PC=Paternal Cousin
MGM=Maternal Grandmother / MGF=Maternal Grandfather / PGM=Paternal Grandmother / PGF=Paternal Grand Father

Heart:	**You**	**Mother**	**Father**	**Sibling**	**Grandparents**	**Aunt/Uncle**	**Cousin**
Stroke							
Heart Attack							
Heart Disease -- from Birth							
Heart Disease -- Other							
Hardening of the arteries							

Blood:	**You**	**Mother**	**Father**	**Sibling**	**Grandparents**	**Aunt/Uncle**	**Cousin**
Anemia							
Sickle-cell anemia							
Hemophilia or other bleeding problem							
Leukemia							
Immune deficiency							
A- or B- Thalacemia							
Inherited hypercholesterolemia							
Other blood disorder							

Respiratory (lungs):	**You**	**Mother**	**Father**	**Sibling**	**Grandparents**	**Aunt/Uncle**	**Cousin**
Asthma							
Emphysema							
Tuberculosis							
Lung Cancer							
Pneumonia							
Other Lung Disease							

Gastro-Intestinal:	**You**	**Mother**	**Father**	**Sibling**	**Grandparents**	**Aunt/Uncle**	**Cousin**
Ulcer of the stomach or Duodenum							
Gall Stones							

Gastro-Intestinal cont'd	You	Mother	Father	Sibling	Grandparents	Aunt/Uncle	Cousin
Hepatitis A (infectious)							
Hepatitis B (serum)							
Cirrhosis							
Other Liver Disease							
Colon Cancer							
Ulcerative Colitis							
Crohn's Disease							
Cystic Fibrosis							
Intestinal Cancer							
Any other cancer or problem of the digestive system							

Metabolic/Endocrine:	You	Mother	Father	Sibling	Grandparents	Aunt/Uncle	Cousin
Diabetes							
Hypoglycemia							
Thyroid cancer							
Goiter							
Adrenal Dysfunction or disorder							
Hyperactivity							

Urinary	You	Mother	Father	Sibling	Grandparents	Aunt/Uncle	Cousin
Kidney Disease							
Other Disease of the Urinary Tract							
Rectal Disorder							

Genital/Reproductive System:	You	Mother	Father	Sibling	Grandparents	Aunt/Uncle	Cousin
Undescended Testicle							
Hypo-Spadiasis							
Prostate Cancer							
Uterine Fibroids							
Ovarian Cysts							
Cancer of the Cervix							

Cancer of the Ovaries							
Neurological:	**You**	**Mother**	**Father**	**Sibling**	**Grandparents**	**Aunt/Uncle**	**Cousin**
Migraines							
Mental Retardation							
Cerebral Palsy							
Multiple Sclerosis							
Senility before age 50							
Epilepsy							
Hydrocephalus							
Disorders of the Spinal							
Huntington's Chorea							
Gaucher's Disease							
Wilson's Disease							
Tay Sachs							
Other Diseases of the Nervous System							

Mental Health:	**You**	**Mother**	**Father**	**Sibling**	**Grandparents**	**Aunt/Uncle**	**Cousin**
Schizophrenia							
Manic Depression							
Clinical Depression							
Other Mental Health Disorders							

Muscles/Bones/Joints:	**You**	**Mother**	**Father**	**Sibling**	**Grandparents**	**Aunt/Uncle**	**Cousin**
Muscular Dystrophy							
Other Chronic Muscle Disease							
Lupus							
Osteoporosis							
Deformity of the Spine (scoliosis)							
Dwarfism							
Hereditary low back							
Arthritis							
Gout							

Sight/Sound/Smell:	You	Mother	Father	Sibling	Grandparents	Aunt/Uncle	Cousin
Deafness before the age of 60							
Deformity of the Ear							
Cataracts before the age of 50							
Blindness							
Color Blindness							
Glaucoma							
Deviate Septum							
Any other sight, sound, smell disorder							

Skin:	You	Mother	Father	Sibling	Grandparents	Aunt/Uncle	Cousin
Acne							
Eczema							
Skin Cancer							
Pigmentation Disorders							
Other Disorder of the Skin							

Other:	You	Mother	Father	Sibling	Grandparents	Aunt/Uncle	Cousin
Alcoholism							
Drug Abuse, Misuse or Addiction							
Eating Disorder							
Breast Cancer							
Any other cancer not mentioned above							
Any other condition not mentioned above							

Please answer the following questions thoughtfully and completely so that interested couples can get some insight into who you are as an individual (attach extra pages if needed)**.**

Why do you want to be an Ovum Donor?

What will you use your fee for?

If you are married or in a committed relationship, have you discussed donorship with your husband or partner? If so, what was his/her reaction?

Have you discussed donorship with any of your family and friends? If so, what was their reaction?

How would you feel about the child (with parental supervision) having a one time interaction with you at in the future?

Would you submit yearly address changes and your social security number to the recipient or an agreed upon 3rd party so that the Recipient could contact you in case of a medical emergency with the child and so that you could contact the recipient or the 3rd party if you or one of your family members contracted an inheritable disease?

Would you contact the recipient/third party if you or one of your family fell ill with an inheritable disease?

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

Describe yourself as a child: (personality, health)

Describe your children's (if any) interests and personality:

What traits did you get from you mother? (physical, personality)

What traits did you get from your father? (physical, personality)

What personal standards to you strive to uphold?

What is the most influential experience in your life?

Whom do you most admire and why?

What are your hobbies, interests, and talents?

Describe your creative abilities, if any.

What are your favorite sports / recreational activities:

What are your career / educational goals?

What are your favorite books, works of art, and/or movies?

Do you speak any foreign languages?

If you could pass a message on to the couple you would be a donor for, what would that message be?

Are you willing to be an anonymous donor? ☐ Yes No ☐

Are you willing to meet the Intended Parent(s)? ☐ Yes No ☐

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

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

Are you willing to work with a gay or lesbian couple? ☐ Yes No ☐

Do you want to know the outcome of your donation? ☐ Yes No ☐

If offspring 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 ☐

I f you have delivered a child of your own, would you be interested in being a gestational surrogate carrier as part of our surrogacy program? ☐ Yes No ☐

How did you become aware of Jacquelyne Gorton Nurse Attorney, Inc.?

☐ Internet	Please Specify:	
☐ Newspaper Ad	Please Specify:	
☐ Newspaper/magazine article	Please Specify:	
☐ Friend/acquaintance	Name:	

Thank you for taking the time to complete this application!

I understand that any significant misrepresentation or omission is grounds for dismissal from the donor program and that I can then be held financially responsible for any lab, medical, or psychological costs involved in furtherance of the proposed donorship. I declare that all of the following information and statements made regarding myself and my family's health history are true and correct. The Following Ovum Donor Health History and Background form has been completed under penalty of perjury under the laws of the State of California.

Signature (first name only): Date:

Please e-mail or bring this completed health history form, consents, photos of yourself as a child, copies of transcripts, and driver's license to:

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