

Medical History form for Egg donors: Victoria Fertility Centre

Please could print this form and fax it to VFC at 250 704 0034

Please write clearly

Full Name: _____
(as on Care Card)

Date of Birth: _____
(day/month/year)

Care Card Number _____

Family Doctor _____

Home Address: _____
(include postal code)

e mail address _____

Phone number Home _____ Work _____
Cell _____

Name of your partner (as it appears on his care card)

Obstetrical History

Total number of pregnancies _____

Vaginal deliveries _____

C sections _____

Miscarriages _____

Tubal pregnancies _____

Therapeutic abortions _____

Gynecological History

Age when you had first period _____

Do you have regular cycles ? Yes or no _____
If you do not have a cycle every month – please explain

How long are your cycles ? (e.g. 28 days,25 days) _____

How many days do you usually bleed for _____

Do you spot for a few days before your period ? _____

Do you have pain with your periods ? _____

If yes – describe please _____

Do you have pain with intercourse ? _____

Have you had a Pap in the last year ? _____

Have you ever been treated for an abnormal Pap ? e.g. colposcopy, cryotherapy, laser, LEEP, Cone biopsy. If so, please give details and dates.

Have You ever been treated for Herpes, chlamydia, Gonorrhoea, syphilis, genital warts or trichomonas ? If so please indicate the dates you were treated.

Have you ever had a laparoscopy or hysteroscopy ? if yes – when, by whom, and what were the findings ?

Previous experience. If you have been an egg donor or have done IVF before – please could you explain below:

Personal History

How many years have you been with your current partner ? _____

What is your Occupation ? _____

Do you smoke cigarettes ? _____

Do you smoke Marijuana ? _____

Do you drink coffee ? (how much) _____

What exercise do you do ? _____

If yes, details please _____

Family History

Age and health of Mother _____

Age and health of Father _____

List siblings by age please _____

Is there any Family history of.....

Diabetes	Yes	No
Hypertension (high BP)	Yes	No
Connective tissue disease e.g. Lupus,rheumatoid	Yes	No
Blood clots i.e. Deep vein thrombosis	Yes	No
Stroke at a young age	Yes	No
Exposure to Diethyl stilboestrol (DES)	Yes	No
Alcoholism	Yes	No

Mental illness e.g. depression,schizophrenia,OCD	Yes	No
Genetic disorders		
e.g.Cystic fibrosis,Polycystic Kidneys,Downs etc	Yes	No
Cancer (any forms)	Yes	No
Neurological disorders.e.g Epilepsy	Yes	No
Recurrent miscarriages	Yes	No

If yes to any of the above – please describe in detail below.....

Past medical History

Do you have any ongoing medical problems

Do you have any allergies ? If you do please list these.

Are you allergic to Latex Yes No

Have you ever had any surgery before. Please list below:

Please list any medications (and vitamins) you are on (Include dosages)

Review of Current Health

Height _____

Weight _____

Body Mass Index. _____

(you can calculate your body mass index by going to this website..
www.nhlbisupport.com/bmi/)

Please describe any health problems or other concerns that you currently have.

Could you briefly explain how you became interested in being an egg donor ?
