Dominion Fertility and Endocrinology
46 South Glebe Road, Suite 301, Arlington VA 22204 • (703) 920-3890

How Did You Hear About Us? (Check one)

☐ Newspaper ☐ Magazine ☐ Friend ☐ Website _____
☐ Commercial ☐ Radio ☐ Doctor ☐ Other _____
☐ Internet ☐ Previous Patient ☐ Referral

PATIENT NAME:

_____

Address: _____ City: _____ State:_____

Zip:_____ Phone (Home):_____ Work: _____ Cell: _____

E-Mail: _____ ☐ Married ☐ Single

Social Security Number: _____ Date of Birth: _____

Patient Relationship to the Responsible Party: ☐ Self ☐ Spouse ☐ Child ☐ Other

Responsible Party Name: _____Responsible Party Signature: _____

Primary Care Physician: _____

Employer (Company): _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

PRIMARY INSURANCE COMPANY:_____

Address: _____ City: _____ State:_____

Zip: _____ Phone: _____ Subscriber Name: _____

Contact (ID) Number: _____ Group Name: _____

Group Number Patient's Relationship to Insured Party: ☐ Self ☐ Spouse ☐ Child ☐ Other

Copayment Amount: _____ Birth Date of Insured Party: _____

SECONDARY INSURANCE COMPANY:_____

Address: _____ City: _____ State:_____

Zip:_____ Phone: _____ Subscriber Name: _____

Contact (ID) Number: _____Group Name:_____

Group Number: _____ Patient's Relationship to Insured Party: ☐ Self ☐ Spouse ☐ Child ☐ Other

Copayment Amount: _____ Birth Date of Insured Party: _____

Patient's Signature: _____**Date:** _____

Dominion FERTILITY

Dominion Fertility and Endocrinology

DONOR INFORMATION AND MEDICAL HISTORY

46 South Glebe Road, Suite 301, Arlington VA 22204 • (703) 920-3890

Name: _____ Soc. Sec.#: _____ _____ _____

Maiden Name: _____ Email: _____

Date: _____ _____ _____ Home Phone: (_____, _____ _____

Address: _____ Cell Phone: (_____, _____ _____

_____ Work Phone: (_____, _____ _____

What is the best number at which to contact you? _____

Is it okay to leave you a message at this number? _____

Name of Emergency Contact Person: _____

Phone Number of Emergency Contact Person: _____

AD # _____(office use only)

REV 0512

Dominion FERTILITY

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DONOR INFORMATION AND MEDICAL HISTORY
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Donor #_____(office use only)

Please note, applications are shared with potential donor recipients.
Please do not disclose any identifiable information
i.e. place of work, name of college etc.

Birth date:_____ _____ _____ Age:_____ Marital Status:_____

Height:_____ Weight:_____ Blood Group & Rh:_____

Race:_____ Religion:_____ Ethnic Background: _____

Maternal Ancestry: _____ Paternal Ancestry: _____

Education (Check one):

☐ high school ☐ in college ☐ college degree ☐ 2-year degree GPA_____

Please list any extra-curricular activities you participated in during your high school years:

_____

Please list any special awards you received:

_____

What subjects did you enjoy most?_____

☐ advanced degree and GPA (please specify): _____

Please list any college/advanced degree awards you received: _____

_____

☐ specialized/ vocational/ technical training (please specify): _____

_____

SAT/GRE/LSAT/ACT Score: _____

Current Occupation: _____

Hair type: ☐ thin ☐ curly ☐ average ☐ wavy ☐ thick ☐ straight

Natural Hair Color:_____

Eye Color: _____

Complexion: ☐ fair ☐ medium ☐ dark ☐ freckled ☐ few ☐ many

Sun Exposure: ☐ tan ☐ burn

Body Build: ☐ small ☐ medium ☐ large

Adult Shape of Lips: ☐ thin ☐ medium ☐ full

Adult Shape of Mouth: ☐ small ☐ medium ☐ large

REV 0512

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Donor #_____ (office use only)

Any unique facial features (dimples, cleft chin, large smile, moles, large eyes) _____

_____

Adult Shape of Eyes:	☐ prominent/round	☐ almond	☐ hooded	☐ other _____
Adult Spacing of Eyes:	☐ wide set	☐ close set	☐ deep set	
Adult Size of Eyes:	☐ small	☐ medium	☐ large	
Adult Shape of Face:	☐ long	☐ oval	☐ round	☐ square
Forehead Set:	☐ low	☐ average	☐ high	
Adult Nose:	☐ straight	☐ round	☐ wide	
Adult Nose Profile:	☐ straight	☐ round	☐ bump	

Has anyone ever told you that you look like someone famous? If so, who? _____

_____

Shoe Size: _____

Dimensions: Bust: _____ Waist: _____ Hips: _____

Dress Size: _____

Did you wear braces? _____

Sexual Orientation: ☐ heterosexual ☐ bisexual ☐ lesbian

Are you right-handed or left-handed? ☐ right-handed ☐ left-handed

How would you describe your personality and character? _____

_____

_____

Have you ever been given a personality test and if so, what were the results? _____

_____

_____

How would you describe your childhood? _____

_____

What is your favorite childhood memory? _____

_____

What is your happiest moment and your hardest moment you have experienced to date in your life?

_____

What do you like to do in your spare time? _____

_____

What are your plans/goals for your future? _____

_____

Donor #_____(office use only)

What are you most proud of? _____

_____

_____

_____

Who is the most influential person in your life and why? _____

_____

_____

_____

What hobbies do you enjoy? _____

_____

_____

_____

Do you have any special musical/artistic/athletic/culinary or other talents? _____

_____

_____

_____

What is your favorite color: _____ food: _____

book: _____ movie: _____quote: _____

music: _____ season: _____

Why do you want to be a donor?_____

_____

_____

_____

_____

Is there anything else you would like a potential recipient to know about you?

_____

_____

_____

_____

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Donor #_____(office use only)

Please think carefully as you answer the following questions.
It is essential that your medical history be as accurate and complete as possible.

FERTILITY:

Have you ever been pregnant before? ☐ yes ☐ no
Number of abortions:_____Number of miscarriages:_____ Number of children: _____
If you have children, do they have any health problems? ☐ yes ☐ no
If yes, please specify: _____
Have you ever donated eggs before? ☐ yes ☐ no
If yes, when and where? _____

PERSONAL HEALTH:

Vision (uncorrected): ☐ poor ☐ fair ☐ good ☐ excellent
Do you wear glasses/contact lenses? ☐ yes ☐ no
Are you: ☐ near sighted ☐ farsighted ☐ other, please specify:_____

Hearing: Normal? ☐ yes ☐ no If no, please specify: _____

_____

Have you ever had surgery? ☐ yes ☐ no If yes, please explain_____

_____

_____

Have you been hospitalized for other reasons? ☐ yes ☐ no If yes, please explain: _____

_____

_____

Have you ever had any major illnesses: ☐ yes ☐ no If yes, please explain: _____

_____

_____

Are you currently taking any medications? ☐ yes ☐ no If yes, please explain: _____

_____

_____

What medications have you been on in the past?_____

_____

Do you have any food allergies? If so, please list: _____

_____

Do you have any environmental allergies? If so, please list:_____

_____

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Donor #_____(office use only)

Do you currently use any of the following?
(this information is strictly confidential):

- ☐ marijuana
- ☐ amphetamines
- ☐ cocaine
- ☐ hallucinogens
- ☐ barbiturates
- ☐ tranquilizers
- ☐ narcotics (heroin, methadone)

Do you drink alcohol?

- ☐ never
- ☐ occasionally
- ☐ frequently

Do you smoke cigarettes? ☐ yes ☐ no
If yes, how much? _____

Have you had any of the following?

- ☐ blood transfusion
- ☐ major radiation or x-ray exposure
- ☐ syphilis
- ☐ gonorrhea
- ☐ non-specific urethritis
- ☐ venereal warts
- ☐ herpes
- ☐ chlamydia
- ☐ other sexually transmitted diseases _____

In the past six months have you been exposed to:

- ☐ toxic chemicals _____
- ☐ sprays _____
- ☐ fumes/exhaust _____
- ☐ radiation
- ☐ flea powders/sprays
- ☐ lead or lead products
- ☐ asbestos/asbestos products
- ☐ other toxic products (please specify) _____

Have you had any tattoos, ear or body piercings within the past year? ☐ yes ☐ no
If yes, when? _____

Are your family members generally:

- ☐ taller than average
- ☐ shorter than average
- ☐ of average height

Have any of your relatives had more than one miscarriage, any stillbirths or early childhood deaths? ☐ yes ☐ no
If yes, please explain that person's relationship to you, the cause(s) of their child(ren)'s death(s) and the child(ren)'s age(s) at death: _____

_____

_____

Have any of your family members had one or more children with serious birth defects?

- ☐ yes If yes, please specify: _____
- ☐ no _____

_____

Donor #_____(office use only)

Please provide the following information on your family members:

Relationship	Age if living	Age at death	Cause of death	Height	Weight	Hair Color	Eye Color	Health Problems
Paternal Grandfather								
Paternal Grandmother								
Maternal Grandfather								
Maternal Grandmother								
Father								
Mother								
Brother #1								
#2								
#3								
#4								
Sister #1								
#2								
#3								
#4								
Child #1								
#2								
#3								
#4								
Paternal Uncles								
Paternal Aunts								
Maternal Uncles								
Maternal Aunts								

Donor #_____(office use only)

Dominion FERTILITY

FAMILY HISTORY

Look through the list of medical problems and indicate which ones you or your relatives have had:

Medical Problem	You	Mother	Father	Sibling	Grand-parents	Aunts/ Uncles	Cousins
Stroke	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐
Hardening of the Arteries	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐	☐	☐
Hemophilia/Bleeding Problem	☐	☐	☐	☐	☐	☐	☐
Leukemia	☐	☐	☐	☐	☐	☐	☐
Immune Deficiency Disorder	☐	☐	☐	☐	☐	☐	☐
Thalassemia	☐	☐	☐	☐	☐	☐	☐
Tay-Sachs	☐	☐	☐	☐	☐	☐	☐
Sickle Cell	☐	☐	☐	☐	☐	☐	☐
Hay Fever	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐
Emphysema	☐	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐	☐
Lung Cancer	☐	☐	☐	☐	☐	☐	☐
Other Lung Disease	☐	☐	☐	☐	☐	☐	☐
Ulcer of Duodenum or Stomach	☐	☐	☐	☐	☐	☐	☐
Gallstones	☐	☐	☐	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐	☐	☐	☐
Pyloric Stenosis	☐	☐	☐	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐	☐	☐	☐
Ulcerative Colitis	☐	☐	☐	☐	☐	☐	☐
Crohn's Disease	☐	☐	☐	☐	☐	☐	☐
Intestinal Cancer	☐	☐	☐	☐	☐	☐	☐
Other Cancer of Digestive System	☐	☐	☐	☐	☐	☐	☐
Other Digestive Disease	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐	☐
Other Endocrine Disease	☐	☐	☐	☐	☐	☐	☐
Cleft lip or palate	☐	☐	☐	☐	☐	☐	☐
Club foot	☐	☐	☐	☐	☐	☐	☐
Congenital Heart Disease	☐	☐	☐	☐	☐	☐	☐
Other Birth Defects	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐
Other Urinary Tract Disease	☐	☐	☐	☐	☐	☐	☐
Undescended Testicle	☐	☐	☐	☐	☐	☐	☐

FAMILY HISTORY (Continued)

Look through the list of medical problems and indicate which ones you or your relatives have had:

Medical Problem	You	Mother	Father	Sibling	Grand-parents	Aunts/ Uncles	Cousins
Hypospadiasis	☐	☐	☐	☐	☐	☐	☐
Prostate Cancer	☐	☐	☐	☐	☐	☐	☐
Uterine Fibroids	☐	☐	☐	☐	☐	☐	☐
Cancer of Cervix, Ovaries, or Uterus	☐	☐	☐	☐	☐	☐	☐
Mental Retardation	☐	☐	☐	☐	☐	☐	☐
Down's Syndrome	☐	☐	☐	☐	☐	☐	☐
Senility Before Age 50	☐	☐	☐	☐	☐	☐	☐
Mental Disorder (Hospitalization)	☐	☐	☐	☐	☐	☐	☐
Crippling Disorders	☐	☐	☐	☐	☐	☐	☐
Schizophrenia	☐	☐	☐	☐	☐	☐	☐
Manic Depressive Disorder	☐	☐	☐	☐	☐	☐	☐
Other Mental Disorder (Hospitalized)	☐	☐	☐	☐	☐	☐	☐
Multiple Sclerosis	☐	☐	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐	☐	☐
Hydrocephalus (Water on the Brain)	☐	☐	☐	☐	☐	☐	☐
Spinal Cord Disorders	☐	☐	☐	☐	☐	☐	☐
Huntington's Chorea	☐	☐	☐	☐	☐	☐	☐
Other Nervous System Disorders	☐	☐	☐	☐	☐	☐	☐
Deafness Before Age 50	☐	☐	☐	☐	☐	☐	☐
Cataracts Before Age 50	☐	☐	☐	☐	☐	☐	☐
Blindness	☐	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐	☐
Muscular Dystrophy	☐	☐	☐	☐	☐	☐	☐
Other Chronic Muscle Diseases	☐	☐	☐	☐	☐	☐	☐
Spina Bifida/Other Spinal Deformity	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐
Hereditary Low Back Disease	☐	☐	☐	☐	☐	☐	☐
Eczema	☐	☐	☐	☐	☐	☐	☐
Skin Cancer	☐	☐	☐	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐	☐	☐	☐
Other Cancer Not Mentioned Above	☐	☐	☐	☐	☐	☐	☐
Alcohol Related Problem	☐	☐	☐	☐	☐	☐	☐
ADD/ADHD	☐	☐	☐	☐	☐	☐	☐
Other (please list below):	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐

Dominion FERTILITY

Dominion Fertility and Endocrinology
PATIENT INFORMATION QUESTIONNAIRE
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Women's History

1. PATIENT NAME:_____ **2.** _____
LAST FIRST

3. Birth date: _____ **4.** Age: _____ **5.** Height:_____**6.** Weight _____

7. Occupation _____

8) MEDICAL PROBLEMS: (Please check as many as are appropriate)

- ☐ a. never had periods
- ☐ b. stopped having periods
- ☐ c. irregular periods
- ☐ d. pelvic pain
- ☐ e. bleeding between periods
- ☐ f. heavy periods (usually so)
- ☐ g. usually light periods
- ☐ h. cannot get pregnant
- ☐ i. have never been pregnant
- ☐ j. have been pregnant before, but not now
- ☐ k. can get pregnant, but lose the pregnancy
- ☐ l. have had tubes tied, cut, or burnt, and want them reversed
- ☐ m. breast problems (discharge, lumps or pain)
- ☐ n. overweight
- ☐ o. underweight (according to your relatives or friends)
- ☐ p. excess hair on face and/or body
- ☐ q. other gynecological problem (see below)

9. If you checked q, please give details: _____

_____

_____

OTHER RELEVANT HISTORY: (Please select any appropriate answers)

10. Do you exercise: ☐ not at all ☐ occasionally ☐ moderately ☐ strenuously and regularly?
11. Do you train strenuously for competitive sports (including dance)? ☐ yes ☐ no
12. Do you: ☐ smoke tobacco? ☐ use marijuana? ☐ drink at least one alcoholic beverage per day?
13. Medications that you are currently taking (including vitamins):

_____

_____

14. List any other physician you see, along with their specialty:

_____

_____

15. List any known allergies:

_____

16. Age you first noticed breast development : _____
17. Age you first noticed pubic hair:_____
18. Age when you had your first period: _____
19. Did your mother take hormones when she was pregnant with you? ☐ yes ☐ no
    If yes, which hormone? _____
20. How many days from the beginning of one period to the next (usually)? _____

21. Can you tell a period is coming? ☐ yes ☐ no

22. If yes, how?

☐ a. breast tenderness
☐ b. personality changes
☐ c. pelvic fullness
☐ d. swelling of ankles or wrists
☐ e. headaches

23. Do you have: ☐ bleeding between periods? ☐ heavy flow, making you weak? ☐ scanty, almost absent flow?

24. Date of last menstrual period (month/date/year) _____

25. If periods are irregular, how many months can you go without one? _____

26. If you have pain, is it worse: ☐ before the period? ☐ during? ☐ or after?

27. What medication do you take to help the pain? _____Does it help? _____

28. If your problem is lack of periods, do you have

☐ a. hot flashes
☐ b. vaginal dryness (discomfort with intercourse)
☐ c. vaginal spotting

29. Do you take hormones? ☐ yes ☐ no

If yes, which hormones? _____

30. Other comments on your periods, not covered above: _____

_____

_____

31. Name of regular gynecologist? _____

32. Have you had an abnormal "Pap" smear? ☐ yes ☐ no

If yes, was this treated by biopsy antibiotics freezing of cervix cautery of cervix other surgery?

33. Date of last "Pap" smear: _____ Normal? ☐ yes ☐ no

34. Have you ever had a tubal infection? ☐ yes ☐ no

35. If more than once, how many times? _____

36. Were you treated with antibiotics? ☐ yes ☐ no

37. Were you ever hospitalized for a tubal Infection(s)? ☐ yes ☐ no

38. How old were you when you had the infection(s)? _____

39. Have you had gonorrhea? ☐ yes ☐ no If yes, at what age? _____

40. Have you had syphilis? ☐ yes ☐ no If yes, at what age? _____

PREVIOUS PREGNANCIES:

Please list all, including miscarriages and abortions. List the date of delivery or abortion, the number of months pregnant, select the outcome (vaginal, cesarean section, miscarriage, or voluntary abortion) and whether or not there were postpartum complications, such as infection or fever.

	Date	Months	Outcome	Complications
41.		42.	43.	44.
45.		46.	47.	48.
49.		50.	51.	52.

53. Comments, if not able to list above: _____

_____

54. Pills, if used, were taken:

- ☐ a. less than one year
- ☐ b. 1-2 years
- ☐ c. 2-5 years
- ☐ d. greater than five years

55. Did you have complications attributed to the pill?

- ☐ a. irregular or absent periods
- ☐ b. stroke or heart disease
- ☐ c. high blood pressure
- ☐ d. diabetes
- ☐ e. other

56. IUD, if used, was in place from:

_____ to _____ and ;

_____ to _____

57. Problems with IUD included:

- ☐ a. abnormal bleeding requiring removal of IUD
- ☐ b. perforation of the uterus, requiring surgery
- ☐ c. pregnancy with the IUD, carried to term (delivery)
- ☐ d. infection requiring removal of IUD
- ☐ e. pregnancy with the IUD with subsequent abortion
- ☐ f. none

58. Other methods of contraception used include:

- ☐ a. diaphragm
- ☐ b. condom
- ☐ c. foam
- ☐ d. cervical cap
- ☐ e. rhythm

59. Previous abdominal surgeries (please select any which are appropriate and fill in the date):

- ☐ a. tuboplasty _____
- ☐ b. removal of fibroids _____
- ☐ c. hysterectomy _____
- ☐ d. removal of biopsy of ovary(s) _____
- ☐ e. appendectomy _____
- ☐ f. intestinal surgery _____
- ☐ g. removal of tube _____
- ☐ h. clearing of adhesion(scar tissue)_____
- ☐ i. sterilization by laparoscopy _____
- ☐ j. sterilization by other technique_____

60. Other surgery, not listed above: _____

_____

61. List all medications you take, prescription and non-prescription: _____

_____

_____

_____

62. List any significant medical conditions for which you are being treated:_____

_____

_____

_____

_____

63. If you have problems with any of the following, please select the appropriate letter:

- ☐ a. headache, convulsions, stroke
- ☐ b. sinus problems, nosebleed, hearing problems
- ☐ c. difficulty swallowing or talking
- ☐ d. asthma, TB, coughing blood, pneumonia, chronic cough
- ☐ e. heart problems, murmurs, irregular heartbeat, rheumatic fever
- ☐ f. digestion problems, nausea, vomiting, ulcers, jaundice, diarrhea, black bowel movements, constipation
- ☐ g. kidney infections, bladder infections, kidney stones, blood in your urine
- ☐ h. loss of urine(incontinence)
- ☐ i. bone or joint pain(arthritis)
- ☐ j. skin problems(acne, excess hair)
- ☐ k. nervous problem(anxiety, depression)
- ☐ l. easy bruising, bleeding doesn't stop easily
- ☐ m. diabetes, thyroid problems

64. How many times a week do you have intercourse (on average):

65. Intercourse is painful ☐ occasionally ☐ frequently ☐ usually ☐ ever

66. If you have pain, is it: ☐ in the vagina ☐ deeper inside ☐ towards the front ☐ inside, toward the back (near the rectum)

67. The pain has been present: ☐ less than one year ☐ 1-3 years ☐ 4-5 years ☐ greater than 5 years

68. Have you been treated with medicine or surgery for the pain: ☐ yes ☐ no

If yes, with what?_____

69. Percent of time you have orgasm with intercourse: ☐ 0% ☐ 25% ☐ 50% ☐ 75% ☐ greater than 75%

70. Other issues you wish to discuss:

Dominion Fertility and Endocrinology

FDA SCREENING QUESTIONNAIRE

46 South Glebe Road, Suite 301, Arlington VA 22204 • (703) 920-3890

Patient _____ ☐ **Egg Donor** ☐ **Genetic Parent**

FDA Screening Questions	Yes	No	Don't Know	Comments
1. Have you injected drugs for a non-medical reason in the last 5 years, including intravenous, intramuscular, or subcutaneous injection?	☐	☐	☐	
2. Do you have a clotting disorder for which you have received human-derived clotting factor concentration?	☐	☐	☐	
3. Have you had sex for drugs or money in the past 5 years?	☐	☐	☐	
4. In the past 12 months, have you given money or drugs to anyone to have sex with you?	☐	☐	☐	
5. Have you had sex in the past 12 months with anyone who would answer yes to the above 4 questions?	☐	☐	☐	
6. Female: In the past 12 months, have you had sex with a man who has had sex with another man in the past 5 years? Male: Have you had sex with another male in the past 5 years?	☐	☐	☐	
7. In the past 12 months, have you had sex with a person known or suspected to have HIV, or active hepatitis B or C?	☐	☐	☐	
8. In the past 12 months, have you been exposed to known or suspected HIV, hepatitis B, and/or hepatitis C infected blood through pericutaneous inoculation, contact with an open wound, non-intact skin, or mucous membrane?	☐	☐	☐	
9. In the past 12 months, have you been in close contact (i.e., sharing kitchen and bathroom) with a person having activeviral hepatitis?	☐	☐	☐	
10. In the past 12 months, have you had tattooing, ear or body piercing in which shared instruments were used?	☐	☐	☐	
11. After the age of 11, have you ever had viral hepatitis (Hep A excluded: IgM anti-HAV test)?	☐	☐	☐	
12. Have you yourself received or had intimate contact (i.e., exchanged body fluids, including sharing toothbrushes and razors) with someone who has received organs or cells from non-human sources?	☐	☐	☐	
13. Have you had a recent smallpox vaccination?	☐	☐	☐	
14. In the past 4 weeks have you had any shots or vaccinations?	☐	☐	☐	
15. Have you been diagnosed with West Nile Virus?	☐	☐	☐	
16. In the past 12 months have you been diagnosed or treated for Chlamydia or Gonorrhea?	☐	☐	☐	
17. Have you had a blood transfusion or infusion within the past 48 hours before your blood test for eligibility?	☐	☐	☐	
18. Have you ever received growth hormone made from human pituitary glands?	☐	☐	☐	
19. Have you ever received a dura mater (brain covering) graft?	☐	☐	☐	
20. Have you or any of you blood relatives ever been diagnosed with dementia resulting from Creutzfeldt-Jakob disease or any other infection?	☐	☐	☐	
21. In the past 12 months, have you had a positive syphilis test?	☐	☐	☐	

Dominion Fertility and Endocrinology

FDA SCREENING QUESTIONNAIRE

46 South Glebe Road, Suite 301, Arlington VA 22204 • (703) 920-3890

Patient _____ ☐ **Egg Donor** ☐ **Genetic Parent**

FDA Screening Questions	Yes	No	Don't Know	Comments
22. In the past 12 months, have you had or been treated for syphilis or gonorrhea?	☐	☐	☐	
23. In the past 12 months, have you been in jail for more than 3 days in a row?	☐	☐	☐	
24. In the past three years have you been outside the United States or Canada?	☐	☐	☐	
25. Between 1980 and 1996, did you spend three months or more cumulatively in the United Kingdom?	☐	☐	☐	
26. Since 1980, have you lived cumulatively for five or more years in Europe? (Includes: England, Ireland, Scotland, Wales, the Isle of Man, the Channel Islands, Gibraltar, or the Falkland Islands)	☐	☐	☐	
27. Are you a member of the US military or a civilian military employee, or a dependent of a military member or civilian employee who resided at a US military base in Northern Europe (Germany, UK, Belgium, Netherlands) or elsewhere in Europe (Greece, Turkey, Spain, Portugal, Italy) for 6 months or more from 1980 – 1996?	☐	☐	☐	
28. Have you been in a place affected by SARS or with an affected person within the past 14 days?	☐	☐	☐	
29. Have you been treated for SARS in the last 28 days?	☐	☐	☐	
30. Were you born in, have you lived in, or have you traveled to any African country since 1977?	☐	☐	☐	
31. When you traveled to _____, did you receive a blood transfusion or any other medical treatment with a product made from blood?	☐	☐	☐	
32. Have you had sexual contact with anyone who was born in or lived in any African country since 1977?	☐	☐	☐	
33 Have you had any illnesses, surgeries, or other significant changes in your health since your last egg donation?	☐	☐	☐	

Patient's Name: _____ Date: _____
SIGNATURE

Witness: _____ _____ Date: _____
PRINT NAME SIGNATURE

Date Reviewed: _____ Signature: _____

Eligibility Determination: ☐ Eligible ☐ Ineligible

REV 0512

HIPAA Notice of Privacy Practices

Please review this notice carefully. It describes how medical information about you may be used and disclosed and how you can get access to this information.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. As another example, your protected health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for hospital admission.

Healthcare operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

Use required by law: We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law; Public Health issues as required by law; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners; Funeral Directors; and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures. Under the law, we must make disclosures to you and when, required by the Secretary of the Department of Health and Human Services, to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance to the use or disclosure indicated in the authorization.

HIPAA Notice of Privacy Practices

Your Rights

The following is a statement of you rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

You have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, or your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our HIPAA Compliance Officer of your complaint. We will not retaliate against your for filing a complaint.

This notice was published and becomes effective on April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main number.

Signature Below is only an acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature: _____ Date: _____