Health Questionnaire for potential Egg and Sperm Donors

Herts & Essex Fertility Centre

Name: ……..…… Date of birth: ……..……

Address: ……..……

……..

Telephone Number: …… Email: ……..

Medical history

1. Have you or any member of your immediate family ever had a heart attack, and if so at what age?
   ……..
2. Is there any history of heart disease in your family?
   ……
3. Do you, or any of your family take medication for high blood pressure?
   ……
4. Is there any history of kidney disorders in your family
   ……
5. Has anyone in your family been born with a cleft palate?
   ……
6. Do you or any member of immediate family have any mental health issues such as bipolar disorder or schizophrenia?
   ……
7. Do you or anyone in your family suffer from epilepsy?
   ……
8. Is there any history of Multiple Sclerosis in your family?
   ……
9. Is there any history of Parkinson's disease in your family?
   ……

10. Do you know of any other inheritable illnesses or diseases that either you or any member of your family suffers from?

    ……

11. Have you ever donated previously at another clinic?

    ……

12. Has anyone in your family had cancer? If so please give details

    ……

13. Do you or anyone in your family suffer from diabetes, and if so what type?

    ……

14. Have you been in an area affected by the ebola virus in the last 9 months?

    ……

15. Do you smoke currently? Yes □ No □

16. Did you smoke in the past? Yes □ No □

    If yes, when did you stop? ……..

17. Recreational drug use now/ in the past? Yes □ No □

    If yes,please specify ……

Signed: …… Date: ……

GP consent

I confirm that I am the General Practitioner for the above named patient. I hereby certify that, to my knowledge, the medical history provided on this form is correct.

Signed: …… Date: ……

Print name……..

GP official stamp