The RENEW Biobank
Reproductive Material Donation Form

IVF Clinic:

Donor Information:

Egg Donor Last Name:	Sperm Donor Last Name:
Egg Donor First Name:	Sperm Donor First Name:
Egg Donor DOB:	Sperm Donor DOB:
Ethnicity: ☐ Hispanic or Latinx ☐ Not Hispanic or Latinx ☐ Other	**Ethnicity:** ☐ Hispanic or Latinx ☐ Not Hispanic or Latinx ☐ Other
Race (check as many as apply): ☐ Asian ☐ Black or African American ☐ White ☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander ☐ Middle Eastern/North African ☐ Other Please specify if other: Please check as many as apply if you selected "Asian": ☐ East Asian (China, Hong Kong, Japan, South Korea, Mongolia, Taiwan, Macau) ☐ South Asian (India, Pakistan, Bangladesh, Nepal, Maldives, Bhutan, Sri Lanka) ☐ Southeast Asian (Vietnam, Cambodia, Thailand, Indonesia, Laos, Myanmar, Malaysia, Singapore, the Philippines, Brunei, Timor-Leste) ☐ Other	**Race (check as many as apply):** ☐ Asian ☐ Black or African American ☐ White ☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander ☐ Middle Eastern/North African ☐ Other Please specify if other: Please check as many as apply if you selected "Asian": ☐ East Asian (China, Hong Kong, Japan, South Korea, Mongolia, Taiwan, Macau) ☐ South Asian (India, Pakistan, Bangladesh, Nepal, Maldives, Bhutan, Sri Lanka) ☐ Southeast Asian (Vietnam, Cambodia, Thailand, Indonesia, Laos, Myanmar, Malaysia, Singapore, the Philippines, Brunei, Timor-Leste) ☐ Other
Gender: ☐ Male (cisgender) ☐ Female (cisgender) ☐ Male (transgender, identifies as male and assigned female at birth) ☐ Female (transgender, identifies as female and assigned male at birth) ☐ Genderqueer/non-binary/gender non-conforming individual who was assigned female at birth ☐ Genderqueer/non-binary/gender non-conforming individual who was assigned male at birth ☐ Genderqueer/non-binary/gender non-conforming individual who is intersex (biological sex considered ambiguous) ☐ Other ☐ Choose not to disclose	**Gender:** ☐ Male (cisgender) ☐ Female (cisgender) ☐ Male (transgender, identifies as male and assigned female at birth) ☐ Female (transgender, identifies as female and assigned male at birth) ☐ Genderqueer/non-binary/gender non-conforming individual who was assigned female at birth ☐ Genderqueer/non-binary/gender non-conforming individual who was assigned male at birth ☐ Genderqueer/non-binary/gender non-conforming individual who is intersex (biological sex considered ambiguous) ☐ Other ☐ Choose not to disclose

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Please specify if other:	Please specify if other:
Sexual Orientation: ☐ Heterosexual/straight ☐ Homosexual/gay or lesbian ☐ Bisexual ☐ Pansexual ☐ Asexual ☐ Queer ☐ Questioning ☐ Other ☐ Choose not to disclose Please specify if other:	**Sexual Orientation:** ☐ Heterosexual/straight ☐ Homosexual/gay or lesbian ☐ Bisexual ☐ Pansexual ☐ Asexual ☐ Queer ☐ Questioning ☐ Other ☐ Choose not to disclose Please specify if other:
Religious Affiliation: ☐ Buddhist ☐ Christian (please specify sect): ☐ Hindu ☐ Jewish ☐ Muslim ☐ Not religious/atheist ☐ Other not listed ☐ Choose not to disclose Please specify if other:	**Religious Affiliation:** ☐ Buddhist ☐ Christian (please specify sect): ☐ Hindu ☐ Jewish ☐ Muslim ☐ Not religious/atheist ☐ Other not listed ☐ Choose not to disclose Please specify if other:
Highest Level of Education Completed: ☐ Less than High School ☐ High School ☐ Some College ☐ Bachelor's Degree ☐ Master's Degree ☐ Doctoral/Professional Degree (PhD, MD, JD) ☐ Other ☐ Choose not to disclose Please specify if other:	**Highest Level of Education Completed:** ☐ Less than High School ☐ High School ☐ Some College ☐ Bachelor's Degree ☐ Master's Degree ☐ Doctoral/Professional Degree (PhD, MD, JD) ☐ Other ☐ Choose not to disclose Please specify if other:
On a scale of 1-5 (5 being the most difficult), how difficult was your decision to donate? (circle one option) **1 2 3 4 5**	**On a scale of 1-5 (5 being the most difficult), how difficult was your decision to donate? (circle one option)** **1 2 3 4 5**
If you did not have the option to donate your embryos to research what would be your second choice? ☐ Continue to store the embryos ☐ Donate the embryos to another couple ☐ Discard the embryos ☐ Other Please specify if other:	**If you did not have the option to donate your embryos to research what would be your second choice?** ☐ Continue to store the embryos ☐ Donate the embryos to another couple ☐ Discard the embryos ☐ Other Please specify if other:
When you created your embryos, did you feel adequately counseled regarding what to do with embryos still in storage upon completion of your	**When you created your embryos, did you feel adequately counseled regarding what to do with embryos still in storage upon completion of your**

Questions? Please Contact:
Anjali Wignarajah, Clinical Research Coordinator Associate, Office: (650) 721-2259, Email: kawignar@stanford.edu

fertility treatment? Please rate the quality of your counseling on a scale of 1-5 (5 being the best). (circle one option) **1 2 3 4 5**	**fertility treatment? Please rate the quality of your counseling on a scale of 1-5 (5 being the best). (circle one option)** **1 2 3 4 5**
Do you think that you would have benefitted from additional counseling throughout your treatment regarding what to do with embryos in storage upon completion of your fertility treatment? Please rate the degree to which you believe you would have benefitted from additional counseling on a scale of 1-5 (5 being the largest benefit). (circle one option) **1 2 3 4 5**	**Do you think that you would have benefitted from additional counseling throughout your treatment regarding what to do with embryos in storage upon completion of your fertility treatment? Please rate the degree to which you believe you would have benefitted from additional counseling on a scale of 1-5 (5 being the largest benefit). (circle one option)** **1 2 3 4 5**

Infertility History

How long did you and your partner attempt to achieve pregnancy prior to seeking infertility treatment? ____________________ (years & months)

Cause of infertility (Please select yes to all that apply)

Diminished Ovarian Reserve	☐ Yes ☐ No
Fertility Preservation	☐ Yes ☐ No
History of Endometriosis	☐ Yes ☐ No
Hypothalamic Amenorrhea	☐ Yes ☐ No
Indication for use of Gestational Carrier	☐ Yes ☐ No
Male Infertility	☐ Yes ☐ No
Other Ovulation Disorders	☐ Yes ☐ No
Polycystic Ovarian Syndrome	☐ Yes ☐ No
Recurrent Pregnancy Loss	☐ Yes ☐ No
Tubal Factor	☐ Yes ☐ No
Unexplained Infertility	☐ Yes ☐ No
Uterine Factor	☐ Yes ☐ No
Not Applicable	☐ Yes ☐ No
Other; specify:	

Total Number of Previous Intrauterine Insemination (IUI) Cycles	________	(no. of previous IUI cycles)
Total Number of Previous Egg Retrievals	________	(no. of previous egg retrievals)
Total Number of Previous Embryo Transfers	________	(no. of previous embryo transfers)
Total Number of Pregnancies	________	(no. of pregnancies)

Total Number of Miscarriages ________ (no. of losses)

Total Number of Live Births ________ (no. of deliveries $\geq$ 28 weeks of gestation)

Egg Donor Medical History

Do you have or have you ever had (check all that apply):

- ☐ Arthritis
- ☐ Autoimmune disease (eg. Lupus, rheumatoid arthritis)
- ☐ Chronic bronchitis
- ☐ Chronic headaches
- ☐ Cancer? (Specify: __________________________)
- ☐ Cystic fibrosis
- ☐ Diabetes
- ☐ Endometriosis
- ☐ Gallbladder disease
- ☐ Heart disease
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Kidney problems
- ☐ Liver problems
- ☐ Neurological problems
- ☐ Psychiatric problems
- ☐ Seizures
- ☐ Thyroid problems

Any other health problems or symptoms? ____

Are you allergic to any medications? ☐ Yes ☐ No

If yes, please indicate name of medication and reaction to it:

Have you ever had any surgeries in the past? ☐ Yes ☐ No

If yes, please indicate date, type, findings of surgery:

Egg Donor Family History

Have any of these illnesses occurred in your family? Check all that apply and indicate relationship to you:

Illness:	**Relationship to you:**	**Illness:**	**Relationship to you:**
☐ High blood pressure		☐ Parkinson's	
☐ Diabetes		☐ Alzheimer's	
☐ Heart disease		☐ Cystic fibrosis	
☐ Cancer *(Please Specify Type)* ________________________		☐ Other	

Sperm Donor Medical History

Do you have or have you ever had (check all that apply):

- ☐ Arthritis
- ☐ Autoimmune disease (eg. Lupus, rheumatoid arthritis)
- ☐ Heart disease
- ☐ Hepatitis

- ☐ Chronic bronchitis
- ☐ Chronic headaches
- ☐ Cancer? (Specify: _________________________)
- ☐ Cystic fibrosis
- ☐ Diabetes
- ☐ Endometriosis
- ☐ Gallbladder disease
- ☐ High blood pressure
- ☐ Kidney problems
- ☐ Liver problems
- ☐ Neurological problems
- ☐ Psychiatric problems
- ☐ Seizures
- ☐ Thyroid problems

Any other health problems or symptoms? ____

Are you allergic to any medications? ☐ Yes ☐ No

If yes, please indicate name of medication and reaction to it:

Have you ever had any surgeries in the past? ☐ Yes ☐ No

If yes, please indicate date, type, findings of surgery:

Sperm Donor Family History

Have any of these illnesses occurred in your family? Check all that apply and indicate relationship to you:

Illness:	**Relationship to you:**	**Illness:**	**Relationship to you:**
☐ High blood pressure		☐ Parkinson’s	
☐ Diabetes		☐ Alzheimer’s	
☐ Heart disease		☐ Cystic fibrosis	
☐ Cancer *(Please Specify Type)* ________________________		☐ Other	

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