



[info@donatedeggs.com](mailto:info@donatedeggs.com)

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Castle Rock, CO 80104  
Tel: (720) 733-0184  
Fax: (720) 733-2433

Today's Date: \_\_\_\_\_

**RECIPIENT QUESTIONNAIRE**  
**(Please attach 2 recent photos of IM and IF)**

**How did you hear about our agency?** (If internet, please specify site): \_\_\_\_\_

Intended Mother: \_\_\_\_\_ DOB: \_\_\_\_\_

Intended Mother SS#: \_\_\_\_\_ Age: \_\_\_\_\_

Intended Father: \_\_\_\_\_ DOB: \_\_\_\_\_

Intended Father: SS#: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Intended Mother Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Intended Mother Email: \_\_\_\_\_

Intended Father Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Intended Father Email: \_\_\_\_\_

How often do you check your email? All day ( ) Once a day ( ) Weekly ( ) Rarely ( )

Are you Married? Yes No If So: Ceremonial or Common Law

How many years have you been together / married? \_\_\_\_\_

Emergency Contact Info: Name: \_\_\_\_\_ Phone: \_\_\_\_\_

May we leave detailed messages? Home ( ) Work ( ) Cell ( )

**Occupations:**

Intended Mother: \_\_\_\_\_

Intended Father: \_\_\_\_\_

Does your insurance cover any of the donor/IVF process? Yes No Unsure

If yes, please state the coverage for you and your donor: \_\_\_\_\_

**Name of Fertility Clinic:** \_\_\_\_\_ **Name of Doctor:** \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Email: \_\_\_\_\_ Best Contact Person: \_\_\_\_\_

**Name of your Attorney:** \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Email: \_\_\_\_\_

<b><u>Physical Characteristics:</u></b>	<i>(Intended Mother)</i>	<i>(Intended Father)</i>
Natural Hair Color:	_____	_____
Hair Texture/Type:	_____	_____
Eye Color:	_____	_____
Complexion:	_____	_____
Height:	_____	_____
Current Weight:	_____	_____
Build:	_____	_____
Blood Type (if known):	_____	_____
Birthplace:	_____	_____
Ancestry:	_____	_____
Religion:	_____	_____
Children & Ages:	_____	_____

<b><u>Education:</u></b>		
High School:	_____	_____
College:	_____	_____
Years Completed:	_____	_____
Degrees & Dates:	_____	_____

**Personal History:**

Please describe infertility history below:

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What genetic/health problems are of most concern when choosing your egg donor?

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How many cycles of IVF have you undergone using your own eggs? \_\_\_\_\_

How many donor IVF cycles have you undergone? \_\_\_\_\_

**LIST THE DONOR CHARACTERISTICS YOU:**

REQUIRE

DESIRE

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**If the donor agrees, are you interested in:** Meeting your donor in person? Yes No Maybe

Talking on the phone? Yes No Maybe

Emailing each other? Yes No Maybe

**Please write a brief description of Intended Mother’s personality and temperament:**

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**Please write a brief description of Intended Father’s personality and temperament:**

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**What hobbies do you/your family enjoy?**

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**How soon are you hoping to cycle?** \_\_\_\_\_

**Credit Card Info**

**Name on Card:** \_\_\_\_\_

**Credit Card Number:** \_\_\_\_\_ **Type:** Visa    MasterCard

**Expiration:** \_\_\_\_\_ **Security Number on back:** \_\_\_\_\_

(To be used for outside monitoring costs (if applicable), donor mailings, copies, faxing, travel costs, miscellaneous medications donor may be instructed to purchase. ) All receipts will be provided.

## **RECIPIENT BIO**

We would like to give you an opportunity to tell your donor a little about yourself. Please use this space to share your story with her. Please refrain from using your last names or any other identifying information, as this will be forwarded to her for her review and decision to donate for you. Thank You!