NURTURING LIVES

TURNING DREAMS INTO FAMILIES

Nurturing Lives
790 E. Colorado Blvd 9th Floor
Pasadena, CA 91101

Egg Donation Application
捐卵者申請表

We greatly appreciate your willingness and efforts to help a family to bring joy to their life. Please take your time to complete this application. Below information except otherwise noted "confidential" will be presented to the Intended Parents, Psychologists, and the Intended Parent's Physicians.

The Information on This Page Will Be Kept Confidential 以下一頁為保密資料

BASIC INFORMATION 基本資料

Full Name 中文姓名: _____

護照上名字英文拼寫: _____

Passport # 護照號碼: _____

Date of Birth 出生日期: _____ Month 月 / _____ Day 日 / _____ Year 年

Age 年齡: _____

Height 身高: _____'_____" (_____ CM)

Weight 體重: _____ lb (_____ KG)

Blood Type 血型: _____

RH Factor 恒河猴因子: ____ Positive 陽性 ____ Negative 陰性

Ethnic Origin 請列出父母的種族血統 (Please be specific - French, German, Chinese, etc. 請詳細註明, 如: 法國, 德國, 中國, 等):

Maternal 母親: _____

Paternal 父親: _____

Marital Status 婚姻狀況:

____ Single 單身 ____ Married 已婚 ____ Committed Relationship 穩定伴侶

____ Separated 分居 ____ Divorced 離婚 ____ Widowed 守寡

Religion 宗教信仰: _____

School Attending/Graduated 就讀於/畢業於哪間學校 _____

Occupation 職業: _____ Length of Employment 就職時間: _____

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Address 地址: _____

City 城市: _____ State 州: _____ Zip Code 郵遞區號: _____

Home Phone 家用電話: _____

Cell Phone 手機號碼: _____

Work Phone 工作電話: _____

Email Address 電子郵件: _____

US Citizen/Green Card 美國公民/綠卡:

____ Yes 是 ____ No 否

VISA 簽證: ____ J1 ____ F1 ____ H1B ____ B1 ____ B2

If you are not a U.S. citizen, please indicate your citizenship 國籍: _____

Social Security Number 社安號碼: _____

Driver License Number 駕照號碼: _____

Health Insurance Carrier 保險公司: _____

Policy Holder 保險方案所有者: _____

Group # 團體號碼: _____

Policy # 保險方案號碼: _____

Name of Emergency Contact 緊急聯絡人姓名: _____

Emergency Contact Number 聯繫人的電話號碼: _____

Relationship 與您的關係: _____

How Did You Hear About Us 如何得知我們: _____

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PHYSICAL APPEARANCE 外貌描述

Natural Eye Color 眼睛顏色: _____

Natural Hair Color 自然髮色: _____

Hair Texture 自然髮質:

____ Straight 直髮 ____ Wavy 波浪捲 ____ Curly 捲 ____ Thin 細

____ Average 中等 ____ Thick 粗

Complexion 自然膚色:

____ Fai 白皙 ____ Medium 中等 ____ Olive 橄欖色 ____ Dark 偏深

Physical Build 體型:

____ Petite 嬌小 ____ Average 標準 ____ Heavy 偏重 ____ Other 其它

Predominant Hand 習慣用手:

____ Right Handed 右撇子 ____ Left Handed 左撇子 ____ Ambidextrous 左右均可

EDUCATION 教育程度

Years of High School Completed 讀完幾年高中: _____ GPA 平均成績: _____

Years of College Completed 讀完幾年大學: _____ GPA 平均成績: _____

Major 主修: _____ Degree 學位: _____

Have you ever had/Do you have any learning disabilities 您是否有(過)學習障礙?

____ Yes 是 ____ No 否

If yes, please explain 如是, 請說明: _____

DONATION HISTORY 捐卵史

Have you ever been an egg donor before 您之前有否捐過卵? ____ Yes 是 ____ No 否

If yes, how many times 如有, 請問共捐過多少次? _____

How many eggs were retrieved each time 每次各取得多少個卵子? _____

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Did any of the eggs result in pregnancy 這些卵子有否幫助到受贈者懷孕?

____ Yes 是 ____ No 否 ____ I don't know 不知道

What is the reason you want to be an egg donor 您考慮捐卵的原因:

_____

_____

_____

_____

_____

PERSONALITY 性格

Which of the following describes you? Select all that apply. 以下選項最能形容您的性格? 請勾選所有合適的選項:

____ Rational 理性 ____ Sensitive 敏感 ____ Extravert 外向 ____ Introvert 內向
____ Confident 自信 ____ Passive 被動 ____ Assertive 堅定 ____ Energetic 有活力
____ Quiet 安靜 ____ Reserved 內斂 ____ Meticulous 謹慎 ____ Optimistic 樂觀
____ Sociable 隨和 ____ Generous 大方 ____ Reliable 可靠 ____ Flexible 靈活
____ Practical 實際 ____ Humorous 幽默 ____ Serious 嚴肅 ____ Organized 有條理
____ Self-discipline 自律 ____ Compassionate 富同情心 ____ Creative 富創造能力
____ Detail-oriented 注重細節 ____ Compassionate 富同情心 ____ Ambitious 有抱負

MY FAVORITE 愛好

What are your favorite books 最喜歡的書籍: _____
What are your favorite colors 最喜歡的顏色: _____
What are your favorite foods 最喜歡的食物: _____
What kind of sports do you enjoy 喜歡什麼運動:_____
What languages do you speak 您會說哪些語言: _____
What are your hobbies 您的興趣愛好是什麼: _____
Please describe any special talents, skills, or abilities you have 請形容任何你所會的特別才藝和技能: _____

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REPRODUCTIVE HISTORY 生育史

Number of Pregnancy 懷孕過幾次? _____

Number of Children 生過幾個孩子? _____

# of Vaginal Delivery 幾次自然產? _____

# of C-Section 幾次剖腹產? _____

Have you ever had a miscarriage 是否有過自然流產?

____ Yes 是 ____ No 否 Please list the dates 請提供日期: _____

Have you ever had an induced abortion 是否有過墮胎？

____ Yes 是 ____ No 否 Please list the dates 請提供日期: _____

Have you ever had a stillbirth 是否有過死胎?

____ Yes 是 ____ No 否 Please list the dates 請提供日期: _____

Delivery 生產次數	Biological 親生 or 或 Surrogacy 代孕"	Vaginal 順產 or 或 Cesarean 剖腹	Date of Delivery 生產日期	Gender 性別	Weight 體重	Weeks at Birth 孕期幾週	Complications 併發症
#1	_____	_____	_____	_____	_____	_____	_____ _____
#2	_____	_____	_____	_____	_____	_____	_____ _____
#3	_____	_____	_____	_____	_____	_____	_____ _____
#4	_____	_____	_____	_____	_____	_____	_____ _____
#5	_____	_____	_____	_____	_____	_____	_____ _____

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YOUR CHILDREN'S INFORMATION 您的孩子資料

How many children do you have 您有幾位孩子? _____

____ Female 女 ____ Male 男
Age 年齡_____ Hair Color 髮色 _____ Eye Color 眼睛顏色 _____
Any health problems 是否有健康問題? _____

____ Female 女 ____ Male 男
Age 年齡_____ Hair Color 髮色 _____ Eye Color 眼睛顏色 _____
Any health problems 是否有健康問題? _____

____ Female 女 ____ Male 男
Age 年齡_____ Hair Color 髮色 _____ Eye Color 眼睛顏色 _____
Any health problems 是否有健康問題? _____

____ Female 女 ____ Male 男
Age 年齡_____ Hair Color 髮色 _____ Eye Color 眼睛顏色 _____
Any health problems 是否有健康問題? _____

HEALTH INFORMATION 健康狀況

Are you currently under a physician's care for any reason/condition 目前有否因為任何狀況而看醫生? ____ Yes 是 ____ No 否

If yes, please explain 如有，請說明: _____

The date of your last pap smear 您上次做子宮頸抹驗檢查的日期: _____
Result 檢查結果: ____ Normal 正常 ____ Abnormal 不正常 ____ Don't Know 不確定

Have you ever had an abnormal Pap Smear 檢查結果是否曾經有過不正常?

____ Yes 是 ____ No 否 ____ Don't Know 不確定

If yes, please list date(s) & treatment 如有，請提供日期和治療過程:

_____

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The date of your last HIV/AIDS screening 您上次做艾滋病病毒檢查的日期: _____

Result 檢查結果: ____ Positive 陽性 ____ Negative 陰性 ____ Don't Know 不確定

Have you ever been diagnosed with any of the Sexually Transmitted Diseases (STD) below 您是否曾經檢查出以下任何傳染疾病?

Chlamydia 衣原體 ____ Yes 是 ____ No 否
Fungal Infection 霉菌感染 ____ Yes 是 ____ No 否
Gonorrhea 淋病 ____ Yes 是 ____ No 否
Yeast Infection 酵母菌感染 ____ Yes 是 ____ No 否
Syphilis 梅毒 ____ Yes 是 ____ No 否
Recurrent Vaginitis 復發性陰道炎 ____ Yes 是 ____ No 否
Hepatitis B 乙肝 ____ Yes 是 ____ No 否
Genital Herpes 生殖器疱疹 ____ Yes 是 ____ No 否
Hepatitis C 丙肝 ____ Yes 是 ____ No 否
Genital Warts 尖銳濕疣 ____ Yes 是 ____ No 否
Trichomoniasis 滴蟲病 ____ Yes 是 ____ No 否

Has your partner ever been diagnosed with any of the Sexually Transmitted Diseases (STD) below 您的伴侶是否曾經檢查出以下任何傳染疾病?

Chlamydia 衣原體 ____ Yes 是 ____ No 否
Fungal Infection 霉菌感染 ____ Yes 是 ____ No 否
Gonorrhea 淋病 ____ Yes 是 ____ No 否
Yeast Infection 酵母菌感染 ____ Yes 是 ____ No 否
Syphilis 梅毒 ____ Yes 是 ____ No 否
Recurrent Vaginitis 復發性陰道炎 ____ Yes 是 ____ No 否
Hepatitis B 乙肝 ____ Yes 是 ____ No 否
Genital Herpes 生殖器疱疹 ____ Yes 是 ____ No 否
Hepatitis C 丙肝 ____ Yes 是 ____ No 否
Genital Warts 尖銳濕疣 ____ Yes 是 ____ No 否
Trichomoniasis 滴蟲病 ____ Yes 是 ____ No 否

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VACCINATION 疫苗

Last Vaccination Date 上次接種日期：

Hep B 乙肝 ____ Yes 是 ____ No 否 日期: _____
Varicella 水痘 ____ Yes 是 ____ No 否 日期: _____
Smallpox 牛痘 ____ Yes 是 ____ No 否 日期: _____
Influenza 流感 ____ Yes 是 ____ No 否 日期: _____

If never vaccinated, willing to receive vaccination 如從未接種，是否願意接受疫苗?
____ Yes 是 ____ No 否

MEDICATIONS 藥物

Please list all the current medications you are taking (prescription, OTC, herbs)
請列出目前服用的藥物(處方藥，非處方藥，中藥)

Medication 藥物	Frequency 使用頻率	Reason 使用原因

ALLERGY 過敏

Please list all allergies and your reaction to each 請列出所有的過敏原和症狀.

Allergen 過敏原	Reaction 過敏反應

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QUESTIONNAIRE 問卷調查

How is your appetite 您的胃口如何? _____

Describe what type of food your regular diet consists of 請描述您的平時的飲食結構:

_____

Are you near-sighted 是否近視? ____ Yes 是 ____ No 否

If yes, you wear 如是，您戴 ____ Glasses 眼鏡 ____ Contact lenses 隱形眼鏡

What is the condition of your teeth 您的牙齒狀況如何?

____ Excellent 非常好 ____ Good 好 ____ Fair 一般 ____ Poor 不好

Do you drink alcohol 您喝酒嗎? ____ Yes 是 ____ No 否

If yes, how many drinks per week 如您喝酒，每週喝多少? _____

Do you have history of alcohol abuse 您是否有(過)酗酒的習慣?

____ Yes 是 ____ No 否

If yes, please explain 如有，請說明: _____

Do you smoke cigarettes 您吸菸嗎? ____ Yes 是 ____ No 否

If yes, how many per day 如您吸菸，每週吸多少根? _____

Do you/have you ever used illegal drugs 您使用(過)違禁毒品嗎? ____ Yes 是 ____ No 否

If yes, please explain 如有，請說明: _____

Are you/have you ever been under the care of a psychiatrist 目前或過去是否看過精神科?

____ Yes 是 ____ No 否

If yes, please explain 如有，請說明: _____

Have you ever been convicted of a crime/felon 是否有犯罪記錄? ____ Yes 是 ____ No 否

If yes, please explain 如有，請說明: _____

Do you have any tattoos 有沒有紋身? ____ Yes 是 ____ No 否

If yes, please list date and location on body 如有，請列出日期和紋身位置:

_____

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Do have any piercing 有沒有穿洞? ____ Yes 是 ____ No 否

If yes, please list date and location on body 如有，請列出日期和穿洞位置:

_____

Have you had any plastic surgery 是否有做過整形或微整形手術? ____ Yes 是 ____ No 否

If yes, please explain 如有，請說明: _____

Do you have recurring/unresolved headaches 是否有復發持續性頭痛/頭暈?

____ Yes 是 ____ No 否

If yes, how often per week 如有，一周幾次? _____

____ Mild 輕微 ____ Moderate 中等 ____ Severe 嚴重 ____ Migraine 偏頭痛

____ Stress related 壓力造成 ____ With visual changes 視力隨著改變

____ With Vomiting 伴隨著嘔吐

Medication used for symptoms 使用的藥物: _____

PHYSICAL HEALTH HISTORY 身體健康疾病史

Do you now have/Have you ever had any of the following conditions 您現在或過去是否有過以下的情況?

	Y 是	N 否		Y 是	N 否
Abdominal pain 腹部疼痛	____	____	Psychiatric Disorder 心理精神疾病	____	____
Abnormal Color of Urine 尿液顏色異常	____	____	Psychiatric Treatment 精神病治療	____	____
Abnormal Liver Function 肝功能異常	____	____	Pulmonary Embolism 肺栓塞	____	____
Abnormal Thyroid Function 甲狀腺功能異常	____	____	Cough 咳嗽	____	____
Acne 面皰	____	____	Crohn's disease 克隆氏胃腸炎	____	____
Anaphylaxis 過敏性反應	____	____	Damp Skin 皮膚潮濕	____	____
Anemia 貧血	____	____	Denture 假牙	____	____

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Anesthetic Complication 麻醉併發症	____	____	Diabetes 糖尿病	____	____
Angina 心絞痛	____	____	Diarrhea 腹瀉	____	____
Arthritis 關節炎	____	____	Double Vision 視力重影	____	____
Artificial Heart Valve 人造心臟瓣膜	____	____	Drug Addiction 藥物依賴	____	____
Asthma 哮喘	____	____	Easily Winded 容易喘不過氣	____	____
Back Pain 背痛	____	____	Emphysema 肺氣腫	____	____
Bladder Infection 膀胱感染	____	____	Epilepsy or Seizures 癲癇	____	____
Bleeding Disorder 出血障礙	____	____	Excessive Hair Growth 毛髮生長過多	____	____
Bleeding from Gum 牙齦出血	____	____	Excessive Thirst 煩渴	____	____
Blood Clots in Legs 腿部有血凝塊	____	____	Fainting Spells/Dizziness 暈厥	____	____
Blood Clots in Lungs 肺部有血凝塊	____	____	Fatigue 勞累	____	____
Blood Disease 血液病	____	____	Fibrocystic Breast Disease 乳腺纖維囊性增生	____	____
Blood in Stool 血便	____	____	Food Intolerance 食物不耐症	____	____
Blood in Urine 血尿	____	____	Frequent Cough 頻繁咳嗽	____	____
Blood Transfusion 輸血	____	____	Frequent Diarrhea 頻繁腹瀉	____	____
Breast Implants 隆乳	____	____	Frequent Headaches 頻繁頭痛	____	____
Breast Mass 胸部硬塊	____	____	Gallstones 膽結石	____	____
Bronchitis 支氣管炎	____	____	Glaucoma 青光眼	____	____
Bruise Easily 容易淤青	____	____	Goiter 甲狀腺腫大	____	____
Cardiovascular Disease 心血管疾病	____	____	Hay Fever 花粉熱	____	____
Calf Pain 小腿痛	____	____	Head Injury 頭部受傷	____	____
Cancer 癌症	____	____	Hearing Loss 聽力衰退	____	____
Chemotherapy 化療	____	____	Heart Attack/Failure 心臟功能衰退	____	____
Chest Pains 胸痛胸悶	____	____	Heart Burns 胃燒灼痛	____	____
Chest X-Ray 胸部 X 射線檢查	____	____	Heart Murmur 心臟雜音	____	____

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Chickenpox 水痘	____	____	Heat or Cold Intolerance 冷熱不耐症	____	____
Chronic Constipation 長期便秘	____	____	Hematemesis 吐血	____	____
Cold Sores 口唇泡疹	____	____	Hemophilia 血友病	____	____
Colitis/Enteritis 結腸炎/腸炎	____	____	Hemorrhoids 痔瘡	____	____
Congenital Heart Disorder 先天性心臟病	____	____	Hepatic Lipidosis 脂肪肝	____	____
Convulsions 抽搐痙攣	____	____	Hepatitis A 甲肝	____	____
Cortisone Medicine 服用激素藥物	____	____	Hepatitis B 乙肝	____	____
Cough Up blood 咳血	____	____	Hepatitis C 丙肝	____	____
Hives 蕁麻疹	____	____	Hernia 疝氣	____	____
Hypoglycemia 低血糖症	____	____	High Blood Pressure 高血壓	____	____
Hypothyroidism 甲狀腺機能減退	____	____	High Cholesterol 高膽固醇	____	____
Inability to Control Urination 排尿障礙	____	____	Rash 皮疹	____	____
Inability to Smell 嗅覺障礙	____	____	Recent Anxiety Increase 近期焦慮增加	____	____
Irregular Heartbeat 心律不齊	____	____	Recent Stress Increase 近期壓力增加	____	____
Irritable Bowel Syndrome 大腸激躁症	____	____	Recent Weight Change 近期體重改變	____	____
Jaundice 黃疸	____	____	Rheumatic Fever 風濕熱	____	____
Kidney Disease 腎病	____	____	Rheumatism 風濕病	____	____
Kidney Infection 腎臟感染	____	____	Ringing In Ears 耳鳴	____	____
Kidney Stones 腎結石	____	____	Rubella 德國麻疹	____	____
Leg Swelling 腿部腫脹	____	____	Scarlet Fever 猩紅熱	____	____
Leukemia 白血病	____	____	Shingles 帶狀泡疹	____	____
Liver Disease 肝病	____	____	Shortness of Breath 氣促	____	____
Low Blood Pressure 低血壓	____	____	Sickle Cell Disease 鐮刀型紅血球疾病	____	____
Lung Disease 肺病	____	____	Sinus Problems 鼻腔問題	____	____

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Major Injury/Accident 重大傷害/意外	____	____	Sinusitis 鼻竇炎	____	____
Mammogram 乳房影像檢查	____	____	Skin Cancer 皮膚癌	____	____
Measles 麻疹	____	____	Skin Disorder 皮膚病	____	____
Mitral Valve Prolapse 二尖瓣脱垂	____	____	Spinal Disease 脊椎疾病	____	____
Mononucleosis 單核細胞增多症	____	____	Stomach/Intestinal Disease 胃腸病	____	____
Mumps 腮腺炎	____	____	Stroke 中風	____	____
Muscle Weakness 肌無力	____	____	TB Skin Test 結核病篩檢	____	____
Nausea & Vomiting 噁心嘔吐	____	____	Thyroid Disease 甲狀線疾病	____	____
Night Sweats 夜間盜汗	____	____	Tonsillitis 扁桃體炎	____	____
Nipple Discharge 乳頭溢液	____	____	Tuberculosis 肺結核	____	____
Nose Bleeds 流鼻血	____	____	Tumors or Growths 腫瘤	____	____
Numbness/Loss of Sensation 感覺喪失	____	____	Ulcer 潰瘍	____	____
Osteoporosis 骨質疏鬆症	____	____	Unusual Hair Loss 異常毛髮脫落	____	____
Pain in Jaw Joints 顎關節疼痛	____	____	Urgency of Urination 尿急/尿頻	____	____
Painful Urination 小便澀痛	____	____	Urinary Tract Infection 尿道炎	____	____
Parathyroid Disease 甲狀旁腺疾病	____	____	Varicose Veins 靜脈曲張	____	____
Peptic Ulcer 消化性胃潰瘍	____	____	Wheezing 哮鳴	____	____
Pneumonia 肺炎	____	____			
Prolonged Bleeding 出血不易停止	____	____			
Psoriasis 銀屑病	____	____			

If you answer yes to any of the above condition(s), please explain
如以上症狀您回答是，請說明:_____

_____

_____

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FAMILY HISTORY 家庭健康史

Were you adopted 您是否被收養的? ____ Yes 是 ____ No 否

Have you or has anyone in your biological family had 您或是跟您有血緣關係的家人是否有以下症狀:

	Y 是	N 否		Y 是	N 否
Alzheimer's disease 老年失智症	____	____	Heart disease 心臟疾病	____	____
Anencephaly 無腦兒	____	____	Hemophilia 血友病	____	____
Autism 自閉症	____	____	High cholesterol 高膽固醇	____	____
Birth defects 先天性缺陷	____	____	Huntington chorea 亨廷頓舞蹈症	____	____
Canavans 海綿狀腦白質營養不良	____	____	Hypertension 高血壓	____	____
Cancer 癌症	____	____	Mental retardation/Fragile X 智力障礙	____	____
Cerebral palsy 腦性麻痺	____	____	Multiple sclerosis 多發性硬化	____	____
Chromosomal disorder 染色體異常	____	____	Muscular dystrophy 肌肉營養失調	____	____
Cleft palate/lip 腭裂/唇裂	____	____	Neutral tube defects 神經管缺陷	____	____
Club foot 畸形足	____	____	Parkinson's disease 帕金森氏症	____	____
Congenital heart defect 先天性心臟缺陷	____	____	Sickle cell disorder or trait 鐮刀型紅血球疾病	____	____
Cystic fibrosis 囊性纖維化	____	____	Spina Bifida 脊柱裂	____	____
Deafness 耳聾	____	____	Stroke 中風	____	____
Diabetes 糖尿病	____	____	Tay-Sachs disease 家族黑蒙性癡呆症	____	____
Down syndrome 唐氏综合症	____	____	Thalassemia 地中海貧血	____	____
Gaucher 高雪氏症	____	____			

If you answer yes to any of the above condition(s), please explain
如以上症狀您回答是，請說明:_____

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	Age 年齡	Height 身高	Ancestry 血統	Education 教育程度	Occupation 職業	Health & Psychiatric 身心健康/疾病	Age at Death & Cause 年齡&原因
Father 父親	_____	_____	_____ _____ _____	_____	_____	_____ _____ _____	_____ _____ _____
Mother 母親	_____	_____	_____ _____ _____	_____	_____	_____ _____ _____	_____ _____ _____
Paternal Grandfather 祖父	_____	_____	_____ _____ _____	_____	_____	_____ _____ _____	_____ _____ _____
Paternal Grandmother 祖母	_____	_____	_____ _____ _____	_____	_____	_____ _____ _____	_____ _____ _____
Maternal Grandfather 外祖父	_____	_____	_____ _____ _____	_____	_____	_____ _____ _____	_____ _____ _____
Maternal Grandmother 外祖母	_____	_____	_____ _____ _____	_____	_____	_____ _____ _____	_____ _____ _____

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Sibling 兄弟 姊妹	_____	_____	_____ _____ _____	_____	_____	_____ _____ _____	_____ _____ _____
Sibling 兄弟 姊妹	_____	_____	_____ _____ _____	_____	_____	_____ _____ _____	_____ _____ _____
Sibling 兄弟 姊妹	_____	_____	_____ _____ _____	_____	_____	_____ _____ _____	_____ _____ _____
Child 小孩	_____	_____	_____ _____ _____	_____	_____	_____ _____ _____	_____ _____ _____
Child 小孩	_____	_____	_____ _____ _____	_____	_____	_____ _____ _____	_____ _____ _____
Child 小孩	_____	_____	_____ _____ _____	_____	_____	_____ _____ _____	_____ _____ _____

NURTURING LIVES

TURNING DREAMS INTO FAMILIES

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Have you or your family members ever had difficulty conceiving
您或您的親屬是否有(過)不易懷孕的困擾?

Yourself 您自己 ____ Yes 是 ____ No 否
If yes, please explain 如是，請說明: _____

Maternal 母親/母親家庭 ____ Yes 是 ____ No 否
If yes, please explain 如是，請說明: _____

Paternal 父親/父親家庭 ____ Yes 是 ____ No 否
If yes, please explain 如是，請說明: _____

Siblings 兄弟姊妹 ____ Yes 是 ____ No 否
If yes, please explain 如是，請說明: _____

Does any of your extended family members have any physical or psychiatric problems 其他親戚現在及過往是否有身體及心理健康問題? ____ Yes 是 ____ No 否
If yes, please explain 如有，請說明:
Maternal Relatives 母親家庭: _____
Paternal Relatives 父親家庭: _____

I certify that all the information provided is complete, accurate and true to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform Nurturing Lives of any changes in medical status.
根據我所了解和掌握的信息，我確認並證明以上所填的資料完整而且準確. 我清楚明白提供不正確的信息會有可能對我的健康造成威脅. 如有任何健康醫療狀況的變化，我有責任告知 Nurturing Lives 團隊.

_____	_____	_____
Name of Egg Donor Applicant 捐卵申請者姓名(正楷)	Signature of Egg Donor Applicant 捐卵申請者簽字	Date 日期

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CONFIDENTIAL 保密資料

The following information will be kept confidential 以下資料將對外保密:

Do you agree to comply with the following requirements 您可以遵守以下的要求嗎?

Egg donors are required to have Infectious Disease Screening Tests at the expense of the Intended Parents 捐卵者需要接受傳染病檢查，費用將由受贈者支付.
____ Yes 是 ____ No 否

Egg donors must abstain from sexual activity or stimulation while undergoing the egg donation cycle unless they have had a Tubal Ligation or their partner has had a vasectomy
除非已經結紮，捐卵者在捐卵過程期間必須停止所有性生活或引起性欲的活動.
____ Yes 是 ____ No 否

Egg donors are required to attend approximately 8 to 10 appointments throughout the donation cycle 捐卵過程期間，捐卵者必須要參與 8 到 10 次的門診.
____ Yes 是 ____ No 否

Egg donors are required to take self-administered injections for approximately 3-4 weeks
有三到四周的時間，捐卵者必須自行注射所需藥物.
____ Yes 是 ____ No 否

Egg donors are required to undergo a procedure under sedation to retrieve the eggs from their ovaries 捐卵者在取卵時必需經過麻醉及手術.
____ Yes 是 ____ No 否

Egg donors are required to have reliable transportation for appointments.
捐卵者必需要有可靠的交通運輸工具.
____ Yes 是 ____ No 否

Egg donors are required to have a driver on the day of the egg retrieval.
捐卵者在取卵當天必需由他人接送.
____ Yes 是 ____ No 否

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No legal fees, psychological testing fees, medical testing fees or medical procedure fees will be charged to the applicant or her partner. However, any expenses incurred (mileage, babysitting, etc.) while applying to the program and throughout the egg donation process are the responsibilities of the egg donor 捐卵者無需擔負律師，心理評估，醫療檢查之費用；但是其它支出（包括交通費，保姆費等）必須由捐卵者自行負責.

____ Yes 是 ____ No 否

I consent to being notified of any medical information discovered about me during the egg donation process 我同意被告知在捐卵過程中所發現的關於我的健康信息.

____ Yes 是 ____ No 否

_____	_____
Name of Egg Donor Applicant (Print) 捐卵申請者姓名(正楷)	Name of Witness (Print) 見證人姓名(正楷)
_____	_____
Signature of Egg Donor Applicant 捐卵申請者簽字	Signature of Witness 見證人簽字
_____	_____
Date 日期	Date 日期

Please remember to "SAVE" your application and email it to Nurturing Lives at info@nlivesusa.com or turn in a hard copy to one of our staff.

請記得存檔您的申請書並電郵至培孕捐卵代孕中心信箱 info@nlivesusa.com 或是轉交給我們的工作人員.