SOUTHWEST
FERTILITY CENTER
MAKING DREAMS COME TRUE SINCE 1980

Sujatha Gunnala, M.D.,F.A.C.O.G., Medical Director
Vinay Gunnala, M.D., F.A.C.O.G.
Shelley Rosander, MSN, WHNP, RNFA
Tara Denton, MSN, WHNP

Dear Potential Egg Donor,

Thank you for your interest in becoming an Oocyte Donor in our program. Prior to becoming a donor, please complete the extensive medial and social history attached. Due to the nature of Oocyte donation, it is extremely important that you complete the questionnaire accurately and in its entirety. You may mail, fax or confidentially email your paperwork back to us. We would also like photos of you, to include a full body, a closer up face and a childhood photo.

Mail packet and photos to: Southwest Fertility Center
Attn: Donor Egg Coordinator
3125 N 32nd St, Ste 200
Phoenix, AZ 85018

Email packet and photos to: donorcoordinator@southwestfertilitycenter.com

Fax packet to: 602-956-7591
(Photos to be brought in later)

Upon receipt of the packet and photos, we will review and you will be contacted if any info needs to be clarified. After the review, we will call you to do a donor interview and consult, where we will go over the program in its entirety, taking photos if necessary. We will then add you to our donor pool. When you are matched, we will contact you with the next steps in testing.

If you are deemed ineligible for our program for any reason, you will receive a denial letter.

Thank you so much for you interest in our program! We look forward to working with you.

Sincerely,

Tara Denton, MSN, WHNP
Donor Coordinator

Southwest Fertility Center
3125 N 32nd Street, Suite 200
Phoenix AZ 85018
PH 602-956-7481, Fax 602-956-7591

Date _____/_____/_____

Patient Name _____Age _____ Date of Birth ____/____/_____

Address_____ City _____ State _____ Zip _____

Home Phone _____ Cell _____ Work _____

Email address: _____

Social security number _____ Sex _____

Employer _____ Occupation _____

Address _____ City _____State _____Zip _____

Name of Parent or Spouse _____ Age ____ Date Birth _____

Home Phone _____ Work Phone _____SS# _____ Sex ___

Employer _____ Occupation _____

Address _____ City _____State _____Zip _____

In Case of Emergency, Notify _____ Phone: _____

Signature _____ Date _____

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OOCYTE DONOR MEDICAL AND SOCIAL HISTORY

Donor number_____

Interviewer_____ Date: ___/___/___ Updated history____/____/____

Physical Characteristics:
Date of Birth:_____/_____/_____ Age:_____ Race:_____
Ht.:_____ Weight: _____ Do you smoke? Y N
Eye color: _____ Hair Color: _____ Curly____Wavy____Straight____
Complection: Fair _____ Med. _____ Dark _____
Body Type: Sm _____ Med. _____ Large_____ Family: Sm _____ Med_____ Lg._____

Ethnic Ancestry/ origin: _____
Do you have any Jewish ancestors? Yes No Unknown
Do you have any African ancestors? Yes No Unknown
Do you have any Mediterranean(Greek, Spanish, Italian) ancestors? Yes No Unknown

Education: (Check all that apply)
_____ Completed Grade School
_____ Completed High School Grade Point Average GPA _____
_____ Currently in college studying_____ GPA _____
_____ Completed College Degree in _____ GPA _____
_____ Currently pursuing advanced degree in _____GPA _____
_____ Completed Advance degree in _____GPA _____
_____ Trade School in _____ GPA _____

Menstrual History
Menstrual cycle: Regular_____ Irregular_____ age of 1st period _____
Length of cycle (from 1st day of one period to the 1st day of the next)_____
Length of flow: _____ Light _____ Mod _____ Heavy_____
Menstrual Cramping: Y N Severity (0 none-10 severe) _____
Medications taken:_____
Any spotting between periods? Y N
Any breast tenderness or nipple discharge? Y N
Ever have an abnormal pap? Y N If yes explain:_____
Ever have a pelvic infection? Y N Explain_____

Marital status: Married Number of years married: _____
Single Number of years in present relationship._____
Number of partners in last year. _____
Current method of contraception_____
Past types of contraception _____

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Donor number_____

Obstetrical History

Have you ever been Pregnant? Yes No

If yes , How many pregnancies? _____How many Males _____ Females_____

Have you ever had an infection, fever, pain, or bleeding following childbirth, miscarriage or abortion?_____

	Date	Abortion Ectopic	Miscarriage	Complications	Conception Time	Live Birth	Gestation Week
1 Preg:							
2 Preg:							
3 Preg:							
4 Preg:							

For each child, please write their age and any health problems they may have.

AGE	Sex	Health Problems

Health History:

Do you have any allergies to medications? Y N Please list:_____

_____

Do you have any allergies to food or environmental allergens? Please list: _____

_____

Please list any health problems you have been diagnosed with.

_____

_____

Have you had any surgeries or hospitalizations? Y N If yes please explain:

_____

How is your vision without glasses? Poor_____ Fair _____ Good _____

Do you wear glasses/ contacts? Y N Nearsighted _____ Farsighted _____

Other Please specify _____ Your vision is about _____/_____

Do you have normal hearing? Y N If no please specify_____

What is the condition of your teeth? Good Fair Poor

Are you on a special diet? _____

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OOCYTE DONOR MEDICAL AND SOCIAL HISTORY

Donor number_____

Exercise History: None Occasionally Regularly Professional level
What type of exercise? _____
How many hours per week? _____

Social History:

Do you drink Alcoholic beverages? Never Occasionally Moderate Daily
Explain_____
Has there ever been a time where you drank more than you do now? Y N
If yes how much? _____ How long ago? _____

Have you or your sexual partners ever had or have had a reactive screening test to:

HIV	Y N	Self / Partner	When_____	Treated	Y	N
Hepatitis B	Y N	Self / Partner	When_____	Treated	Y	N
Hepatitis C	Y N	Self / Partner	When_____	Treated	Y	N
Chlamydia	Y N	Self / Partner	When_____	Treated	Y	N
Veneral Warts	Y N	Self / Partner	When_____	Treated	Y	N
HPV	Y N	Self / Partner	When_____	Treated	Y	N
Herpes	Y N	Self / Partner	When_____	Treated	Y	N
Syphilis	Y N	Self / Partner	When_____	Treated	Y	N
Other	Y N	Self / Partner	When_____	Treated	Y	N

Please Specify: _____

Social History continued:
Have you ever used or do you currently use any of the following drugs:

		Frequency/ Years	How used
Y N	Marijuana	_____	_____
Y N	Cocaine	_____	_____
Y N	Barbiturates	_____	_____
Y N	Narcotics/Opiates (Heroin, methadone, opium, morphine, or codeine)	_____	_____
Y N	Amphetamines	_____	_____
Y N	Hallucinogens	_____	_____
Y N	Crystal	_____	_____
Y N	Huffing	_____	_____
Y N	Tranquilizers	_____	_____
Y N	PCP	_____	_____
Y N	Inhalants	_____	_____
Y N	Other	_____	_____

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Donor number_____

Prescription medications: Please list what you are taking, the dosage, and for how long you have been on the medication.

_____

_____

_____

In the past 6 months have you ever been exposed to any of the following:

EXPOSED TO	WHEN	HOW OFTEN
Toxic Chemicals	_____	_____
Radiation	_____	_____
Lead/ Lead products	_____	_____
Asbestos products	_____	_____
Commercial cleaning Solutions/ solvents	_____	_____

Personal Description

In general, are you? (Circle all that apply)

Somewhat shy Sociable Very outgoing Demanding Perfectionist

Very cautious Planner Take it as it comes Risk Taker

Do you have special abilities or talents that seem to come naturally? (Check all that apply)

Ability	None	Some Talent	Very Talented	Expert	Explain
English Language & Writing	____	_____	_____	_____	_____
Foreign Language(s)	____	_____	_____	_____	_____
Mathematics	____	_____	_____	_____	_____
Physical Sciences (physics, chemistry, geology, etc.)	____	_____	_____	_____	_____
Social Sciences (psychology, politics, etc.)	____	_____	_____	_____	_____
Intuition	____	_____	_____	_____	_____
Business	____	_____	_____	_____	_____
Organization	____	_____	_____	_____	_____

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Donor number_____

Ability	None	Some Talent	Very Talented	Expert	Explain
Music	____	_____	_____	_____	_____
Singing Voice	____	_____	_____	_____	_____
Artistic	____	_____	_____	_____	_____
Athletic	____	_____	_____	_____	_____
Other:	____	_____	_____	_____	_____

Do you have specific interests/hobbies? (Reading, travel, musical instrument, sewing, clubs, woodworking, painting, etc.)

_____

Donor History

Have you ever been refused as a blood donor? Y N If yes please explain

_____

Have you ever been an egg donor before? Y N If yes When_____
Where_____ How many eggs obtained: _____
How many births resulted from your donation? _____
Have you ever been refused as an egg donor before? Y N If yes please explain:

_____

Have you ever had a problem conceiving? Y N If yes please explain

_____

Did your parents, sisters, or aunts have problems conceiving? Y N
Explain: _____

Immediate Family Attributes (specify below)

Relation	Age	Eye Color	Hair Color	Complexion	Height	Body	Vision
Mother	____	_____	_____	_____	_____	_____	_____
	If deceased age at death_____			Cause _____			
Maternal Grandmother	____	_____	_____	_____	_____	_____	_____
	If deceased age at death_____			Cause _____			
Maternal Grandfather	____	_____	_____	_____	_____	_____	_____
	If deceased age at death_____			Cause _____			
Father	____	_____	_____	_____	_____	_____	_____
	If deceased age at death_____			Cause _____			
Paternal Grandmother	____	_____	_____	_____	_____	_____	_____
	If deceased age at death_____			Cause _____			

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Donor number_____

Relation	Age	Eye Color	Hair Color	Complexion	Height	Body	Vision
Paternal Grandfather	____	_____	_____	_____	_____	_____	_____
	If deceased age at death_____ Cause _____						
Brother	____	_____	_____	_____	_____	_____	_____
Brother	____	_____	_____	_____	_____	_____	_____
Brother	____	_____	_____	_____	_____	_____	_____
Brother	____	_____	_____	_____	_____	_____	_____
	If deceased age at death_____ Cause _____						
Sister	____	_____	_____	_____	_____	_____	_____
Sister	____	_____	_____	_____	_____	_____	_____
Sister	____	_____	_____	_____	_____	_____	_____
Sister	____	_____	_____	_____	_____	_____	_____
	If deceased age at death_____ Cause _____						

How many blood siblings are in your family (including yourself)? _____
Do twins run in your family? Y N If yes, what relation are they to you? _____

_____

Family history:

Has any member of your family, including yourself, had a problem or defect at birth of any of the following systems?

_____ Bones, muscles, joints or limbs
_____ Nervous system, brain, or spinal cord
_____ Organ (Heart, lung. Kidney Etc.)
_____ Metabolic (Hormones, enzymes, Etc.)
_____ Vision or Eye problems
_____ Respiratory system
_____ Blood circulation
_____ Genital/ urinary systems
_____ Gastrointestinal systems
_____ Hearing or Ear problems

Family history continued:

Do you have any siblings who died in infancy or childhood? Y N
If yes what was the cause? _____

Are there any known genetic diseases or conditions that run in your family, such as Cystic fibrosis, Sickle cell anemia, Thalassemia, or TaySachs disease? Y N
If yes please list: _____

Has anyone in your family, including yourself, experienced recurring and/or chronic physical symptoms that have not been evaluated by a physician? Y N
If yes please explain: _____

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Donor number_____

Consider the list below and indicate if a physician has ever diagnosed you or a family member with one of the following conditions.

Medical problems	none	you	Mother	Father	Siblings	Grandparents	Aunt/uncle
Heart							
1. Unknown							
2. Stroke							
3. Heart Attack							
4. Heart disease (from birth)							
5. Harding of the Arteries							
6. High blood pressure							
7. Heart disease (other)							
8. Anemia							
9. Sickle-cell Anemia							
10. Hemophilia/ bleeding problems							
11. Leukemia							
12. Immune deficiency							
13. Other blood disorders							
14. Hay fever							
15. Asthma							
16. Emphysema							
17. Tuberculosis							
18. Lung Cancer							
19. Other lung disease							
20. Hepatitis A (infectious)							
21. Hepatitis B (serum)							
22. Hepatitis C							
23. Other liver disease							
24. Colon cancer							
25. Ulcerative colitis							

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Donor number_____

Medical Problems	None	You	Mother	Father	Siblings	Grandparents	Aunt/uncle
26. Crohn's disease							
27. Cystic fibrosis							
28. Other cancer or problems of the digestive system							
29. Diabetes mellitus (juvenile onset)							
30. Diabetes (adult)							
31. Hypoglycemia							
32. Thyroid disease							
33. TaySach's disease							
34. Adrenal disorder or dysfunction							
35. Kidney disease							
36. Other diseases of the urinary tract							
37. Rectal disorders							
38. Endometriosis							
39. Hypospadias							
40. Uterine fibroids							
41. Ovarian cyst							
42. Cancer of cervix ovaries, or uterus							
43. Migraines							
44. Mental retardation							
45. Alzheimer's							
46. Multiple sclerosis							
47. Cerebral palsy							
48. Epilepsy							
49. Hydrocephalus (water on the brain)							
50. Disorders of the spinal cord							
51. Other diseases of nervous system							
52. Manic Depressive (bipolar)							
53. Schizophrenia							

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Donor number_____

Medical Problems	None	You	Mother	Father	Siblings	Grandparents	Aunt/uncle
54. Other mental health problems requiring hospitalizations							
55. Dementia							
56. Muscular dystrophy							
57. Lupus							
58. Deformity of spine							
59. Dwarfism							
60. Arthritis							
61. Deafness before 60 years							
62. Deformity of ears							
63. Cataracts before 50 years							
64. Blindness							
65. Color blindness							
66. Glaucoma							
67. Eczema							
68. Skin cancer							
69. Pigmentation disorders							
70. Alcoholism							
71. Breast cancer							
72. West Nile Virus							
73. Creutzfeldt-Jakob disease							
74. Other (explain below)							

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OOCYTE DONOR MEDICAL AND SOCIAL HISTORY

Donor number_____

In your own words

Why do you want to be a donor?

Describe your personality and character.

What are your hobbies, interests, and talents?

If you could pass a message to the recipients of your oocytes, what would that message be?

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FDA Risk Assessment

Donor number_____

Date: ___/___/___

Question	Yes	No	Comment
Have you injected drugs for non-medical reason in the preceding 5 years, including intravenous, intramuscular, or subcutaneous injections?			
Do you have hemophilia or other related clotting disorders and have received human-derived clotting factor concentrates in the preceding 5 years, not including receiving clotting factors once to treat an acute bleeding even more than 12 months ago?			
Have you engaged in sex in exchange for money or drugs in the preceding 5 years?			
Have you had sex in the preceding 12 months with any person who would have answered yes to any of the 3 previous items, or had sex with a male who has had sex with another male in the preceding 5 years or with any person known or suspected to have HVG infection, including any person who has had a positive or reactive test for HIV virus, hepatitis B (HBV) infection or clinically active (symptomatic hepatitis C (HCV) infection?			
Have you been exposed in the preceding 12 months to known or suspected HIV, HBV, and/or HCV infected blood through percutaneous inoculation (e.g., needle-stick) or through contact with an open wound, non-intact skin, or mucous membrane?			
Have you been in juvenile detention, lock-up, jail or prison for more than 72 consecutive hours in the preceding 12 months?			
Have you, anyone in your household or any of your intimate contacts ever been diagnosed with any form of hepatitis?			
Have you lived with (resided in the same dwelling) another person who has hepatitis B or clinically active (symptomatic) hepatitis C infection in the preceding 12 months?			
Within the preceding 12 months, have you undergone tattooing, ear piercing, or body piercing in which sterile procedures were not used e.g., contaminated instruments and/or ink were used, or shared instruments that had not been sterilized between procedures were used?			
Have you had a past diagnosis of clinical, symptomatic viral hepatitis after your 11 birthday, unless evidence from the time of illness documents that the hepatitis was identified as being caused by hepatitis A virus (e.g., a reactive IgM anti-HAV test), Epstein-Barr Virus (EBV), or cytomegalovirus (CMV)?			

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FDA Risk Assessment

Donor number_____

Question	Yes	No	Comment
Do you have or suspect that you have sepsis (systemic infection at this time?			
Have you or any of your close contacts had a smallpox vaccine within the past 8 weeks?			
If you have had a smallpox vaccination (vaccinia virus) in the preceding 8 weeks, has your scab separated spontaneously?			
If you have had a smallpox vaccination (vaccinia virus) in the preceding 8 weeks, has it been 21 days post-vaccination?			
If you have had a smallpox vaccination (vaccinia virus) in the preceding 8 weeks and have had complications as a result of that vaccine, have your complications been completely resolved for at least 14 days?			
Have you been diagnosed with clinically recognizable vaccinia virus infection and developed scabs or skin lesions acquired by close contact with someone who received the smallpox vaccine (ie., touching the vaccination area or the scab, including the covering bandages, or touching clothing, towels, or bedding that might have come into contact with an un-bandaged vaccination area or scab) and the resulting scab has since spontaneously separated?			
Have you been diagnosed with clinically recognizable vaccinia virus infection and developed other complications of vaccinia infection acquired by close contact with someone who received the small pox vaccine (i.e., touching the vaccination area or the scab, including the covering bandages, or touching clothing, towels, or bedding that might have come into contact with an un-bandaged vaccination area or scab)?			
Have you ever tested positive for or been treated for West Nile Virus (WNV)?			
Have you had a medical diagnosis, onset of illness, or suspicion of WNV infection (including diagnosis based on symptoms and/or laboratory results or confirmed WNV viremia) in the preceding 120 days?			
Have you test positive or reactive for WNV infection using an FDA-licensed or investigational WNV NAT donor screening test in the preceding 120 days?			
Have you ever tested positive or been treated for a sexually-transmitted disease?			
Have you been treated for or had syphilis within the preceding 12 months?			

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Question	Yes	No	Comment
Have you been treated for or had Chlamydia Trachomatis or Neisseria Gonorrhea infection in the preceding 12 months?			
Have you or any of your blood relative ever been diagnosed with Creutzfeldt-Jakob Disease (CJD)?			
Have you ever been diagnosed with vCJD or any other form of Creutzfeldt-Jakob disease (CJD)?			
Have you been diagnosed with dementia or another neurological disease of unknown cause?			
Have you ever been diagnosed with dementia or any degenerative or demyelinating disease of the central nervous system or other neurological disease of unknown etiology?			
Have you received a non-synthetic dura mater transplant, received human pituitary derived growth hormone, and/or have one or more blood relatives diagnosed with CJD that was not subsequently found to be an incorrect diagnosis, found to be iatrogenic, or that laboratory testing (gene sequencing) shows that you do not have a mutation associated with CJD?			
Since 1977, have you or any of your intimate contacts ever traveled to or lived in Europe or Africa?			
Have you spent 3 months or more, cumulatively, in the UK (England, Northern Ireland, Scotland, Wales, the Isle of Man, the Channel Islands, Gibraltar, or the Falkland Islands) form the beginning of 1980 through the end of 1996?			
Are you current or former US military member, civilian military employee, or dependent of a military member or civilian employee, who has resided at US military bases in northern Europe (Germany, Belgium, and Netherlands) for 6 months or more cumulatively from 1980 through 1996?			
Have you lived cumulatively for 5 years or more in Europe (Albania, Austria, Belgium, Bosnia-Herzegovina, Bulgaria, Croatia, Czech Republic, Denmark, England, Finland, France, Germany Greece, Hungary, Ireland, Italy, Liechtenstein, Luxembourg, Macedonia, Netherlands, Norway, Poland, Portugal, Romania, Slovak Republic, Slovenia, Spain, Sweden, Switzerland, Scotland, Wales, Isle of Man, Channel Islands, Gibraltar, Falkland Islands, and Yugoslavia) from 1980 until present?			
Have you received any transfusion of blood or blood components in the UK (England, Northern Ireland, Scotland, Wales, the Isle of Man, the Channel Islands, Gibraltar, or the Falkland Islands) or France between 1980 and the present?			

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Question	Yes	No	Comment
Were you or any of your sexual partners born in or have you or any of your sexual partners lived in Cameroon, Central African Republic, Chad, Congo, Equatorial Guinea, Gabon, Niger, or Nigeria after 1977?			
Have you received a blood transfusion or any medical treatment that involved blood in Cameroon, Central African Republic, Chad, Congo, Equatorial Guinea, Gabon, Niger, or Nigeria after 1977?			
Have you or any of your intimate contacts ever undergone a medical procedure involving non-human (animal) cells, tissues or organs?			
Have you been the recipient of a xenotransplantation product (transplantation, implantation, or infusion) of either cells, tissues or organs from a nonhuman animal source (this includes human bodily fluids, cells or organs that have had ex-vivo contact with live nonhuman animal cells, tissues or organs)?			
Has anyone you have had close contact with (e.g., intimate or living in the same household, where sharing of kitchen and bathroom facilities occurs regularly) been the recipient of a xenotransplantation product (transplantation, implantation, or infusion) of either cells, tissues or organs from a nonhuman animal source (this includes human bodily fluids, cells, or organs that have had ex-vivo contact with live nonhuman animal cells, tissues, or organs) not including the product Epicel?			
Does your medical history or medical records show any evidence of a diagnosis or a prior positive or reactive screening test result for HIV?			
Have you ever had unexplained weight loss?			
Have you ever had unexplained night sweats?			
Have you ever had blue or purple spots on or under the skin or mucous membranes typical of Kaposi's sarcoma?			
Have you ever had disseminated lymphadenopathy (swollen lymph nodes) for longer than one month?			
Have you ever had an unexplained temperature of greater that 100.5 F (38.6 C) for more than 10 days?			
Have you ever had unexplained persistent cough or shortness of breath?			
Have you ever had opportunistic infections (infections that takes advantage of a weakened immune system)?			
Have you ever had unexplained persistent diarrhea?			

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SOUTHWEST FERTILITY CENTER
ARIZONA'S TOP FERTILITY DOCTOR

Sujatha Gunnala, M.D. ,F.A.C.O.G., Medical Director
Shelley Rosander, MSN, WHNP, RNFA
Charles Cornwell, MS, Embryologist

FDA Risk Assessment

Donor number_____

Question	Yes	No	Comment
Have you ever had unexplained persistent white spots or unusual blemishes in the mouth?			
Does your medical history of medical records show any evidence of diagnosis or prior positive or reactive screening test result for Hepatitis B Virus or Hepatitis C Virus?			
Have you ever had unexplained jaundice?			
Have you ever had unexplained hepatomegaly (enlarged liver)?			
Have you had a past diagnosis of clinical, symptomatic viral hepatitis after your 11th birthday that was not later identified as being caused by hepatitis A virus, Epstein Barr Virus, or cytomegalovirus?			
Within the past 120 days, have you experienced unexplained fever, headache, body aches, or eye pain that may have been accompanied by skin rash on the trunk of the body or by swollen lymph glands?			
Within the past 120 days, have you experienced a severe illness such as encephalitis, meningitis, meningoencephalitis, or acute flaccid paralysis?			
Within the past 120 days have you experienced signs and symptoms of severe illness, including headache, high fever, neck stiffness, stupor, disorientation, coma, tremors, convulsions and muscle weakness or paralysis?			
Have you, in the last 12 months, been diagnosed with sepsis (including bacteremia, septicemia, sepsis syndrome, systemic infection, systemic inflammatory response syndrome (SIRS) or septic shock)?			
Have you ever had clinical evidence of infection with two or more of the following systemic resp0onses to infection if unexplained: temperature of greater than 100.4 F (38 C), elevated heart rate, elevated respiratory rate or elevated white blood cell count?			
Have you, in the last 12months, experienced more severe signs of sepsis including unexplained hypoxemia, elevated lactate, oliguria (less than normal urination), altered mentation and hypotension (low blood pressure)?			
Have you in the last 12 months, had a blood test that resulted in a positive blood cultures associated with the conditions in the previous question?			
Does your medical history or medical records show any evidence of a diagnosis or a prior positive or reactive screening test result for HTLV?			

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Question	Yes	No	Comment
Have you ever experienced unexplained paraparesis (weakness in the lower extremities)?			
Have you ever been diagnosed with adult T-cell leukemia?			
Have you ever been diagnosed with a Zika Virus infection in the past 6 months?			
Have you resided in, or traveled to an area with active Zika virus transmission within the past 6 months? Including: Caribbean, Mexico, Central or South America and South Pacific Islands.			
Have you had sexual intercourse within the past 6 months with a male who is known to have either been diagnosed with the Zika Virus or has resided or traveled to an area with active Zika virus transmission within the past 6 months?			
In the past 4 weeks have you had any shots or vaccinations?			
Were you born in, have you lived in, or have you traveled to any African country since 1977?			
Did you ever receive blood transfusion (s) or any other medical treatment (s) with products made from human blood?			
Have you had sexual contact with anyone who was born in or lived in any African country since 1977?			
Have you been diagnosed with ZIKV infection in the past 6 months?			
Have you residence in, or travel to, an area with active ZIKV transmission within the past 6 months? Per CDC map of affected areas.			
Have you had sex within the past 6 months with a male who was diagnosed with ZIKV in the past 6 months, or travelled or resided in an area with active ZIKV transmission in the past 6 months? Per CDC map of affected areas.			

Reviewed: _____ Date:_____

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