

# PREGNANCY REPORT

This report concerns your most recent pregnancy with TSBC samples. If you are unsure about a question, just leave it blank. We'll contact you if we need clarification. We guarantee complete confidentiality. Thank you.

Your/Recipient's full name: \_\_\_\_\_ Pronouns: \_\_\_\_\_ Your Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Partner's full name (if applicable): \_\_\_\_\_ Pronouns: \_\_\_\_\_

Is your partner a recipient at TSBC? *Yes No* If yes, did your partner conceive w/TSBC sperm? *Yes No*

Has your address, email or phone changed? *No Yes (please provide new info here):*

How many TSBC pregnancies have you had? (including this one) 1 2 3 4 5 6

Do you have other TSBC children? *Yes No* If yes, how many? 1 2 3 4

What is your parenting arrangement: *Single Couple Other: \_\_\_\_\_*

Are you interested in sibling vials? *No Maybe Yes (availability not guaranteed, contact TSBC as soon as possible)*

Your TSBC donor #: \_\_\_\_\_ Your age at conception: \_\_\_\_\_ Due date: \_\_\_\_/\_\_\_\_/\_\_\_\_

If IVF or IVF-ICSI, age at transfer: \_\_\_\_\_ Age at retrieval: \_\_\_\_\_

# of TSBC cycles to conceive this pregnancy? \_\_\_\_\_ Type? *Vaginal IUI IVF IVF-ICSI Surrogacy*

# of TSBC vials used for this cycle: \_\_\_\_\_ # TSBC vials remaining at clinic/MD: 0 1 2 3 \_\_\_\_\_

If Vaginal/IUI – Insemination Dates: #1: \_\_\_\_/\_\_\_\_/\_\_\_\_ #2: \_\_\_\_/\_\_\_\_/\_\_\_\_ #3: \_\_\_\_/\_\_\_\_/\_\_\_\_

Location? *Home Clinic/MD office Other: \_\_\_\_\_*

If IVF or IVF/ICSI – Retrieval Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Transfer Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ # Embryos stored: \_\_\_\_\_

Did you use: *Own eggs Partner's eggs Egg donation Frozen eggs Fresh embryos Stored/frozen embryos*  
(Circle all that apply)

# Embryos transferred: \_\_\_\_\_ Age of egg donor/partner at retrieval (if known/applicable): \_\_\_\_\_

Means to track ovulation/LH surge this pregnancy? (Circle all that apply)

*Ovulation Predictor Kit Ultrasound Fertility Monitor Basal Body Temp Controlled cycle (i.e., IVF) HCG trigger shot*  
*Mucus Blood Test(s) Cervical Exam Mittelschmerz Pain Other: \_\_\_\_\_*

Did you use fertility drugs, hormones, etc. for this pregnancy? *Yes No* If yes, which? \_\_\_\_\_

How were the vials transported? *Shipped Picked-up* Transported in: *Liquid N<sub>2</sub> Tank Dry Ice*

THANK YOU VERY MUCH FOR YOUR TIME

INTERNAL USE ONLY:

Recipient Account Number: \_\_\_\_\_

Date Received: \_\_\_\_/\_\_\_\_/\_\_\_\_ Staff: \_\_\_\_\_