

B Coming Options to Infertility

Fertility Assistant Profile – Egg Donor – Part I

Please note: Any confidential information (i.e.: last names, addresses, phone number(s), social security numbers, driver's license numbers, employers and personal references), will not be released to anyone without your prior written consent. B Coming will use your personal information that you have given us to verify your identity and protect you from identity theft. All applications can be send it by e-mail or fax, but must be mailed with original signature by mail too. Pictures can be e-mailed or send your originals and we will scan them for you and returned them to you as soon as possible (please provide pre-stamped envelope with your mailing address).

Note of Application processing fee: There is a \$25.00 application fee, make payment payable to **B Coming**

I. Identifying Information – Donor and Spouse if Applicable

Donor Name: _____

Spouse Name: _____

Address: _____

City: _____ State: CA Zip: _____

Home Phone: _____

Cell Phone: _____

Spouse Cell Phone: _____

E-mail Address: _____

Occupation: _____

Driver's License Number: _____ State: _____

Social Security Number: _____

Health Insurance Company: _____ Insurance Policy Number: _____

Age: _____ Birth Date: _____ / _____ /19 Birth Place: _____ Race: _____

Maternal Ethnic Ancestry: _____ Paternal Ethnic Ancestry: _____

Religion: _____ Practicing? Yes No Native Tongue: _____

Twins in family history: _____ Boys or Girls predominated: _____

Contact person in case of an emergency: _____

Address: _____

Phone Number: _____ Relationship: _____

Contact person in case of an emergency: _____

Address: _____

Phone Number: _____ Relationship: _____

Contact person in case of an emergency: _____

Address: _____

Phone Number: _____ Relationship: _____

II. Education

- High School Some College AA BS BA MS MA MBA PHD MD
 JD Trade School Apprenticeship Other

What college do/did you attend? _____

Campus Location: City _____ State _____

Please specify what you study/studied: _____

Degree(s) received (what year?): _____

What was your high school point average? _____ What was/is your college grade point average? _____

In which subjects did you receive the highest grades? _____

What was your SAT score? _____ ACT ? _____ Did you have any learning disabilities? ___ Yes ___ No

If yes, explain: _____

Societies: _____

Have you ever had your intelligence tested? ___ Yes ___ No Date of test and score: _____

If you have not had an I.Q. test, are you willing to at the expense of the prospective parent(s)? ___ Yes ___ No

Note: All college students must provide a GPA verification form/letter from the college that you are attending.

III. Physical Characteristics

Natural hair color:

- Blond
 Brown
 Black
 Auburn
 Red
 Straw/Blond
 Grey
 Other

Natural Hair Texture:

- Straight
 Wavy
 Curly
 Very Curly
 Thin
 Thick
 Average

Natural Eye Color:

- Blue
 Brown
 Green
 Grey
 Hazel
 Black
 Other

Physical Build:

- Very Small
 Small
 Medium
 Large
 Very Large

Skin Complexion:

- Fair
 Medium
 Dark
 Olive
 Pink
 White

Tanning Ability:

- None
 Slight
 Moderate
 Very Easily

Predominant Hand:

- Right
 Left
 Ambidextrous

Freckles:

- None
 Light
 Moderate
 Heavy

Location: _____

Other Characteristics:

Height: _____ Weight: _____
 Dimples location: _____
 Cleft Chin? Yes No Small, Medium, Large? _____
 Birth Mark(s)? Yes No Location/Type: _____
 Birth Defects (even if minor or correctable)? Yes No Describe: _____
 Moles/Warts? Yes No Location/Type: _____
 Thinning Hair? Yes No Location: _____
 Other: _____

IV. Medical History

Do you have or have had (check all that applies)? If yes, specify the year.

- | | | | |
|---------------------------------------|------------------------------|-----------------------------|---------------------------------------|
| 1. Albumin, Sugar, Pus, etc. in Urine | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 2. Anemia or Jaundice | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 3. Any bone or joint disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 4. Arthritis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 5. Appendicitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 6. Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 7. Bladder Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 8. Bone or Joint Pain | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 9. Breast Milk Discharge | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 10. Breast Soreness | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 11. Bright's Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 12. Breast Tenderness | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 13. Bursitis/Sciatica | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 14. Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 15. Chemical/Drug Dependency | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 16. Chemical/Drug Poisoning | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 17. Chest Pain | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 18. Chickenpox | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 19. Chlamydia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 20. Chronic Bronchitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 21. Chronic Headaches | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 22. Chronic or Frequent Cough | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 23. Colitis or Other Bowel Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 24. Color Blind | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 25. Constipation or Diarrhea | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 26. Convulsions | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 27. Depression or Anxiety | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 28. Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 29. Difficulty in Urinating | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 30. Diphtheria | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 31. Dizziness | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 32. Ear Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 33. Ear Injury | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 34. Endometriosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 35. Enlarged Glands | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 36. Epilepsy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 37. Eye Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 38. Extreme tiredness or weaknesses | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |

- | | | | |
|-------------------------------------|------------------------------|-----------------------------|---------------------------------------|
| 39. Eye injury | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 40. Fainting Spells | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 41. Food Poisoning | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 42. Frequent Colds | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 43. Frequent Infections/Boils | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 44. Frequent or Severe Headaches | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 45. Frequent Sore Throats | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 46. Gallbladder Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 47. Goiter or Enlarged Thyroid | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 48. Gonorrhea | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 49. Hallucinations | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 50. Hay Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 51. Heart Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 52. Hemorrhoids or Rectal Bleeding | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 53. Hepatitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 54. Herpes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 55. High Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 56. Hirsutism (Excess Hair Growth) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 57. Hives or Eczema | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 58. HIV | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 59. Impaired Hearing | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 60. Impaired Sight | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 61. Indigestion | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 62. Influenza | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 63. Liver Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 64. Loss of Balance | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 65. Loss of Consciousnes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 66. Lumbago | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 67. Low Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 68. Kidney Disease or Stones | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 69. Measles | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 70. Measles – German | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 71. Meningitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 72. Migraine | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 73. Mumps | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 74. Nervous Breakdown | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 75. Neuritis/Neuralgia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 76. Neurological Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 77. Night Sweats | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 78. Nongonococcal Urethritis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 79. Ovarian Cysts | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 80. Palpitation or Fluttering Heart | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 81. Paralysis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 82. Pelvic Infection | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 83.Parasitic Infection | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 84. Pleurisy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 85. Pneumonia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 86. Polio | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 87. Poor Sense of Smell | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 88. Recent Change in Appetite | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 89. Change in Eating Habits | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 90. Rheumatic Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 91. Rheumatism | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 92. Scarlet Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 93. Scarlatina | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 94. Seizures | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 95. Shortness of Breath | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 96. Sinuses | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |
| 97. Skin Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know |

- 98. Smallpox Yes No I don't know
- 99. Spitting up of Blood Yes No I don't know
- 100. Swelling of Hands/Feet/Ankles Yes No I don't know
- 101. Stomach Trouble or Ulcers Yes No I don't know
- 102. Syphilis Yes No I don't know
- 103. Thyroid Problems Yes No I don't know
- 104. Trouble with Nose Yes No I don't know
- 105. Trouble with Mouth Yes No I don't know
- 106. Trouble with Throat Yes No I don't know
- 107. Tuberculosis Yes No I don't know
- 108. Ulcers Yes No I don't know
- 109. Vaginitis # of episodes: Yes No I don't know
- 110. Varicose Veins Yes No I don't know
- 111. Visual Disturbances Yes No I don't know
- 112. Whooping Cough Yes No I don't know

Are you allergic to? _____

- | | | |
|--|---|--|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Aspirin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Morphine | <input type="checkbox"/> Mycins or Other Antibiotics |
| <input type="checkbox"/> Merthiolate/Mercurochrome | <input type="checkbox"/> Any Other Drug | <input type="checkbox"/> Any Foods |
| <input type="checkbox"/> Adhesive Tape | <input type="checkbox"/> Nail Polish or Cosmetics | <input type="checkbox"/> Tetanus Antitoxin or Serum |

Have you had any?

- | | | |
|---------------------------------------|--|--|
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Sprains or Dislocations | <input type="checkbox"/> Lacerations (Extensive) |
| <input type="checkbox"/> Concussions | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Ever Been Knocked Out |

What is your blood type & RH? _____

Have you ever had any blood or plasma transfusion? Yes No

Have you ever been treated for cancer? Yes No

If yes, explain therapy _____

Within the last year, have you had any illness? Yes No

If yes, explain: _____

Within the last year, have you taken any prescription medications? Yes No

If yes, list all medications and the reason _____

Are you taking any over-the-counter medications on a regular basis? Yes No

If yes, list all medications and the reason _____

Do you use or have you ever used illicit or recreational drugs (marijuana, cocaine, etc.) Yes No

If yes, specify _____

Vaccinations:

- Chickenpox (Varicella): No Yes (dates___) I don't know
- MMR – Measles, Mumps, and Rubella (German Measles): No Yes (dates___) I don't know
- BCG (Tuberculosis): No Yes (dates___) I don't know
- Hepatitis B: No Yes (dates___) I don't know
- Polio: No Yes (dates___) I don't know
- Hepatitis A: No Yes (dates___) I don't know
- Tetanus: No Yes (dates___) I don't know
- Influenza: No Yes (dates___) I don't know

V. Personal Health History

Vision

Vision without corrective lenses: Poor Fair Good Excellent

Do you wear corrective lenses? Yes No For what problems? Nearsighted Farsighted

Please explain any vision problems that were caused by injury or accidents: _____

Hearing:

Hearing without corrective aids: Poor Fair Good Excellent

Do you wear corrective aids? Yes No For what problems? _____

Please explain any vision problems that were caused by injury or accidents: _____

Teeth:

Poor Fair Good Excellent Any abnormalities? Yes No

Orthodontic work? If yes explain: _____

Habits:

Do you follow a particular food diet or have any special dietary habits? Yes No

If yes, specify: _____

List the forms and frequency of regular exercise: _____

Do you sleep well? Yes No How many hours? _____

Do you use alcohol beverages? Yes No Quantity/How often: _____

Do you smoke? Yes No Quantity: _____

Additional:

Plastic Surgery: _____

Corrective Surgery: _____

Reconstructive Surgery: _____

Elective Surgery: _____

Marital and Reproductive Health History

Marital History: Single Married Divorced Widowed

If Married: How many years married _____ any prior marriages Yes No

If Divorced: How many years divorced _____

Age of first period: _____ When was the last menstrual period? _____

Are your periods regular? Yes No If yes, what is the usual number of days between periods? _____

If no, how many times a year you menstruate? _____

What is the usual duration of your period? _____

Are cramps present before, during, or after your period? _____

Are cramps? Mild Moderate Severe Do you have to take pain medication? Yes No

If yes, specify medication(s): _____ Do you bleed or spot between periods? Yes No

How many pregnancies have you had? _____ Please list approximate dates: _____

How many abortions have you had? _____ Please list approximate dates: _____

Did you need any medical assistance to conceive your children? Yes No If yes, please explain: _____

Were there any complications during or after your pregnancies? Yes No If yes, please explain: _____

Please list the age, sex and general health condition of each of your children: _____

Were all your children born healthy? Yes No N/A If not, please explain: _____

Were any of them born at an extremely high or low weight? Yes No N/A If yes, please explain: _____

Have you ever failed to carry a pregnancy to full term? Yes No N/A If yes, please explain: _____

Please check any of the following you've experienced with any of your pregnancies:

- | | | |
|---|---|--------------------------------------|
| <input type="checkbox"/> Abortion | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Still Birth |
| <input type="checkbox"/> Caesarian Section | <input type="checkbox"/> Physician Ordered Bed Rest | <input type="checkbox"/> Toxemia |
| <input type="checkbox"/> Ectopic Pregnancy | <input type="checkbox"/> Placenta Previa | <input type="checkbox"/> Other |
| <input type="checkbox"/> Gestational Diabetes | <input type="checkbox"/> Premature Birth | <input type="checkbox"/> None |

Please explain the circumstances of each: _____

Have you had any of the following?

(If yes, please indicate the date(s), complications, outcome and any extenuating circumstances involved)

Anorexia/Bulimia	<input type="checkbox"/> Y	<input type="checkbox"/> N	_____
Asheman's Syndrome	<input type="checkbox"/> Y	<input type="checkbox"/> N	_____
Chlamydia	<input type="checkbox"/> Y	<input type="checkbox"/> N	_____
DES Exposure	<input type="checkbox"/> Y	<input type="checkbox"/> N	_____
Endometriosis	<input type="checkbox"/> Y	<input type="checkbox"/> N	_____
Genital Herpes	<input type="checkbox"/> Y	<input type="checkbox"/> N	_____
Gonorrhea	<input type="checkbox"/> Y	<input type="checkbox"/> N	_____
Hepatitis	<input type="checkbox"/> Y	<input type="checkbox"/> N	_____
HIV Exposure	<input type="checkbox"/> Y	<input type="checkbox"/> N	_____
Hysterectomy	<input type="checkbox"/> Y	<input type="checkbox"/> N	_____
Infected Tubes or Ovaries	<input type="checkbox"/> Y	<input type="checkbox"/> N	_____
Ovarian Cancer	<input type="checkbox"/> Y	<input type="checkbox"/> N	_____
Ovarian Cysts	<input type="checkbox"/> Y	<input type="checkbox"/> N	_____
Ovarian/Uterine Tumor	<input type="checkbox"/> Y	<input type="checkbox"/> N	_____
Pelvic Inflammatory Disease	<input type="checkbox"/> Y	<input type="checkbox"/> N	_____
Removal of Ovary/Ovaries	<input type="checkbox"/> Y	<input type="checkbox"/> N	_____
Removal of Tubes	<input type="checkbox"/> Y	<input type="checkbox"/> N	_____
Syphilis	<input type="checkbox"/> Y	<input type="checkbox"/> N	_____
Venereal Warts	<input type="checkbox"/> Y	<input type="checkbox"/> N	_____
Other	<input type="checkbox"/> Y	<input type="checkbox"/> N	_____

VI. Contraceptive and Sexual History

What form of contraception do you use now or have you used in the past? Check all that apply:

Pills name _____
 IUD Name _____
 Diaphragm
 Withdrawal
 Foams/Jellies
 Condom
 Rhythm
 None
 Other _____

For each contraceptive method used, specify length of use and reason for discontinuance:

Method	Length of Use	Reason for Discontinuance

If you have ever been on oral contraceptives (pills), were your periods regular after stopping the pills?

Yes No

How many times per week do you and your partner have sexual intercourse?

Is intercourse painful or difficult for you? Yes No

VII. Personal Profile

Have you ever been arrested and/or convicted of a crime/felony? Yes No

If yes, please explain: _____

Have you ever been under the care of a psychiatrist? Yes No

If yes, please explain: _____

Have you ever received treatment for drug and/or alcohol abuse? Yes No

If yes, please explain: _____

Were you adopted? Yes No

If yes, what do you know about your biological medical history? _____

Are you willing to take health related tests at the expense of the prospective parent(s)? Yes No

Please describe your character (personality): _____

Please list any clubs, organizations, hobbies, interests, sports teams, activities, etc you are involved in: _____

Please describe any special skills, talents and abilities you have: _____

Please describe your achievements and future goals (personal and career): _____

Briefly explain your personal reasons for wanting to be a fertility assistant: _____

What would you respond if the prospective parents wanted to meet or speak with you? _____

What would you respond if the child wanted to meet you? _____

Is your husband/partner aware and willing to cooperate if she is required to be medically screened? Yes No

Have you ever been an egg donor? Yes No If yes, when and where: _____

All information given in the application is true and correct to the best of my knowledge and I agree that you may keep this application whether or not you approve it. By submitting this complete form, I authorize you to obtain any information you feel is necessary in connection with the application. Finally, I authorize you to release my pictures and to give information about me to prospective patients, physicians, and any other health care professional. I also understand that the information I provided may be used to conduct a driving records check, criminal background check, and other records where required by local, state, or federal law.

I also understand that once B Coming has matched me with a Recipient and B Coming has started incurring Fee's for my medical screening, and I decide to cancel (for any reason), **I will be liable** for all fee's that apply (medical screening, laboratory testing, medications, background check, experience credit check, etc.) fee's start at \$1,500.00 and up.. If for any reason, the above expense is not paid within 30 days, B Coming will **report** my Debt to **Experian Credit Bureau** and will stay on my credit report for Seven Years. B Coming is committed to provide responsible Egg Donors and Surrogate Mothers. B Coming has taken this action, to protect all parties involved from fraudulent people working the system.

Date: ____/____/____

Signature

B Coming

PO Box 6807 – Beverly Hills, CA 90212

phone: 310-247-0616 – fax: 310-247-0059 – email: info@b-coming.com – website: www.b-coming.com

B Coming

“Options to Infertility”

Picture Release

I here by authorize B Coming “Options to Infertility” to publish my personal pictures (that I’ve submitted with my application) on, but not limited to, the B Coming website and informational packets for prospective parents. The information and photos that I have provided will be used for prospective parents (Intended Parent/s), physician/s, other healthcare professionals, attorney’s and court systems.

Donor Print Name: _____

Signature: _____

Spouse Print Name: _____

Signature: _____

Date: ____/____/____

B Coming Representative: _____

Form revised 01/2009

PO Box 6807 Beverly Hills, CA 90212
phone: 310-247-0616 – fax: 310-247-0059 – email: info@b-coming.com – website: www.b-coming.com