B Coming Options to Infertility

Fertility Assistant Profile – Surrogate Mother

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. Applications can be send via e-mail or fax, but all applications must be mailed with original signature. 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).

I. Personal Information

Circle one: *Married, Divorced, Separate Partner*; How many years: __

Name:____

Email:____

Address:______________________________________

City:__________________State:____________Zip:__________

Home Phone:______________Cell Phone:__________

Occupation:______________________________

Employer Name: ______________________Phone:______________

Employer Address: __________________________________

Driver's License Number:__________State: ____Social Security Number:____________

Health Insurance Company:______________Insurance Policy Number:____________

Age:____Birth Date:_______Birth Place:__________Race:______

Maternal Ethnic Ancestry:____________Paternal Ethnic Ancestry:________

Religion:________Practicing? x Yes ☐ No Native Tongue:____________

Spouse Information:

Name:____

Email:____

Address:______________________________________

City:__________________State:____________Zip:__________

Home Phone:______________Cell Phone:__________

Occupation:______________________________

Employer Name: ______________________Phone:______________

Employer Address: __________________________________

Driver's License Number:______________State: ______Social Security Number:___________________

Health Insurance Company:_______________________Insurance Policy Number:__________________

Age:____Birth Date:__________Birth Place:________________Race:________

Maternal Ethnic Ancestry:__________________Paternal Ethnic Ancestry:____________

Religion:____________Practicing? x Yes ☐ No Native Tongue:____________________

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? ____

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:____

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

Type of Surrogacy: ☐Gestational ☐ Traditional

Compensation Fee Required: _______________ Are you negotiable: ☐ Yes ☐ No

III. Medical History

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

Condition			
1. Albumin, Sugar, Pus, etc. in Urine	☐Yes	☐No	☐ I don't know
2. Anemia or Jaundice	☐Yes	☐No	☐ I don't know
3. Any bone or joint disease	☐Yes	☐No	☐ I don't know
4. Arthritis	☐Yes	☐No	☐ I don't know
5. Appendicitis	☐Yes	☐No	☐ I don't know
6. Asthma	☐Yes	☐No	☐ I don't know
7. Bladder Disease	☐Yes	☐No	☐ I don't know
8. Bone or Joint Pain	☐Yes	☐No	☐ I don't know
9. Breast Milk Discharge	☐Yes	☐No	☐ I don't know
10.Breast Soreness	☐Yes	☐No	☐ I don't know
11.Bright's Disease	☐Yes	☐No	☐ I don't know
12.Breast Tenderness	☐Yes	☐No	☐ I don't know
13.Bursitis/Sciatica	☐Yes	☐No	☐ I don't know
14.Cancer	☐Yes	☐No	☐ I don't know
15.Chemical/Drug Dependency	☐Yes	☐No	☐ I don't know
16.Chemical/Drug Poisoning	☐Yes	☐No	☐ I don't know
17.Chest Pain	☐Yes	☐No	☐ I don't know
18.Chickenpox	☐Yes	☐No	☐ I don't know
19.Chlamydia	☐Yes	☐No	☐ I don't know
20.Chronic Bronchitis	☐Yes	☐No	☐ I don't know
21.Chronic Headaches	☐Yes	☐No	☐ I don't know
22. Chronic or Frequent Cough	☐Yes	☐No	☐ I don't know
23. Colitis or Other Bowel Disease	☐Yes	☐No	☐ I don't know
24.Color Blind	☐Yes	☐No	☐ I don't know
25. Constipation or Diarrhea	☐Yes	☐No	☐ I don't know
26. Convulsions	☐Yes	☐No	☐ I don't know
27. Depression or Anxiety	☐Yes	☐No	☐ I don't know
28. Diabetes	☐Yes	☐No	☐ I don't know
29. Difficulty in Urinating	☐Yes	☐No	☐ I don't know
30. Diphtheria	☐Yes	☐No	☐ I don't know
31. Dizziness	☐Yes	☐No	☐ I don't know
32. Ear Disease	☐Yes	☐No	☐ I don't know
33. Ear Injury	☐Yes	☐No	☐ I don't know
34. Endometriosis	☐Yes	☐No	☐ I don't know
35. Enlarged Glands	☐Yes	☐No	☐ I don't know
36. Epilepsy	☐Yes	☐No	☐ I don't know
37. Eye Disease	☐Yes	☐No	☐ I don't know
38. Extreme tiredness or weaknesses	☐Yes	☐No	☐ I don't know
39. Eye injury	☐Yes	☐No	☐ I don't know
40. Fainting Spells	☐Yes	☐No	☐ I don't know
41. Food Poisoning	☐Yes	☐No	☐ I don't know
42. Frequent Colds	☐Yes	☐No	☐ I don't know
43. Frequent Infections/Boils	☐Yes	☐No	☐ I don't know
44. Frequent or Severe Headaches	☐Yes	☐No	☐ I don't know
45. Frequent Sore Throats	☐Yes	☐No	☐ I don't know
46. Gallbladder Problems	☐Yes	☐No	☐ I don't know
47. Goiter or Enlarged Thyroid	☐Yes	☐No	☐ I don't know
48. Gonorrhea	☐Yes	☐No	☐ I don't know
49. Hallucinations	☐Yes	☐No	☐ I don't know
50. Hay Fever	☐Yes	☐No	☐ I don't know
51. Heart Disease	☐Yes	☐No	☐ I don't know
52. Hemorrhoids or Rectal Bleeding	☐Yes	☐No	☐ I don't know
53. Hepatitis			

Condition			
54. Herpes	☐Yes	☐No	☐ I don't know
55. High Blood Pressure	☐Yes	☐No	☐ I don't know
56. Hirsutism (Excess Hair Growth)	☐Yes	☐No	☐ I don't know
57. Hives or Eczema	☐Yes	☐No	☐ I don't know
58. HIV	☐Yes	☐No	☐ I don't know
59. Impaired Hearing	☐Yes	☐No	☐ I don't know
60. Impaired Sight	☐Yes	☐No	☐ I don't know
61. Indigestion	☐Yes	☐No	☐ I don't know
62. Influenza	☐Yes	☐No	☐ I don't know
63. Liver Problems	☐Yes	☐No	☐ I don't know
64. Loss of Balance	☐Yes	☐No	☐ I don't know
65. Loss of Consciousnes	☐Yes	☐No	☐ I don't know
66. Lumbago	☐Yes	☐No	☐ I don't know
67. Low Blood Pressure	☐Yes	☐No	☐ I don't know
68. Kidney Disease or Stones	☐Yes	☐No	☐ I don't know
69. Measles	☐Yes	☐No	☐ I don't know
70. Measles – German	☐Yes	☐No	☐ I don't know
71. Meningitis	☐Yes	☐No	☐ I don't know
72. Migraine	☐Yes	☐No	☐ I don't know
73. Mumps	☐Yes	☐No	☐ I don't know
74. Nervous Breakdown	☐Yes	☐No	☐ I don't know
75. Neuritis/Neuralgia	☐Yes	☐No	☐ I don't know
76. Neurological Problems	☐Yes	☐No	☐ I don't know
77. Night Sweats	☐Yes	☐No	☐ I don't know
78. Nongonococcal Urethritis	☐Yes	☐No	☐ I don't know
79. Ovarian Cysts	☐Yes	☐No	☐ I don't know
80. Palpitation or Fluttering Heart	☐Yes	☐No	☐ I don't know
81. Paralysis	☐Yes	☐No	☐ I don't know
82. Pelvic Infection	☐Yes	☐No	☐ I don't know
83.Parasitic Infection	☐Yes	☐No	☐ I don't know
84. Pleurisy	☐Yes	☐No	☐ I don't know
85. Pneumonia	☐Yes	☐No	☐ I don't know
86. Polio	☐Yes	☐No	☐ I don't know
87. Poor Sense of Smell	☐Yes	☐No	☐ I don't know
88. Recent Change in Appetite	☐Yes	☐No	☐ I don't know
89. Change in Eating Habits	☐Yes	☐No	☐ I don't know
90. Rheumatic Fever	☐Yes	☐No	☐ I don't know
91. Rheumatism	☐Yes	☐No	☐ I don't know
92. Scarlet Fever	☐Yes	☐No	☐ I don't know
93. Scarlatina	☐Yes	☐No	☐ I don't know
94. Seizures	☐Yes	☐No	☐ I don't know
95. Shortness of Breath	☐Yes	☐No	☐ I don't know
96. Sinuses	☐Yes	☐No	☐ I don't know
97. Skin Disease	☐Yes	☐No	☐ 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 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?

☐ Penicillin
☐ Codeine
☐ Merthiolate/Mercurochrome
☐ Adhesive Tape
☐ Sulfa
☐ Morphine
☐ Any Other Drug
☐ Nail Polish or Cosmetics
☐ Aspirin
☐ Mycins or Other Antibiotics
☐ Any Foods
☐ Tetanus Antitoxin or Serum

Have you had any?

☐ Broken Bones
☐ Concussions
☐ Sprains or Dislocations
☐ Head Injury
☐ Lacerations (Extensive)
☐ Ever Been Knocked Out

Height:____________________Weight:____

What is your blood type and 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

IV. 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:____

V. Marital and Reproductive Health History

Marital History: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ 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 (including 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:

☐ Abortion	☐ Miscarriage year:___	☐ Sill Birth
☐ Caesarian Section	☐ Physician Ordered Bed Rest	☐ Toxemia
☐ Ectopic Pregnancy	☐ Placentia Previa	☐ Other
☐ Gestational Diabetes	☐ Premature Birth	☐ 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	☐ Y	☐ N	________________
Asheman's Syndrome	☐ Y	☐ N	________________
Chlamydia	☐ Y	☐ N	________________
DES Exposure	☐ Y	☐ N	________________
Endometriosis	☐ Y	☐ N	________________
Genital Herpes	☐ Y	☐ N	________________
Gonorrhea	☐ Y	☐ N	________________
Hepatitis	☐ Y	☐ N	________________

HIV Exposure	☐ Y	☐ N	________
Hysterectomy	☐ Y	☐ N	________
Infected Tubes or Ovaries	☐ Y	☐ N	________
Ovarian Cancer	☐ Y	☐ N	________
Ovarian Cysts	☐ Y	☐ N	________
Ovarian/Uterine Tumor	☐ Y	☐ N	________
Pelvic Inflammatory Disease	☐ Y	☐ N	________
Removal of Ovary/Ovaries	☐ Y	☐ N	________
Removal of Tubes	☐ Y	☐ N	________
Syphilis	☐ Y	☐ N	________
Venereal Warts	☐ Y	☐ N	________
Other	☐ Y	☐ 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

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 future goals (personal and career):___________________________________

____

____

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

____

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

____

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

Have you ever been a surrogate mother? ☐ Yes ☐ No If yes, when and where:_________________

All information given in this application is true and correct to the best of my knowledge and I agree that B Coming – Alternatives to Infertility 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, doctor office visits, ultrasounds, traveling expenses, 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 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: – 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:*_______________________________________

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