



**South Florida  
Institute for  
Reproductive Medicine**

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**Reproductive Endocrinology**  
**Infertility**  
**Gynecology**  
**Laparoscopic Reconstructive**  
**Pelvic**  
**Surgery & Microsurgery**  
**Assisted Reproductive**  
**Technologies**  
**Andrology**  
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## **PROSPECTIVE EGG DONOR**

Thank you for your interest in our program. Egg (oocytes) donation is a method of assisted reproduction, which allows a woman with healthy, fertile eggs to donate these eggs to a woman who no longer has any eggs or has no fertile eggs. Thus, egg donation offers these couples a chance to conceive a healthy baby, a chance they might otherwise never have.

The process of egg donation involves retrieving eggs from the ovary of a donor and then fertilizing the eggs with the sperm of the patient's partner. Fertilization occurs in the laboratory and then the resulting embryos are placed in the recipient's uterus.

We are looking for healthy women ages 21-31 that have health insurance. Based on an initial screening questionnaire (attached) we will determine if there is any reason you should not donate. When completing this questionnaire please:

1. Print and fill in all blank spaces
2. Write N/A in spaces not applicable to you
3. Be specific
4. Sign last page
5. Send a baby picture of yourself for our confidential records
6. Return the questionnaire by mail to our South Miami office to the following address:

SFIRM Attn: Yvonne Martinez  
7300 SW 62<sup>nd</sup> Place 4<sup>th</sup> Floor  
Miami, FL 33143

The coordinator will contact you once our Medical Director has received the questionnaire. The coordinator will explain the program to you in detail and review all the screening you will need to undergo to determine your eligibility to be a donor. The screening, which is free of charge to you, consists of consultations, a comprehensive physical examination, Pap smear, vaginal cultures, blood tests, vaginal ultrasounds and a psychological evaluation. This testing will be scheduled according to your menstrual cycle and your daily schedule. When all the testing is completed and the Medical Director has approved you, we will establish a time for the start of the actual cycle.

You will be asked to sign a consent form, which gives us permission to carry out the process of egg donation. If you are married, your

husband will also need to sign the consent form. The actual process of donation requires three weeks of frequent visits to our office for

blood tests and ultrasounds. During this time you will receive daily injections of medicine to make some of your eggs grow and mature. When the eggs are mature, we remove the eggs from the ovaries through a minor surgical procedure done with intravenous (IV) sedation in our office.

You will be able to go home within a few hours, but must limit your activities for a few days after this procedure. You will be seen after the retrieval procedure to ensure your optimal health.

You will be compensated for your time and effort.

By donating eggs, you can make a tremendous difference in the life of the couple receiving them. Without you, they most likely would never experience the joy of bearing a child. We truly appreciate your support and effort.

Thank you,

Sincerely,

**Maria Bustillo, M.D.**  
**Director, Third Party Reproduction**

**Debra Knuckles, R.N.P.**  
**Coordinator, Third Party Reproduction**

**Yvonne Martinez, C.M.T.**  
**Coordinator, Third Party Reproduction**

**EGG DONOR PERSONAL QUESTIONNAIRE**

**Personal Information:**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Age: \_\_\_\_\_  
Social Security #: \_\_\_\_\_  
Home Phone #: \_\_\_\_\_  
Work Phone #: \_\_\_\_\_  
Cell Phone #: \_\_\_\_\_  
Email Address: \_\_\_\_\_

Current Occupation: \_\_\_\_\_  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Eye Color: \_\_\_\_\_ Hair Color: \_\_\_\_\_  
Race: \_\_\_\_\_ Skin Tone: \_\_\_\_\_  
Hair Type: \_\_\_\_\_ Religion: \_\_\_\_\_  
Marital Status: \_\_\_\_\_ Blood Type: \_\_\_\_\_  
Are you adopted? \_\_\_\_\_  
What is your Mother's Ancestry? \_\_\_\_\_  
What is your Father's Ancestry? \_\_\_\_\_

**Educational History:**

High School Graduate: Yes \_\_\_\_\_ No \_\_\_\_\_  
High School GPA: \_\_\_\_\_  
College: Yes \_\_\_\_\_ No \_\_\_\_\_ Major: \_\_\_\_\_  
Degree: \_\_\_\_\_  
Did you graduate? Yes \_\_\_\_\_ No \_\_\_\_\_  
Anticipated Date of Graduation: \_\_\_\_\_  
College GPA: \_\_\_\_\_  
SAT Score: \_\_\_\_\_ ACT Score: \_\_\_\_\_  
Any other Additional Schooling: \_\_\_\_\_

## PERSONAL QUESTIONS:

1. What are your favorite hobbies and interests?
2. What life goals do you have?
3. What other language(s) do you speak?
4. What was your favorite school subject and why?
5. What is your favorite food?
6. What is your favorite color?
7. What is your favorite movie?
8. What is your favorite TV show?
9. What was your favorite memory growing up?
10. Where is your favorite place to travel and why?
11. What kind of music do you like?
12. Do you play any musical instruments, which one(s)?
13. Have you ever been arrested? Yes \_\_\_\_\_ No \_\_\_\_\_ If you answered yes, please explain:

14. Have you ever donated before? Yes \_\_\_\_\_ No \_\_\_\_\_ If you have donated before did a pregnancy occur? Yes \_\_\_\_\_ No \_\_\_\_\_ Don't Know \_\_\_\_\_

15. Please describe your personality with 4 – 5 adjectives:

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

17. Briefly explain your personal reason for wanting to be an egg (ovum) donor.

## MEDICAL HISTORY

### Specific Conditions:

Does any member of your family (your parents, siblings, children, aunts, uncles, grandparents, or cousins) have any of the following conditions?

<u>Yes</u>	<u>No</u>	<u>Conditions</u>
___	___	Down Syndrome (Mongolism)
___	___	Club Foot
___	___	Cleft Lip or Cleft Palate
___	___	Pyloric Stenosis
___	___	Neural Tube Defects (Open Spine or Water on Brain)
___	___	PKU or Inherited Metabolic Disorder
___	___	Progressive Kidney Disease
___	___	Polycystic Kidney Disease
___	___	Diabetes Mellitus Requiring Insulin Therapy
___	___	Diabetes Mellitus Not requiring Insulin Therapy
___	___	Premature Degeneration of any Organ System
___	___	Cataracts before age 40
___	___	Deafness before age 60
___	___	Blindness in both eyes before age 60
___	___	Loss of Muscle Coordination
___	___	Muscular Dystrophy
___	___	Schizophrenia
___	___	Manic Depressive Psychosis
___	___	Mental Deterioration or senility before age 60
___	___	Mental Retardation
___	___	Epilepsy or Seizure Disorder
___	___	Color Blindness
___	___	Rheumatoid Arthritis
___	___	Hemophilia
___	___	Psoriasis
___	___	Alcoholism or other Drug Abuse
___	___	Birth Defects
___	___	Huntington's Disease
___	___	Neurofibromatosis
___	___	More than five coffee-colored spots on the skin
___	___	Numerous moles or lumps under skin
___	___	Early Death or Heart Attacks (less than age 50)
___	___	Cystic Fibrosis
___	___	The same cancer in more than one family member
___	___	Severe Bleeding Tendency

If you answered **yes** to any of the previous questions, please give more information:

Please indicate with a check mark whether you personally have had any of the following:

<u>Yes</u>	<u>No</u>	<u>Condition</u>
_____	_____	Hepatitis B
_____	_____	Endometriosis
_____	_____	Pelvic Infection
_____	_____	Vaginal Bleeding other than your menses
_____	_____	Abnormal Pap Smear Test
_____	_____	Cervical Polyps
_____	_____	Uterine Fibroids
_____	_____	Blood Transfusion
_____	_____	Prolonged Fever
_____	_____	Liver Disease
_____	_____	Kidney Disease
_____	_____	Diabetes
_____	_____	Tuberculosis
_____	_____	Depression
_____	_____	Cancer
_____	_____	Asthma

If you answered yes to any of the above, please explain:

Check the appropriate space for any of the following conditions that have occurred within the past six (6) months:

- |                          |                                   |                          |                                      |
|--------------------------|-----------------------------------|--------------------------|--------------------------------------|
| <input type="checkbox"/> | Rashes, color change              | <input type="checkbox"/> | Frequent Urinating                   |
| <input type="checkbox"/> | Itching                           | <input type="checkbox"/> | Waking at night to urinate (# times) |
| <input type="checkbox"/> | Warts, Moles                      | <input type="checkbox"/> | Eczema, Lumps, Hives                 |
| <input type="checkbox"/> | Sores or Discharge                | <input type="checkbox"/> | Blood Clots                          |
| <input type="checkbox"/> | Very Dry Skin                     | <input type="checkbox"/> | Bleeding or Bruising                 |
| <input type="checkbox"/> | Excessive Sweating                | <input type="checkbox"/> | Trouble Swallowing                   |
| <input type="checkbox"/> | Minor Injury                      | <input type="checkbox"/> | Poor Appetite                        |
| <input type="checkbox"/> | Anemia                            | <input type="checkbox"/> | Gas, Cramps, Pain                    |
| <input type="checkbox"/> | Lymph Node or Gland Swelling      | <input type="checkbox"/> | Heartburn, Indigestion               |
| <input type="checkbox"/> | Nausea, Vomiting,                 | <input type="checkbox"/> | Constipation, Diarrhea               |
| <input type="checkbox"/> | Ear Trouble, Infection            | <input type="checkbox"/> | Blood in Stool or Black Stool        |
| <input type="checkbox"/> | Hearing Loss, Ringing in Ear      | <input type="checkbox"/> | Yellow Jaundice, Hepatitis           |
| <input type="checkbox"/> | Eye Problems                      | <input type="checkbox"/> | Hemorrhoids                          |
| <input type="checkbox"/> | Nose Bleeds                       | <input type="checkbox"/> | Hernia                               |
| <input type="checkbox"/> | Stuffy Nose, Sinus Trouble        | <input type="checkbox"/> | Hay Fever                            |
| <input type="checkbox"/> | Sore Throat                       | <input type="checkbox"/> | Gallbladder Problems                 |
| <input type="checkbox"/> | Hoarseness                        | <input type="checkbox"/> | Pain in Joints, Arthritis            |
| <input type="checkbox"/> | Dental or Gum Problems            | <input type="checkbox"/> | Swollen Joints                       |
| <input type="checkbox"/> | Back Pain, Neck Pain              | <input type="checkbox"/> | Breast Lumps                         |
| <input type="checkbox"/> | Enlarged or Painful Breasts       | <input type="checkbox"/> | Discharge from Nipples               |
| <input type="checkbox"/> | Shortness of Breath               | <input type="checkbox"/> | Head Injury, Concussion              |
| <input type="checkbox"/> | Cough, Chest Colds                | <input type="checkbox"/> | Headaches                            |
| <input type="checkbox"/> | Bringing up Sputum with Blood     | <input type="checkbox"/> | Dizziness, Fainting                  |
| <input type="checkbox"/> | Wheezing, Asthma                  | <input type="checkbox"/> | Convulsions, Seizure, Fits           |
| <input type="checkbox"/> | Chest Pain, Pleurisy              | <input type="checkbox"/> | Shaking, Tremor                      |
| <input type="checkbox"/> | TB or Exposure to TB              | <input type="checkbox"/> | Weakness, Paralysis                  |
| <input type="checkbox"/> | Fevers, Sweats, Chills            | <input type="checkbox"/> | Numbness, Tingling                   |
| <input type="checkbox"/> | Pneumonia                         | <input type="checkbox"/> | Difficulty Walking, Coordination     |
| <input type="checkbox"/> | Depression, Anxiety               | <input type="checkbox"/> | Poor Sleep                           |
| <input type="checkbox"/> | Fast or Irregular Heartbeat       | <input type="checkbox"/> | Trouble Thinking, Remembering        |
| <input type="checkbox"/> | Chest Pain, Tightness, Pressure   | <input type="checkbox"/> | Nervousness, Tension                 |
| <input type="checkbox"/> | Trouble breathing when lying down | <input type="checkbox"/> | Walking Short of Breath              |
| <input type="checkbox"/> | Crying, Upset, Worrying           | <input type="checkbox"/> | Swelling of Feet or Ankles           |
| <input type="checkbox"/> | Sexual Problems                   | <input type="checkbox"/> | Previous Heart Trouble               |
| <input type="checkbox"/> | Cancer                            | <input type="checkbox"/> | Murmurs or Rheumatic Fever           |
| <input type="checkbox"/> | Diabetes                          | <input type="checkbox"/> | High Blood Pressure                  |
| <input type="checkbox"/> | Goiter, Thyroid Problems          | <input type="checkbox"/> | Poor Circulation                     |
| <input type="checkbox"/> | Varicose Veins                    | <input type="checkbox"/> | Any Sexually Transmitted Diseases    |

If you answered yes to any of the above, please explain:

How is your current medical condition?

Describe any past medical problems:

Have you had any operations? Yes \_\_\_\_ No \_\_\_\_ If you answered yes, please explain:

Have you been hospitalized for any other reason other than for surgery?

Are you presently under a physician's care?

Are you presently taking any medication(s) other than birth control? Yes \_\_\_\_ No \_\_\_\_ If you answered yes, please explain what the medication is that you are taking and what it is for:

Do you wear glasses or contact lenses? Yes \_\_\_\_ No \_\_\_\_ If you answered yes, please explain why you need to wear them:

Have you had any vision corrective surgery? Yes \_\_\_\_ No \_\_\_\_ If you answered yes, please explain what for:

Have you ever worn braces on your teeth? Yes \_\_\_\_ No \_\_\_\_

Do you currently smoke? Yes \_\_\_\_ No \_\_\_\_ If you answered yes, how many cigarettes do you smoke a day \_\_\_\_\_ and for how long have you smoked \_\_\_\_\_.

Do you have any allergies? Yes \_\_\_\_ No \_\_\_\_ if you answered yes, please explain what you are allergic to and what reaction(s) do you get from it:

Do you drink alcohol? Yes \_\_\_\_ No \_\_\_\_ If you answered yes, how many times a week do you drink \_\_\_\_\_.

Have you ever used illegal drugs? Yes \_\_\_\_ No \_\_\_\_

Have you recently had any tattoos or body piercing? Yes \_\_\_\_ No \_\_\_\_ If you answered yes, how long ago was it that you got it?

Have you ever had Plastic Surgery? Yes \_\_\_\_ No \_\_\_\_ If you answered yes, what kind of surgery did you have and how long ago did you have it?

Have you or any of your family members ever been under the care of a psychiatrist? Yes \_\_\_\_ No \_\_\_\_ If you answered yes, please explain which family member is being treated and why:

Are there any known genetic condition(s) or birth defects in your family? Yes \_\_\_\_ No \_\_\_\_ If you answered yes, please explain:

**Gynecological History:**

Age of your first menses (period): \_\_\_\_\_

Are your monthly cycles regular? Yes \_\_\_\_ No \_\_\_\_

How many days between one menstrual cycle and the next? \_\_\_\_\_

How many days does your menses last each month? \_\_\_\_\_

Are you currently using any type of birth control? Yes \_\_\_\_ No \_\_\_\_

If yes, which type of birth control are you currently using? \_\_\_\_\_

How many times have you been pregnant? \_\_\_\_\_

How many live births? \_\_\_\_\_

Have you had an abortion? Yes \_\_\_\_ No \_\_\_\_ If yes, how many? \_\_\_\_\_

Have you had any miscarriages? Yes \_\_\_\_ No \_\_\_\_ If yes, how many? \_\_\_\_\_

Have you ever put up any children for adoption? Yes \_\_\_\_ No \_\_\_\_ If yes, please explain:

**FAMILY HISTORY:**

**Your Father:**

Age: \_\_\_\_\_

Eye Color: \_\_\_\_\_

Hair Color: \_\_\_\_\_

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

Ancestry: \_\_\_\_\_  
(What countries he is from/Ethnicity)

Occupation: \_\_\_\_\_

Current Health Condition: \_\_\_\_\_

**Your Mother:**

Age: \_\_\_\_\_

Eye Color: \_\_\_\_\_

Hair Color: \_\_\_\_\_

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

Ancestry: \_\_\_\_\_  
(What countries she is from/Ethnicity)

Occupation: \_\_\_\_\_

Current Health Condition: \_\_\_\_\_

If either of your parents are deceased, please explain what they died of, at what age were they diagnosed, and when did they die:

**Your Children (if any):**

How many children do you have?

What are their ages?

Do they have any special talents?

Do they have any health problems? Yes \_\_\_\_ No \_\_\_\_ If you answered yes, please explain what they have, at what age were they diagnosed and what is their current condition:

**Your Grandparents on your Mother's side:**

**Your Grandfather (your Mother's Father):**

Is he still living or Dead? \_\_\_\_\_

If he is alive, what age is he? \_\_\_\_\_

If he died, what age did he die and please explain what he died of and at what age was he diagnosed with the illness:

If he is alive, please describe any health conditions he has at the present time:

**Your Grandmother (your Mother's Mom):**

Is she still living or Dead? \_\_\_\_\_

If she is alive, what age is she? \_\_\_\_\_

If she died, what age did she die and please explain what she died of and at what age was she diagnosed with the illness:

If she is alive, please describe any health conditions he has at the present time:

**Aunts (your Mother's Sister(s):**

Age	Health Problems	Age Diagnosed	Living/Dead
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Uncles (your Mother's Brother(s):**

Age	Health Problems	Age Diagnosed	Living/Dead
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Your Grandparents on your Father's side:**

**Your Grandfather (your Father's Father):**

Is he still living or Dead? \_\_\_\_\_

If he is alive, what age is he? \_\_\_\_\_

If he died, what age did he die and please explain what he died of and at what age was he diagnosed with the illness:

If he is alive, please describe any health conditions he has at the present time:

**Your Grandmother (your Father's Mom):**

Is she still living or Dead? \_\_\_\_\_

If she is alive, what age is she? \_\_\_\_\_

If she died, what age did she die and please explain what she died of and at what age was she diagnosed with the illness:

If she is alive, please describe any health conditions he has at the present time:

**Aunts (your Father's Sister(s):**

Age	Health Problems	Age Diagnosed	Living/Dead
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Uncles (your Father's Brother(s):**

Age	Health Problems	Age Diagnosed	Living/Dead
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Your Nieces or Nephews (if any):**

Age	Health Problems	Age Diagnosed	Living/Dead
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**MEDICAL AND GENETIC HISTORY CERTIFICATION**

I certify that the above information, to the best of my knowledge, is true and complete.

Applicants Signature: \_\_\_\_\_

Date: \_\_\_\_\_