# FIRST I.V.F

## Florida Institute for Reproductive Sciences and Technologies

Minna Ruth Selub, M.D., F.A.C.O.G., Medical Director

Dear Egg Donor:

Thank you for your interest in the Egg Donor Program at the Florida Institute for Reproductive Sciences and Technologies (F I.R.S.T). We are very pleased to be able to provide donor eggs to women who, for various reasons, are unable to have children using their own eggs. The use of donor eggs is a technique that has been available to infertile women for about 30 years! It carries a very good chance of the recipient giving birth to a baby, about 50% per attempt. Our team has had much experience and success using donor eggs.

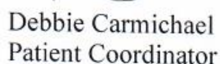
Before you enter our program, we want you to understand the procedures involved in harvesting your eggs. In order to donate eggs, you must inject hormones under your skin daily (the way a diabetic injects insulin) for eight to thirteen days. These injections of naturally occurring hormones stimulate your ovaries to mature multiple eggs.

The success of the procedure is partially dependent on how may eggs we are able to retrieve from your ovaries. To monitor your response to the ovarian stimulation process, you will need to come to our office for frequent blood tests and vaginal ultrasound exams. About four visits are required during the time you are taking the daily hormone injections. You will be able to complete the entire process (including preliminary office visits) in about six or seven total visits. Please do not consider egg donation if you have a tight schedule or inflexible work hours.

Dr. Selub is specially trained to perform the egg harvesting procedure, which she performs in the Surgery Center of Weston outpatient operating suite, located on the second floor in our office building (Broward Health Weston). The egg retrieval is done after you have completed the ovarian stimulation/monitoring process. Dr. Selub has vast experience with the harvesting technique. You will receive intravenous medications for sedation by an anesthesiologist and will need someone to drive you home that day. The egg retrieval involves vaginal ultrasound-guided needle puncture of the upper vaginal wall and ovaries. You may experience only minimal discomfort after this extremely safe procedure. Upon completing the egg donation process (and only after undergoing the egg retrieval), you will receive a $3000.00 check mailed directly to your home address to compensate you for your time and effort for anonymously donating eggs.

After reading and considering the above information, if you are still interested in being an egg donor, please fill out the questionnaire and mail it to us with a photograph of yourself, or drop it off in person. We will contact you to come meet with us in person when we have reviewed your information and determined that your profile warrant further screening tests. We appreciate your desire to give of yourself to help another, and look forward to hearing from you soon. Please do not hesitate to call if you have further questions.

Sincerely,



Debbie Carmichael
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## EGG DONOR HISTORY

Today's Date: ___________ Date of Birth (mm/dd/yy): ___________ Current Age: ____

Name: ______________________________________________________________

Address: ____________________________________________________________

____________________________________________________________________

Phone:
Day ( ) _____________ Night: ( ) _____________ Email: _______________

May leave message? Yes __________ No __________

Health Insurance: ____________________________________________________

Marital Status: ___________ Occupation: ________________

How Many Pregnancies?:______ Of these, how many were:

Full Term Deliveries: _____ Premature Deliveries: ____ Miscarriages:_____ Abortions:_____

How did you hear about our program? ____________________________________

____________________________________________________________________

**For office use only:**

File #: ____________



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## ***Donor Profile***

Why do you want to become an egg donor? ______________________________

______________________________________________

______________________________________________

______________________________________________

Race: ______________________

Age: ______________________

Blood Type: ______________________

Height: ______________________

Weight: ______________________

Build: ______________________

Complexion: ______________________

Eye Color: ______________________

Hair Color: ______________________

Religious Background: ______________________

Highest Level of Education: ______________________

Hobbies / Interests: ______________________

Give the state and country of origin of your ancestors and yourself:

______________________________________________

______________________________________________

______________________________________________

______________________________________________

Are there any known genetic conditions in your family? Yes _______ No _______

If yes, please explain ______________________________________

______________________________________________

Have you ever been tested as a carrier of:

**Tay Sachs Disease** (if of Jewish Ancestry) :

Carrier* ______________ Not Carrier _______________ Unknown _______________

**Sickle Cell Disease** (if Black):

Carrier* ______________ Not Carrier _______________ Unknown _______________

**Cystic Fibrosis** (if White):

Carrier* ______________ Not Carrier _______________ Unknown _______________

**Thalassemia** (if Italian-Greek)

Carrier* ______________ Not Carrier _______________ Unknown _______________

* If you are a carrier, when / where was testing performed? _________________________

_____________________________________________________________________________

Are you a twin? Yes _____________ No ____________

Is there a history of multiple births in your family? Yes ___________ No ____________

Do you have any health problems? Yes ___________ No ____________

If yes, please explain and give age when diagnosed: _____________________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

Where you born with any birth defects? (e.g. heart disease, cleft lip or palate)

Yes ________________ No ________________

If yes, please explain: _______________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

## FATHER'S FAMILY

Father: living ___________ deceased_________ Age ( or age at death): __________

If deceased, cause of death: ______________________________________________

| Health Problems | Age Diagnosed |
| --- | --- |
| | |
| | |
| | |
| | |

Notes: ____________________________________________________________

____________________________________________________________

____________________________________________________________

____________________________________________________________

Grandfather: living ___________ deceased_________ Age ( or age at death): _______

If deceased, cause of death: ______________________________________________

| Health Problems | Age Diagnosed |
| --- | --- |
| | |
| | |
| | |
| | |

Grandmother: living ___________ deceased_________ Age ( or age at death): ______

If deceased, cause of death: ______________________________

| Health Problems | Age Diagnosed |
| --- | --- |
| | |
| | |
| | |
| | |

**LIVING** Aunts and Uncles (your father's brothers and sisters)

| Sex | Age | Health Problems | Age Diagnosed |
| --- | --- | --- | --- |
| | | | |
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| | | | |

**DECEASED** Aunts and Uncles (your father's brothers and sisters)
Please include stillborns, infant deaths, and childhood deaths:

| Sex | Age | Health Problems | Age Diagnosed |
| --- | --- | --- | --- |
| | | | |
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## MOTHER'S FAMILY

Mother: living ___________ deceased_________ Age ( or age at death): __________

If deceased, cause of death: ___________________________________________________

| Health Problems | Age Diagnosed |
|---|---|
| | |
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| | |
| | |

Notes: ______________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Grandfather: living ___________ deceased_________ Age ( or age at death): _______

If deceased, cause of death: ___________________________________________________

| Health Problems | Age Diagnosed |
|---|---|
| | |
| | |
| | |
| | |

Grandmother: living ___________ deceased_________ Age ( or age at death): ______

If deceased, cause of death: ___________________________________________________

| Health Problems | Age Diagnosed |
|---|---|
| | |
| | |
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| | |

**LIVING** Aunts and Uncles (your mother's brothers and sisters)

| Sex | Age | Health Problems | Age Diagnosed |
|---|---|---|---|
| | | | |
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| | | | |

**DECEASED** Aunts and Uncles (your mother's brothers and sisters)
Please include stillborns, infant deaths, and childhood deaths:

| Sex | Age | Health Problems | Age Diagnosed |
|---|---|---|---|
| | | | |
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## SIBLINGS

Your brothers and sisters **LIVING**

| Sex | Age | Health Problems | Age Diagnosed |
|---|---|---|---|
| | | | |
| | | | |
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| | | | |
| | | | |

Your brothers and sisters **DECEASED**

| Sex | Age | Health Problems | Age Diagnosed |
|---|---|---|---|
| | | | |
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## CHILDREN

Your children**, LIVING**

| Sex | Age | Health Problems | Age Diagnosed |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Your children**, DECEASED**

| Sex | Age | Health Problems | Age Diagnosed |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Were any pregnancies terminated because an abnormal prenatal diagnosis?
Yes______ No______

## SPECIFIC CONDITIONS

Has anyone in your family had any of the following conditions?
(Please realize that answering yes to any of these questions may not necessarily eliminate you as a donor.)

| Condition | Yes | No |
|---|---|---|
| 1. Down's Syndrome | | |
| 2. Mental Retardation | | |
| 3. Seizure Disorder | | |
| 4. Loss of Muscle Coordination | | |
| 5. Premature Senility (prior to age 50) | | |
| 6. Deafness (prior to age 50) | | |
| 7. Blindness | | |
| 8. Cataracts | | |
| 9. Schizophrenia, Manic Depression, Mental Illness | | |
| 10. Serious Birth Defects | | |
| 11. Cleft lip and / or palate | | |
| 12. Club Feet | | |
| 13. "Open Spine" or "Water on the Brain" (Neural tube defects) | | |
| 14. Congenital Heart | | |
| 15. Congenital Hip Problems | | |
| 16. Two or More Miscarriages or Stillborn | | |
| 17. Diabetes Mellitus | | |
| 18. Thyroid Disease | | |
| 19. Progressive Kidney Disease | | |
| 20. Skin Disease | | |
| 21. Early Death (prior to age 50) | | |
| 22. Arthritis | | |
| 23. Cystic Fibrosis | | |
| 24. Coffee colored spots on skin | | |
| - size of quarter or larger | | |
| - lumps under skin | | |
| 25. Hemophilia | | |
| 26. Color Blindness | | |
| 27. Undescended Testicles | | |
| 28. Anemia | | |
| 29. Cancer | | |
| 30. Eczema | | |
| 31. Edema | | |
| 32. Epilepsy | | |

| Condition | Yes | No |
|---|---|---|
| 33. Migraine | | |
| 34. Goiter | | |
| 35. Gout | | |
| 36. Hermaphroditism | | |
| 37. Hernia, Inguinal | | |
| 38. Myasthenia Gravis | | |
| 39. Parkinson's Disease | | |
| 40. Paraplegia | | |
| 41. Varicose Veins | | |
| 42. Cirrhosis | | |
| 43. Emphysema | | |
| 44. Jaundice | | |
| 45. Lymphedema | | |
| 46. Allergy | | |
| 47. Heart Attacks | | |
| 48. Huntington's Chorea | | |
| 49. Sexually Transmitted Disease | | |

If you have answered YES to any of these conditions, please answer:

| Question # | Specific Relation | Specific Condition | Age Affected | Other Information |
|---|---|---|---|---|
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