

Prospective Gestational Surrogate Application

Date _____

Personal Information

Full Legal Name _____

Home Address _____

City, State, Zip _____

Home _____

Cell _____

Work _____

Fax _____

Email _____

Age _____ Date of Birth ___/___/___ Social Security # ___-___-_____

Maiden Name if married _____

Please list any other names used in the past _____

Drivers License # _____ State _____ Exp. Date _____

Emergency Contact (other than your spouse or partner)

Name _____

Address _____

Phone Number _____

Relationship _____

Employment Information

Present Employer _____

Job Title _____ Annual Income _____

Address _____

Phone Number _____

Dates of Employment _____

Relationships

Marital Status (please check the appropriate)

Married Partner Single Separated Divorced

Partner/Spouse Full Legal Name _____

How many years have you been together? _____

Are you legally married? Yes No If yes, what year did you marry? _____

Partner/Spouse Present Employer _____

Job Title _____

Health Care

Do you have medical insurance? Yes No

Do you have maternity coverage? Yes No

Health Insurance Carrier _____

Effective Date _____ Yearly Deductible \$ _____

Premium Amount \$ _____ Co-Pay \$ _____

Type of Coverage (please check the appropriate amount)

100% 80% Other _____

Is this policy through an employer? Yes No

Which employer? _____

Medical Information

Height _____ Weight _____

When was your last HIV (AIDS) test? _____ Results _____

Do you smoke or use tobacco in any form? Yes No

If yes, please explain: _____

Does your partner smoke? Yes No

If yes, please explain: _____

Do you drink alcoholic beverages? Yes No

If yes, please explain: _____

Have you ever taken any recreational drugs? Yes No

If yes, please explain: _____

Do you feel you were ever a victim of sexual, physical or psychological abuse?

Yes No If yes, please explain:

Have you ever been treated for any emotional disorders? Yes No

If yes, please explain:

Please list any medications that you are currently taking:

Name	Dosage	Reason
------	--------	--------

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any past and current medical conditions:

Have you ever had surgery? Yes No If yes, please explain and list dates:

Do **you** have any of the following health conditions now, or have you had them in the past? If yes, please explain:

- | | | | |
|---------------------|------------------------------|-----------------------------|-------|
| Anemia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Cystic Fibrosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Depression | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Eating Disorders | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Heart Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| High Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Migraine Headaches | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Muscular Dystrophy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Neck/Back Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Ovarian Cysts | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| PID | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Seizures/Fits | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| TB or TB exposure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Thyroid Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Uterine Fibroids | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |

Have **you or your partner/spouse** ever been diagnosed with the following conditions? If yes, please explain:

Herpes Yes No _____
 Hepatitis B Yes No _____
 Hepatitis C Yes No _____
 HIV (AIDS) Yes No _____
 Gonorrhea Yes No _____
 Syphilis Yes No _____

Reproductive History

How many times have you been pregnant? _____
 How many children do you have? _____

Please complete the following table with details for each pregnancy:

Pregnancies	1 st	2 nd	3 rd	4 th
Full term?				
Birth Weight?				
Months to conceive?				
Miscarriage?				
Abortion?				
Problems or Complications?				
Caesarean or Vaginal?				
Physical/ Mental Birth Defects?				

Children's Names and Ages: _____

Please describe your children's current health and any history of problems:

Have you ever undergone any fertility treatments to become pregnant?

Yes No If yes, please explain: _____

Please mark the type of contraception you are currently using:

Not Sexually Active Depo-Provera Diaphragm
 Birth Control Pills Nuvaring Tubal Ligation
 Contraceptive Gel Condoms Vasectomy

How long have you used this form of birth control? _____

Do you have a menstrual cycle every month? Yes No

How many days apart are your periods? _____

Last Pap Smear: Date ___/___/___ Results: Normal Abnormal

Have you ever tested positive for HPV? Yes No If yes, please explain:

Are you currently breastfeeding? Yes No If yes, how often and when do you plan to discontinue? _____

What is the name and address of your OB/GYN and when did you last see him/her? _____

Education

Completed High School Yes No Year _____ GPA _____
Received GED Yes No Year _____
Testing Scores: SAT _____ ACT _____ GRE _____ MCAT _____ Other _____
Any College Education or attended any Certification Programs? Yes No
If yes, what college or certification program do/did you attend? _____

What is/was your major? _____
Did you earn a degree? Yes No GPA _____
If yes, what is it? _____
If no, when will you finish your degree? _____
Have you pursued an advanced degree? Yes No If yes, name of the institution and what is the degree in? _____

Personal History

Have you ever done any of the following? If yes, please explain:

Filed for Bankruptcy? Yes No

Placed a child up for adoption Yes No

Been past due on child support? Yes No

Had psychological counseling? Yes No

Been hospitalized for Psychiatric care? Yes No

Filed for divorce or legal separation? Yes No

Been refused by an adoption agency? Yes No

Any drug or alcohol abuse? Yes No

Thought about committing suicide? Yes No

Attempted suicide? Yes No

Intentionally hurt or caused yourself physical harm? Yes No

Been convicted of a crime? Yes No

Been in a substance abuse program? Yes No

Been arrested, including DUI arrest? Yes No

Do you currently have any legal cases or claims pending? Yes No

Personality

What was your reason for choosing to become a Gestational Carrier?

Describe your personality and character _____

What are your hobbies, interests and talents? _____

What are your future goals? _____

Is there anything you would like to say to the Intended Parents? _____

Signature _____ Date _____

Please submit the following additional information when returning your application to us:

- **A photocopy of your insurance card (front and back)**
- **Your complete health insurance policy (the complete plan booklet, not just a summary of benefits).**
- **A copy of your obstetric records from your last pregnancy and delivery.**

We want to thank you for your time and patience in filling out this application. If you have any questions or there is anything we can do, please feel free to contact us.

The information provided by you to CEO remains confidential. It will only be shared with potential parents and medical professionals.