

# AN EGGCEPTIONAL MATCH

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## GESTATIONAL CARRIER PERSONAL HISTORY FORM

By signing this form, you agree to share the following information with the prospective parents. We appreciate your honesty upon answering this questionnaire.

### **PERSONAL INFORMATION**

Date of Application: \_\_\_\_\_

First Name Only: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

Spouses First Name: (if applicable): \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Frame: Small Med Large Ex Large

Hair: \_\_\_\_\_ Eyes: \_\_\_\_\_ Blood Type: \_\_\_\_\_ (+ or -)

Ethnicity: \_\_\_\_\_ Religious Preference: \_\_\_\_\_

U.S. Citizen? Yes No

Marital Status: SINGLE MARRIED SEPARATED DIVORCED WIDOWED

If Married, for how long? \_\_\_\_\_ If Divorced, list date(s) \_\_\_\_\_

If Separated, list date of separation \_\_\_\_\_ If Widowed, list date of spouse' death

Are you now or have you in the past experienced significant marital problems including any abuse by your spouse? Yes No

If Yes, please describe the problems, when they occurred and how you are resolving/have resolved them:

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Have you been married previously? Yes No Dates of marriage: \_\_\_\_\_

Why was the marriage terminated? \_\_\_\_\_

If you are not married, are you living with someone in a committed relationship? Yes No

Since what date \_\_\_\_\_

Do you have any other children living in the home? Yes No

If Yes:	DOB	Sex
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

Have you ever placed any children for adoption? Yes No

If Yes, Please share details of your circumstances at the time of each placement:

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Do you have children not living with you? Yes No

If Yes, Please share reasons for each child not living with you:

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Do you feel that your family is complete? Yes No

Were any of your children born by cesarean section (c-section)? Yes No

If Yes, Please describe the reason: \_\_\_\_\_

Would you have objections to delivering via cesarean in the future? Yes No

Have you discussed the potential risks of another pregnancy with your OB/GYN? Yes No

If Yes, Does he/she feel it is medically safe to carry another pregnancy? Yes No

Do you have reliable transportation? Yes No If so, do you have car insurance? Yes No

Do you have a valid driver's license? Yes No If no please explain \_\_\_\_\_

If you do not have reliable transportation, how do you plan to arrive at your appointments?

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Do you have health insurance? Yes No If yes, name of Insurance:

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Policy or Group Number: \_\_\_\_\_ HMO PPO Other:

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Do you have surrogacy/maternity coverage? Yes No Not Sure

Coverage: 80/20 90/10 Other: \_\_\_\_\_

If you have insurance, please provide a copy of your policy or summary plan description with your application
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Have you or your spouse ever been arrested or convicted of a crime? Yes No

If Yes, Please explain in detail including dates, name of offense, etc.:

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Have you or your spouse ever filed for Bankruptcy? Yes No

If yes, has this been dismissed? Date of dismissal: \_\_\_\_\_

**EDUCATIONAL BACKGROUND**

Highest Level of Education Completed: Grade School \_\_\_\_\_

Jr. High School \_\_\_\_\_

Sr. High School \_\_\_\_\_ (GPA: \_\_\_\_\_)

Names of all colleges attended: \_\_\_\_\_

\_\_\_\_\_

Currently in College Pursuing a degree in: \_\_\_\_\_

Completed College with degree in: \_\_\_\_\_

Currently pursuing advanced degree in: \_\_\_\_\_

Completed advanced degree in: \_\_\_\_\_

Vocational/Trade School: \_\_\_\_\_

Test Scores: SAT's: \_\_\_\_\_ ACT's: \_\_\_\_\_ College GPA: \_\_\_\_\_

Name of last school attended by gestational carrier: \_\_\_\_\_

Location of school: Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of last school attended by spouse: \_\_\_\_\_

Location of school: Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_

Have you ever been diagnosed with a learning disability? Yes No

If yes, please describe the diagnosis: \_\_\_\_\_

\_\_\_\_\_

**MEDICAL/HEALTH HISTORY**

General health condition:    Excellent    Good    Fair    Poor

Dietary habits:    Excellent    Good    Fair    Poor

Special dietary needs: \_\_\_\_\_

Exercise habits:    Athletic    Average    Sedentary

How many hours of sleep do you get per night on average? \_\_\_\_\_

Current medical/health problems:

\_\_\_\_\_  
\_\_\_\_\_

Date of last physical: \_\_\_\_\_    Date of last Pap smear: \_\_\_\_\_

Were there any abnormal findings?    Yes    No       If yes, please list findings and treatment below:

\_\_\_\_\_

Known environmental allergies: \_\_\_\_\_

Known drug allergies: \_\_\_\_\_

Do you currently use prescription drugs?    Yes    No       If yes, Please list name, dosage and purpose of each medication:

\_\_\_\_\_  
\_\_\_\_\_

Menstrual cycle:    Age of Onset: \_\_\_\_\_    Are your periods regular?    Yes    No

How long are your cycles from day one to the next day one? \_\_\_\_\_ Days

How long do they last? \_\_\_\_\_ Days

Cramping:    None    Mild    Average    Severe

Type(s) of birth control currently using: \_\_\_\_\_

If none, what have you used in the past? \_\_\_\_\_

Please list types and dates of any and all surgeries:

Date \_\_\_\_\_ Type \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you had any tattoos or piercings within the last 12 months?    Yes    No

If Yes, Please list dates: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PLEASE MARK ANY THAT APPLY:**

	Yes	No	Dates
Anemia	___	___	_____
Blood Transfusion	___	___	_____
Cancer	___	___	_____
Chicken Pox	___	___	_____
Chlamydia	___	___	_____
Chronic Anxiety	___	___	_____
Clotting Disorders	___	___	_____
CMV	___	___	_____
Diabetes	___	___	_____
Diphtheria	___	___	_____
Epilepsy	___	___	_____
Gallbladder Disease	___	___	_____
German Measles	___	___	_____
Gonorrhea or Syphilis	___	___	_____
Heart Disease	___	___	_____
Heart Murmur	___	___	_____
Hepatitis B	___	___	_____
Herpes	___	___	_____
High Blood Pressure	___	___	_____
HIV/AIDS	___	___	_____
Jaundice	___	___	_____
Kidney Infections	___	___	_____
Low Blood Pressure	___	___	_____
Migraines	___	___	_____
Mumps	___	___	_____
Pneumonia	___	___	_____
Polio or Meningitis	___	___	_____

Psychiatric Disorders \_\_\_\_\_  
 Rheumatic Fever \_\_\_\_\_  
 Scarlet Fever \_\_\_\_\_  
 Tuberculosis \_\_\_\_\_  
 Urinary Dysfunction \_\_\_\_\_

**PREGNANCY HISTORY**

**LIST OF PREGNANCIES AND OUTCOMES**

<u>Dates:</u>	<u>Birth</u>	<u>Miscarriage</u>	<u>Termination</u>	<u>Sex</u>	<u>Weight/length</u>	<u>Hours of Labo</u>	<u>Complications</u>

Which of the above were surrogacies? \_\_\_\_\_  
 Which are biological offspring? \_\_\_\_\_  
 Did all of your pregnancies go to term? \_\_\_\_\_ Please explain:  
 \_\_\_\_\_

Total number of Pregnancies: \_\_\_\_\_ Total Live Births: \_\_\_\_\_  
 Terminations: \_\_\_\_\_ Miscarriages: \_\_\_\_\_ Stillbirths: \_\_\_\_\_

**PERSONAL HISTORY**

Do you smoke or have you smoked cigarettes in the past? Yes No  
 If yes, how many cigarettes do/did you smoke per day? \_\_\_\_\_

Do you now or have you used recreational drugs in the past? Yes No  
 If yes, what and how often? \_\_\_\_\_

Have you ever injected any illegal substances into your body in any way? Yes No  
 If yes, what, how often and when was the last incident? \_\_\_\_\_, \_\_\_\_\_  
 \_\_\_\_\_

Do you drink alcohol? Yes No

If yes, how often? \_\_\_\_\_ per day \_\_\_\_\_ per week \_\_\_\_\_ per month

Have you ever been clinically diagnosed with depression? Yes No If yes, please explain in detail

If yes, do you seek or have you sought professional help? Yes No If yes, please explain in detail

Have you ever or do you now take any type of anti-depressant for this condition? Yes No

If yes, name of drug and dosage: \_\_\_\_\_ per day

Have you ever had any psychiatric hospitalization? Yes No

If yes, When, where and for how long? \_\_\_\_\_

Do you have any major stressors in your life currently? Yes No If yes, please explain in detail

Are you willing to participate in a psychological evaluation and allow the results to be shared with An Eggceptional Match, LLC, the Intended Parents and the fertility center? No identifying information will be included with the information provided to the Intended Parents. Yes No

If married, will spouse do the same? Yes No

**GENERAL QUESTIONNAIRE**

What is your motivation for becoming a surrogate?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What is your idea of how surrogacy works?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you previously served as a surrogate in the past? Yes No

If yes, please describe your experience:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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How do you feel about taking daily medications and injections?

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If your physician recommended bed rest, would this be a problem for you? Yes No

Describe your personality and temperament:

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Do you have the support of your family on your decision to become a surrogate? Yes No

If no, how do you plan to maintain your personal feelings and health without their support?

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Are you willing to maintain a healthy diet and exercise regimen during your surrogacy? Yes No

Are you willing to decrease your caffeine and soda intake during your pregnancy? Yes No

Are you willing to pump breast milk for any period of time after the birth? Yes No

Describe your ideal Intended Parents for whom you would be helping:

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Would you want your Intended Parents to accompany you to your OB visits? Yes No

Would you consider terminating or reducing the pregnancy upon the Intended Parent's request? Yes

No

Possibly if: \_\_\_\_\_

Are you willing to carry a multiple gestation? (Twins, triplets, quads, etc...?) Yes No

If yes, please explain:

If recommended by a physician, would you be willing to undergo amniocentesis, CVS or any other diagnostic testing to rule out anomalies? Yes No

If no, please explain:

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Are you hoping to have an open and on-going relationship with your Intended Parents during the pregnancy?

Yes No

After the pregnancy? Yes No

Please explain your expectations:

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What is your preferred form of communication with the IPs during the pregnancy?

Email (Do you check email regularly?) Yes No

Phone (How often would you like to be in touch during the pregnancy?) \_\_\_\_\_

Would you like your IPs present at the birth of their child? Yes No

Is there anyone else you would like present at the birth? Yes No

If yes, whom? \_\_\_\_\_

Are you willing to work with single intended parents including females and males? Yes No

Are you willing to work with same sex couples? Yes No

Are you willing to work with a couple or single parent with a different ethnic background from yours?

Yes No

Are you willing to work with a couple or single parent with different religious preference than yours? Yes

No

Are you willing to travel to another state for the embryo transfer/birth? Yes No

Are you willing to travel to a foreign country for the embryo transfer/birth? Yes No

How soon are you able to commit? \_\_\_\_\_

Are you opposed to the child knowing about you one day? Yes No

If yes, please explain your reservations:

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will include a comprehensive waiver of any and all of your parental rights. Other complex issues will be covered such as abortion, amniocentesis, assumption of the risk, etc. You will be required to have legal counsel represent you during this contract process. The intended parents will pay your attorney's fees and costs. Do you have any objection to this? Yes \_\_\_ No \_\_\_\_\_ Explain in detail if you answer Yes:

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**UNDERSTANDING**

In completing this Application to An Eggceptional Match (AEM), I understand that AEM is not making a commitment that my Application will be accepted. I will sign all Releases requested by AEM in order for a determination to be made on my Application. I hereby consent to AEM providing non-identifying information about me to potential Intended Parents prior to any meeting with any Intended Parents. I also hereby consent to allowing AEM to share the photographs that I provide to potential Intended Parents, including but not limited to, placing the photographs on the AEM website. I understand that identifying information will not be released until I give specific authorization for such release. I agree to sign Releases for AEM to communicate with any mental health professional conducting or having conducted a psychological evaluation relating to the assisted reproduction procedures in which I seek to engage, with any of my medical care providers, and with the clinic selected to conduct assisted reproduction procedures.

**DISCLAIMER, INDEMNIFICATION AND HOLD HARMLESS**

I understand that AEM may, from time to time, refer me and/or Intended Parents to various outside professionals. These may include, without limitation: psychologists and other mental health professionals, accountants, medical doctors and other health care professionals, clinics and financial institutions. I understand that neither Intended Parents nor I are required to use such professionals and that AEM does not control the activities of such professionals. I agree to release AEM and hold it harmless with regard to any and all claims, which relate to the activities of any such professionals or as a result of any such referrals of Intended Parents or me.

**TAX CONSEQUENCES**

*I understand that I am responsible for any tax consequences my spouse or I may experience as a result of any gestational carrier arrangement and understand*

*that AEM will issue a TAX FORM 1099 to each individual who has received payment for the performance of services during the taxable year.*

The statements and commitments made in this Application are, to the best of my knowledge and belief, correct and complete. I agree to provide additional information supplementing and updating the above answers, if it comes to my attention, subsequent to the submission of this Application. I understand that if I knowingly provide false information on this Application, it will be grounds for AEM to refuse to accept me into the program or to refuse to continue to work with me.

**OTHER**

I understand that this process may take some time. I further understand that AEM will expend resources in reliance on my participation in this program. I agree to remain available as a potential gestational carrier/surrogate in AEM's program for 12 months from the date of this Application.

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<b>Signature</b>	<b>Date</b>	<b>Signature of Spouse (if applicable)</b>
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Please list names and telephone numbers of references to contact (no relatives):

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|-------------------|-------|---------------|
| 1. _____<br>_____ | _____ | Relationship: |
| 2. _____<br>_____ | _____ | Relationship: |
| 3. _____<br>_____ | _____ | Relationship: |

If you have any questions about any information requested in this Application, feel free to call us at  
1-877-745-3447 or 720-733-0184

**Please return the completed Personal Information and Application to:**

P.O. Box 1646  
Castle Rock, CO 80104

Please enclose one to two current photos of yourself and your family.

Thank You!!