GESTATIONAL CARRIER APPLICATION

1. Full name: ____

2. Maiden name (if applicable): ______________________________

3. Social Security Number: __________________________________

4. Address:____
   (Including: City/State/Zip/County)

5. How long have you lived at your current address? ________________

6. If less than two years, please list prior addresses for the last two years.

   ____

   ____

   Please list all the states you have lived in for the past 10 years:

   ____

7. Telephone number (include area code):
   Daytime: ____________________
   Evening: ____________________
   Cell: ______________________

8. Do you have voicemail, answering machine, or a place where we can leave messages?
   [ ]Yes [ ]No

   If so, where?____
   Email address: ____
   Best time to contact you: ______________________________

1. Name you would like to be called: _______________

2. Age: ______

3. Date of birth: ____________

4. Height: ____________

5. Weight: ____________

6. Race/ethnic background: [ ]White [ ]African American [ ]Asian [ ]Latin American [ ]Other (Please specify)______________________________

7. U.S. Citizen: [ ]Yes [ ]No

8. Check one: [ ]Married [ ]Divorced [ ]Widowed [ ]Separated [ ]Engaged

9. How long have you been married? ____

10. Have you ever experienced any marital problems? [ ]Yes [ ]No If yes, explain:

    ____

11. If not married, first name of partner: ______________________

    Do you live together: [ ]Yes [ ]No If yes, how long? _____________________

12. Spouse's/Partner's Name: __________________ Age: _______ D.O.B. :__________

13. Sex and Number of children: Males _____ Ages:__________ Females:_______ Ages:___

14. Are children biologically related to your husband/partner? [ ]Yes [ ]No

15. Would you like to have any more children of your own in the future? [ ]Yes [ ]No

16. If divorced, when did it occur? [ ]Yes [ ]No

17. What was the cause of the breakup? ____

18. Have you remarried? [ ]Yes [ ]No

19. How long ago? __________________________

20. Religious background: ____

    Practicing: [ ]Yes [ ]No

21. Preference for the religious background of the intended parents:

[ ]Yes________________________________ [ ]No

22. Would you be willing to work with:

Same sex couple:	[ ]Yes [ ]No
Single male:	[ ]Yes [ ]No
Single female:	[ ]Yes [ ]No
Couple using an egg:	[ ]Yes [ ]No
Couple using a sperm donor:	[ ]Yes [ ]No
An older couple:	[ ]Yes [ ]No
A couple with children:	[ ]Yes [ ]No
An African American couple:	[ ]Yes [ ]No
A Jewish couple:	[ ]Yes [ ]No
A Caucasian couple:	[ ]Yes [ ]No
A Hispanic couple:	[ ]Yes [ ]No
An Indian couple:	[ ]Yes [ ]No
An international couple (Living outside of the U.S.)	[ ]Yes [ ]No
A non-English speaking couple with a translator:	[ ]Yes [ ]No

23. Please list the couples you would not be interested in working with, if not listed above.

____

24. Have you applied or are you currently applying to be a gestational carrier at any other medical facility, law firm and/or agency? [ ]Yes [ ]No

If yes, please list:____

25. Have you ever applied to be a gestational carrier at any other medical facility, law firm, and/or agency and been told you do not meet the facility's criteria to be a gestational carrier: [ ]Yes [ ]No If yes, please explain: ______________________________________
____

HEALTH INFORMATION

1. Do you have health insurance? [ ]Yes [ ]No

   If so, does it have maternity coverage? [ ]Yes [ ]No
   Health insurance company:

   Name: ______________________________
   Address: ______________________________
   Phone: ______________________________

   Is your health insurance provided through a state agency or program? [ ]Yes [ ]No

2. Allergies: ______________________________

3. Do you have any medical problems? [ ]Yes [ ]No If yes, please explain:

   ____

4. Number of pregnancies: ____________

5. Dates of each pregnancy: ______________________________

6. Number of miscarriages: ____________

7. Dates of each miscarriage: ______________________________

8. Number of abortions: ____________

9. Dates of each abortion: ______________________________

10. Number of stillbirths: ____________

11. Dates of each stillbirth: ______________________________

12. Are your menstrual periods regular? [ ]Yes [ ]No

13. How long is your monthly cycle? ______________________________

14. Do you have bleeding between periods? ______________________________

15. How would you describe any cramping you have during your period?

    ____

16. Is there anything unusual about your monthly cycle? [ ]Yes [ ]No If yes, explain:
____

17. How many days does your period last? _________ days

18. How was each of your children conceived? [ ]Naturally [ ]With medical intervention

19. Are you presently using birth control? [ ]Yes [ ]No If yes, please state current method:

20. How long have you used this method of birth control? _______________________

21. Do you smoke cigarettes? [ ]Yes [ ]No If yes, how often? ______________________

22. Does any member of your family smoke cigarettes? [ ]Yes [ ]No If so, who and how often?
____

23. Have you ever smoked cigarettes? [ ]Yes [ ]No If so, when? ____________________

24. Do you drink alcohol? [ ]Yes [ ]No If yes, how often? _______________________

25. Have you ever used illegal drugs or un-prescribed drugs? [ ]Yes [ ]No
If yes, what drugs and how often? ____

26. Has you husband/partner used illegal drugs or un-prescribed drugs? [ ]Yes [ ]No
If yes, what drugs and how often? ____

27. Give a history of all previous pregnancies, including physical and emotional problems during and after each pregnancy (give delivery date, sex and weight of baby and list any complications). Please indicate if the birth(s) were vaginal or cesarean section:
____
____
____

28. Do any of your children have serious health problems? [ ]Yes [ ]No If yes, please explain:
____

29. Are you currently breastfeeding? [ ]Yes [ ]No If so, when do you plan to stop? ________

30. Do you have a history of any eating disorders? [ ]Yes [ ]No If yes, please describe:
____

31. Would you be willing to undergo amniocentesis or other diagnostic testing to determine the presence of birth defects? [ ]Yes [ ]No

32. If there were a serious problem with the fetus and the intended parents wanted to abort, would you be willing to abort? [ ]Yes [ ]No

33. Are there any specific conditions in which you would not abort a pregnancy?[ ] Yes [ ]No

34. Have you ever had surgery? [ ]Yes [ ]No If yes, reasons and results?
____

35. List all serious illnesses and hospitalizations:
____

36. List all medications you are presently taking and the reasons for each:
____

37. Have you gotten a tattoo or any body piercing within the last year and a half? [ ]Yes [ ]No

38. Have you ever been seen by a professional for mental health issues? [ ]Yes [ ] No
If yes, please explain and list time periods: ____
____

39. Have you ever experienced any post-partum depression? [ ]Yes [ ]No
If yes, please give the details and time periods: ____
____

40. Have you ever been prescribed or taken any medications for depression or mental health?
[ ]Yes [ ]No If yes, please list the medications, reason for it and time periods:
____

41. Have you ever had any problems with drug or alcohol abuse? [ ]Yes [ ]No
If yes, please give the details. ____

42. If any of your children are deceased, what was the age and cause of death:
____

43. Are you exposed to excess heat in the way of saunas, hot tubs, and steam rooms? [ ]Yes [ ]No
If yes, please explain: ____

44. Do you have any allergies? [ ]Yes [ ]No
If yes, please explain in detail: ____________________

45. Blood type: __________ RH Factor: [ ]Positive [ ]Negative

46. Have you ever been advised to limit your use of alcohol or any other drug? [ ]Yes [ ]No
If yes, please explain: ____________________

47. Have you ever been advised to have any medical test and/or surgical procedure and failed to take such advice? [ ]Yes [ ]No If yes, please explain: ____________________
____

48. Number of months between stopping birth control and conception? ____________

49. Have you ever been seen by a doctor for infertility? [ ]Yes [ ]No

50. Did your mother take DES while pregnant? [ ]Yes [ ]No

51. Have you ever been told that you were infertile? [ ]Yes [ ]No

52. Have you delivered any children with birth defects? [ ]Yes [ ]No

53. Have your parents had any serious mental or physical illness? [ ]Yes [ ]No

54. If either of your parents are deceased what was their age and cause of death?
____

SEXUAL HISTORY

1. List any contraceptives you have used in the past and any reaction you had to the use of the contraceptive? ____________________
2. Which method do you currently use? ____________________
3. Are you with a sexual partner now? [ ]Yes [ ]No
4. Which method does your partner currently use? ____________________
5. Please indicate with whom you have had sexual contact: [ ]Men [ ]Women [ ]Both
6. Do you currently have more than one sexual partner? [ ]Yes [ ]No

7. How many sexual partners have you had in the past three years? ____________________

8. Have you had sexual contact with a person you do not know well? [ ]Yes [ ]No

9. In the past 10 years, have you had sexual contact with anyone in a high risk group for A.I.D.S.? These include sexually active persons with multiple partners. [ ]Yes [ ]No

10. To your knowledge, have any of your sexual partners been sexually active with anyone in a high risk group for A.I.D.S.? [ ]Yes [ ]No

11. Are you at risk for A.I.D.S.? [ ]Yes [ ]No

12. Have you ever used IV drugs? [ ]Yes [ ]No

13. Have you ever received a blood transfusion? [ ]Yes [ ]No

14. Have you ever had a sexually transmitted disease? [ ]Yes [ ]No If yes, please explain:
    ____

15. Have you or any member of your family had a personal experience with any of the following: Serious accident or crime, rape, assault, incest, or sexual or physical abuse or victim of any crime?
    [ ]Yes [ ]No If yes, please explain:
    ____

EMPLOYMENT INFORMATION

1. Please list your current and previous place of employment, including positions held, dates of employment, and locations of each employer:
   ____
   ____

2. Please list your husband's/partner's current employment, including his position held, and location of employer:
   ____

3. Your current income: ____

4. Are you receiving food stamps or any other public assistance as part of your income?
   [ ]Yes [ ]No If yes, please specify:_______________________________________

5. Husband's/partner's current income: ___________________________________

6. How many persons do you support including yourself? ____________________

EDUCATIONAL HISTORY

1. Please choose highest level attained (only choose one):

   a. [ ]Completed through grade ________
   b. [ ]Graduated high school
   c. [ ]Attended college through (circle one) freshman, sophomore, junior, senior year
   d. [ ]Graduated college- List degrees: ______________________________
   e. [ ]Post Graduate: ______________________________________
   f. [ ]Other (trade school, etc.) _________________________________

GENERAL QUESTIONS

1. Please list any problems you or your spouse/partner have experienced with the law, including, but not limited to, any arrests, convictions, or sentences:

   ____

   ____

2. Have you or your spouse ever served any time in jail? [ ]Yes [ ]No
   If so, how much time did you serve and why?

   ____

3. Briefly explain your understanding of what being a gestational carrier will entail?

   ____

   ____

   ____

4. What qualities would you consider most important that the intended parents have?

   ____

   ____

5. Would you permit the intended parents in the delivery room? [ ]Yes [ ]No

6. Would you permit the intended parents to attend doctor's appointments if they wanted to attend? [ ]Yes [ ]No

7. Would you permit the intended parents to notify the hospital that you were not the biological parent? [ ]Yes [ ]No

8. Would you allow the intended parents' names to be placed on the birth certificate?
   [ ]Yes [ ]No

9. Would you be willing to pump, freeze, and ship breast milk if your intended parents requested it for their child? [ ]Yes [ ]No

10. Please rate how important the following factors were to you in making the decision to apply to be a gestational carrier (1= most important)

    a. ______ I like being pregnant, but don't want any more children of my own.
    b. ______ I need the money.
    c. ______ Giving an infertile couple a child would bring me happiness.
    d. Other please specify: ____

11. Have you ever been an egg donor? [ ]Yes [ ]No If yes, when?______________

12. Have you ever been a gestational carrier or surrogate mother before? [ ]Yes [ ] No
    If yes, please describe your experience on a separate sheet of paper.

13. Have you ever placed a child for adoption? [ ]Yes [ ]No
    If yes, please describe your experience on a separate sheet of paper.

14. Are you adopted? [ ]Yes [ ]No

15. Are any of your children adopted? [ ]Yes [ ]No

16. Have you ever cared for a foster child? [ ]Yes [ ] No If yes, please explain briefly:
    ____
    ____

17. How do you feel about carrying twins?
    ____

18. Although triplets are not too common, please tell us if you would agree to carry triplets as long as your health and the babies' health were not in jeopardy?[ ]Yes [ ]No

19. In the case of a pregnancy with triplets, how do you feel about possibly reducing the pregnancy from three to two? ____
    ____

20. How do you feel about reducing the pregnancy to one? Please explain.

____

____

21. How much contact or information about the child after birth would you like? Please specify. ____

22. Do you feel confident that you will not hesitate to give the couple the child(ren) you will carry for them? [ ]Yes [ ]No

23. What kind of support do you expect for being a gestational carrier from your significant other, siblings, parents, friends, and co-workers? Please give a detailed answer.

____

____

24. How does your husband/partner feel about your participation in this program? Please describe in detail.

____

____

25. Do you have any guns in your home? [ ]Yes [ ]No If yes, please describe why and where they are kept.

____

26. Do you lease a car, own a car, or have access to public transportation? (Please specify).

____

27. Is your vehicle insured? [ ]Yes [ ]No

28. Do you have a valid driver's license? [ ]Yes [ ]No