



P.O. Box 1646  
Castle Rock, CO 80104  
Tel: 720-733-0184  
TF: 877-745-3447  
Fax: 720-733-2433  
[www.donatedeggs.com](http://www.donatedeggs.com)

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

### **INTENDED PARENT'S QUESTIONNAIRE**

Intended Mother's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Intended Father's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

IM Work Phone: \_\_\_\_\_ IF Work Phone: \_\_\_\_\_

IM Cell Phone: \_\_\_\_\_ IF Cell Phone: \_\_\_\_\_

May we leave detailed messages at: Home Work Cell Send Fax without prior notice

IM Email Address: \_\_\_\_\_

IF Email Address: \_\_\_\_\_

IM Social Security #: \_\_\_\_\_ IF Social Security #: \_\_\_\_\_

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

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

IM Employer's Name and Address:

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

IF Employer's Name and Address:

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

Have either of you ever been convicted of a crime? Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, Please explain in detail: \_\_\_\_\_

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

**Status:** Married ( ) Single ( ) Committed Relationship ( )

If married: Ceremonial or Common law      How long have you been together? \_\_\_\_\_

Please give brief description of your infertility history: \_\_\_\_\_

\_\_\_\_\_

Other procedures tried or avenues sought: \_\_\_\_\_

\_\_\_\_\_

Have you considered adoption? \_\_\_\_\_

\_\_\_\_\_

Does one of you feel more strongly than the other about using a surrogate? \_\_\_\_\_

\_\_\_\_\_

Do you have children?      Yes      No

If Yes, how many and ages \_\_\_\_\_. \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

Are they a result of a Gestational Carrier?      Yes      No

If yes, please provide details including any problems and concerns: \_\_\_\_\_

\_\_\_\_\_

How do your children feel about plans to add to your family? \_\_\_\_\_

\_\_\_\_\_

Will partner/spouse be the biological father?      Yes      No

If No, is the sperm donor:      Known      Anonymous

Name of your fertility specialist: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Best Contact Person: \_\_\_\_\_

Are you currently working with an attorney experienced in Assisted Reproduction Law?      Yes      No

If Yes, Name and contact info of attorney: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

How did you hear about An Eggceptional Match?

Clinic Referral

Attorney Referral

Friend (Please specify so we may thank them!) \_\_\_\_\_

Internet (Please be specific) \_\_\_\_\_

**INTENDED MOTHER'S PROFILE**

Are you a U.S. Citizen?    Yes    No    If no, please state citizenship:

Place of Birth: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

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

Do you require your GC to have a similar religious practice?    Yes    No

Driver's License Number: \_\_\_\_\_ State of Issue: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

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

Hair Color: \_\_\_\_\_ Eye Color: \_\_\_\_\_ Blood Type: \_\_\_\_\_ + or -

Including yourself, how many people reside at your current residence? \_\_\_\_\_

\_\_\_\_\_ Adults

\_\_\_\_\_ Children    Ages of son(s) \_\_\_\_\_, \_\_\_\_\_    Ages of daughter(s) \_\_\_\_\_, \_\_\_\_\_

Current income for IM:    \$0-\$24,999    \$25,000-\$49,000    \$50,000-\$74,999    \$75,000-\$99,999  
\$100,000 +

**PERSONAL HEALTH INFORMATION**

Do you consider yourself in good health?    Yes    No

If No, please describe in detail: \_\_\_\_\_

Will this condition impair your normal daily activities or shorten your lifespan?    Yes    No

If Yes, What is your prognosis? \_\_\_\_\_

Do you smoke cigarettes?    Yes    No - # per day: \_\_\_\_\_

Do you drink alcohol?    Yes    No - If yes: \_\_\_\_\_ day \_\_\_\_\_ week \_\_\_\_\_ month

Do you currently use or have you ever used recreational drugs?    Yes    No - If yes: Please describe in as much detail as possible: \_\_\_\_\_

Do you have any allergies?    Yes    No (If yes, please describe in detail):

Are you currently taking prescribed medications?    Yes    No (If yes: name, dosage reason for taking):

Have you had a recent psychological evaluation?    Yes    No

If yes, please provide copy to AEM with application submission

Do you have a history of mental illness?      Yes      No    (If yes, please explain in detail including all diagnoses and treatments):

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Have you ever had any psychiatric hospitalizations?      Yes      No

If yes, please describe in detail including all dates, name of facility and discharge diagnosis:

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Please list all surgeries:

Type: \_\_\_\_\_ Date: \_\_\_\_\_ Location: \_\_\_\_\_  
Type: \_\_\_\_\_ Date: \_\_\_\_\_ Location: \_\_\_\_\_

Age of menses onset: \_\_\_\_\_ Are your cycles regular?      Yes      No

Length of cycle from day one to day one: \_\_\_\_\_ Days    How long do they last? \_\_\_\_\_ Days

Flow:    Light    Moderate    Heavy    Cramps?    None    Mild    Average    Severe

Have you ever been pregnant?      Yes      No If Yes:

Number of pregnancies: \_\_\_\_\_ Number of terminations: \_\_\_\_\_

Number of live births: \_\_\_\_\_ Number of still births: \_\_\_\_\_

Number of miscarriages: \_\_\_\_\_ Number of cesarean births: \_\_\_\_\_

### **QUESTIONNAIRE**

Have you discussed the use of a gestational carrier with your extended family?      Yes      No

If yes, how did they respond? \_\_\_\_\_

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Do you have concerns regarding other's reactions to using a gestational carrier?      Yes      No

Do you have a clear understanding of how surrogacy works?      Yes      No

What type of relationship would you like to have with your Gestational Carrier during the pregnancy?

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Do you want to attend appointments with your GC if possible?      Yes      No

Will you require your GC to have an amniocentesis or other genetic tests?      Yes      No      Maybe

If these tests come back abnormal, would you want your GC to terminate the pregnancy?      Yes      No

Maybe if: \_\_\_\_\_

What type of relationship do you expect with your GC after the birth?

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If there is more than one baby born, do you plan to keep all of them?      Yes      No

If No, what are your plans? \_\_\_\_\_

Do you want to be present at the birth?      Yes      No      Maybe

Is this a requirement of you?      Yes      No

Will you tell your child about your GC?      Yes      No      Maybe

If yes, will you allow them to meet one day if all parties agree?      Yes      No

If No, please explain your feelings: \_\_\_\_\_

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Would you like to leave a message for your Gestational Carrier?

**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	_____	_____	_____

## **FAMILY HEALTH STATUS**

	Age	Living Health Status	Age	Deceased	Cause of Death
Mother					
Father					
Brother: 1.					
2.					
3.					
4.					
Sister: 1.					
2.					
3.					
4.					
Maternal Grandmother					
Maternal Grandfather					
Paternal Grandmother					
Paternal Grandfather					
Children: (If Any) 1.					
2.					
3.					

**INTENDED FATHER'S PROFILE**

Are you a U.S. Citizen?    Yes    No    If no, please state citizenship:

\_\_\_\_\_

Place of Birth: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

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

Do you require your GC to have a similar religious practice?    Yes    No

Driver's License Number: \_\_\_\_\_ State of Issue: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

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

Hair Color: \_\_\_\_\_ Eye Color: \_\_\_\_\_ Blood Type: \_\_\_\_\_ + or -

Including yourself, how many people reside at your current residence? \_\_\_\_\_

\_\_\_\_\_ Adults

\_\_\_\_\_ Children    Ages of son(s) \_\_\_\_\_, \_\_\_\_\_    Ages of daughter(s) \_\_\_\_\_, \_\_\_\_\_

Current income for IM:    \$0-\$24,999    \$25,000-\$49,000    \$50,000-\$74,999    \$75,000-\$99,999

\$100,000 +

**PERSONAL HEALTH INFORMATION**

Do you consider yourself in good health?    Yes    No

If No, please describe in detail: \_\_\_\_\_

\_\_\_\_\_

Will this condition impair your normal daily activities or shorten your lifespan?    Yes    No

If Yes, What is your prognosis? \_\_\_\_\_

\_\_\_\_\_

Do you smoke cigarettes?    Yes    No - # per day and since when: \_\_\_\_\_

Do you drink alcohol?    Yes    No - If yes: \_\_\_\_ day \_\_\_\_ week \_\_\_\_ month

Do you currently or have you ever used recreational drugs?    Yes    No - If yes: Please describe in as much detail as possible:

\_\_\_\_\_

\_\_\_\_\_

Do you have any allergies?    Yes    No (If yes, please describe in detail):

\_\_\_\_\_

\_\_\_\_\_

Are you currently taking prescribed medications?    Yes    No (If yes: name, dosage reason for taking):

\_\_\_\_\_

\_\_\_\_\_

Have you had a recent psychological evaluation?    Yes    No If yes, provide date, name of provider and results \_\_\_\_\_



If yes, please provide copy to AEM with application submission

Do you have a history of mental illness?      Yes      No      (If yes, please explain in detail):

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Have you ever had any psychiatric hospitalizations?      Yes      No

If yes, please provide all dates, name of facility and discharge diagnosis:

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Please list all surgeries:

Type: \_\_\_\_\_ Date: \_\_\_\_\_ Location: \_\_\_\_\_

Type: \_\_\_\_\_ Date: \_\_\_\_\_ Location: \_\_\_\_\_

### **QUESTIONNAIRE**

Have you discussed the use of a gestational carrier with your extended family?      Yes      No

If yes, how did they respond? \_\_\_\_\_

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Do you have concerns regarding other's reactions to using a gestational carrier?      Yes      No

Do you have a clear understanding of how surrogacy works?      Yes      No

What type of relationship would you like to have with your Gestational Carrier during the pregnancy?

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Do you want to attend appointments with your GC if possible?      Yes      No      Maybe

Will you require your GC to have an amniocentesis or other genetic tests?      Yes      No      Maybe

If these tests come back abnormal, would you want your GC to terminate the pregnancy?      Yes      No

Maybe if: \_\_\_\_\_

What type of relationship do you expect with your GC after the birth?

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If there is more than one baby born, do you plan to keep all of them?      Yes      No

If No, what are your plans? \_\_\_\_\_

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Do you want to be present at the birth?      Yes      No      Maybe

Is this a requirement of you?      Yes      No

Will you tell your child about your GC?      Yes      No      Maybe

If yes, will you allow them to meet one day if all parties agree?      Yes      No

If No, please explain your feelings: \_\_\_\_\_

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Would you like to leave a message for your Gestational Carrier?

**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	_____	_____	_____

# FAMILY HEALTH STATUS

	Living Age	Health Status	Deceased Age	Cause of Death
Mother				
Father				
Brother: 1.				
2.				
3.				
4.				
Sister: 1.				
2.				
3.				
4.				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Children: (If Any) 1.				
2.				
3.				

## **REFERENCES**

Please list four references. You may not include family members and should include one physician who has treated your infertility.

- |          |              |
|----------|--------------|
| 1. _____ | Phone: _____ |
|          | Cell: _____  |
| 2. _____ | Phone: _____ |
|          | Cell: _____  |
| 3. _____ | Phone: _____ |
|          | Cell: _____  |
| 4. _____ | Phone: _____ |
|          | Cell: _____  |