



P.O. Box 1646
Castle Rock, CO 80104
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TF: 877-745-3447
Fax: 720-733-2433
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):

Have you ever had any psychiatric hospitalizations? Yes No

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

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? _____

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?

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?

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: _____

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? _____

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

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If No, please describe in detail: _____

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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):

Have you ever had any psychiatric hospitalizations? Yes No

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

Please list all surgeries:

Type: _____ Date: _____ Location: _____

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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

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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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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: _____ |