SURROGATE PROFILE

Date:_____

I. Surrogate Mother

Name: _____
Maiden name or any other name you have been known by in the past: _____
_____
Address: _____
_____
Permanent Address:_____
_____
Telephone (home):_____(cell): _____ (work):_____
Email address: _____
If you are a resident of a state other than Florida, are you willing to
come to Florida for the final stage of pregnancy and birth? _____
How long have you lived at your present address? _____
Birth Date: _____ Birth Place:_____
Religion: _____ Ancestry/Nationality:_____
Race:_____
Marital Status: Single ( ) Married ( ) Separated ( ) Divorced ( )
Marital History (specify dates of marriage, divorce, death of spouse, etc.)
_____
_____
Husband's name: _____ Age: _____

Physical Description
Height: _____ Weight: _____ Hair Color: _____ Eye Color: _____
Complexion: Fair ( ) Olive ( ) Tan ( ) Dark ( ) Other ( )

Family Background Information
Is your family aware of your surrogacy plans? Yes ( ) No ( )
Do they agree with your plan? Yes ( ) No ( )
Do you live with your family? Yes ( ) No ( )
In case of emergency, notify: Name: _____
Address: _____
_____
Telephone: _____

Medicaid
Do you have Medicaid? Yes ( ) No ( )
If so, issued through what county? _____ Medicaid #: _____

Insurance Coverage

Do you have health insurance? Yes ( ) No ( )

Does it have maternity coverage? Yes ( ) No ( )

Is there an exception from coverage for surrogacy pregnancy?

Yes ( ) No ( )

If your insurance will cover your surrogacy pregnancy, please provide:

Name of Insured: _____ Policy Number: _____

Company name : _____

Address: _____

Phone Number: _____

Identification:

Social Security Number: _____ Other: _____

Driver's License: _____

(State) (I.D. No.)

Pregnancy History

Will this be your first pregnancy Yes ( ) No ( )

If not, how many prior pregnancies? _____

Please describe what occurred with these pregnancies (indicate number)

Abortion _____ Miscarriage _____

Birth _____Normal _____ C-Section _____

Were there any problems with prior pregnancies or births? Yes ( ) No ( )

If so, describe:

_____

_____

Are the children with you now? Yes ( ) No ( )

If not, please explain:

_____

_____

Age	Sex	School Grade	Height	Weight	Hair	Eyes	Complex-ion	Full Term?

Would you like to have any more children of your own in the future?

Medical Information

Do you already have a doctor with respect to the contemplated pregnancy?

Yes ( ) No ( )

If so, Name: _____

Address: _____

Telephone number: _____

Name of hospital you will deliver in: _____

Address: _____
Telephone Number: _____

Health Information:

Are your menstrual periods regular?

How long is your monthly cycle?

Do you have any bleeding between periods?

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

Is there anything unusual about your monthly cycle? Yes___ No___

How many days does your period last: ___ Days

Are you presently using birth control? Yes ___ No___
If yes, please state current method:

How long have you used this method of birth control?

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).

_____
_____
_____

Would you be willing to undergo amniocentesis, CVS, or other diagnostic testing to determine the presence of birth defects? Yes___ No___

If there were a serious problem with the fetus and the intended parents wanted to abort,
Would you be willing to abort? Yes___ No___

Are there any specific conditions in which you would not abort a pregnancy?
If yes, please explain:

_____
_____

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

_____
_____
_____

Have you had any therapy with a psychiatrist or any other mental health professional?

If yes, please explain:

_____

_____

_____

Have you ever had any problems with drug or alcohol abuse?

If yes, please give the details:

_____

_____

Blood type: _____

RH Factor: Positive ___ Negative ___

Are you at risk for H.I.V./A.I.D.S.?

Have you ever used IV Drugs?

Have you ever received a blood transfusion?

Have you ever had a sexually transmitted disease? If yes, please explain:

American Indian Heritage

Are you a registered member of any American tribe or Alaskan village?

Yes ( ) No ( )

If so, please indicate the tribe, its location and your registration or identification number: _____

Educational History

Number of years attended: Grade School ___ High School ___ College ___

Educational Achievements: _____

Educational Goals: _____

Vocational and/or other training: _____

Occupational Background

Present occupation: _____ Salary: _____

Address of present employer: _____

_____

Telephone number: _____ Work Hours: _____

Can you be called at work? Yes ( ) No ( )

Length of employment: _____

Do you plan to stop working at any point during pregnancy? Yes ( ) No ( )

If so, when? _____

Hobbies, Talents, Interests

_____

_____

_____

Legal Representation

Are you represented by an attorney? Yes ( ) No ( )

If so, Name: _____

Address: _____

Telephone Number: _____

General Questions

Please list any problems you have experienced with the law, including, but not limited to, any arrest, convictions, and sentences:

_____

_____

_____

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

_____

_____

_____

Generally, please describe yourself, i.e. your personality, hobbies, and interests?

_____

_____

_____

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

_____

_____

_____

Would you permit the intended parents in the delivery room?

Would you permit the intended parents to attend doctor's appointments if they want to attend?

Would you permit the intended parents to notify the hospital that you are not the biological parent?

Would you allow the intended father's name to be placed on the birth certificate?

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:

Have you ever been a gestational carrier or surrogate mother before?
If yes, please describe your experience on a separate sheet of paper.

Have you ever placed a child for adoption?
If so, please describe your experience on a separate sheet of paper.

Are you adopted?

Are any of your children adopted?

How do you feel about carrying twins?

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

How much contact or information about the child after birth would you like?
Please specify: _____
_____

Do you feel confident that you will not hesitate to give the couple the child(ren) you will carry for them? Please explain. _____
_____

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

_____
_____
_____
_____
_____

Do you lease a car, own a car, or have access to public transportation? _____
_____

FAMILY BACKGROUND [if you are: 1) supplying the egg or 2) an egg donor]

	Your Mother	Your Father	Your Sisters	Your Brothers
Name:				
Age:				
Race:				
Education:				
Hobbies/ Interests:				
Occupation:				
Height:				
Hair Color:				
Eye Color:				
Complexion:				

	Your Mother's Mother	Your Mother's Father	Your Father's Mother	Your Father's Father
Name:				
Age:				
Race:				
Education:				
Hobbies/ Interests:				
Occupation:				
Height:				
Hair Color:				
Eye Color:				
Complexion:				

MEDICAL INFORMATION OF SURROGATE

Indicate by checking appropriate box if you have had, or now have, the medical conditions listed below. If you are donating the egg for the surrogacy or are interested in being an egg donor, please also provide information regarding your relatives (parents, grandparents, sisters, brothers, aunts, uncles).

PLACE AN **'X'**	**CONGENITAL IMPAIRMENTS**	**List yourself and the member(s) from your maternal or paternal side of your family who have or had each impairment**
	Club foot or any orthopedic problem	
	Harelip (Cleft lip) or Cleft palate	
	Cerebral Palsy	
	Down's Syndrome	
	Hydrocephalus (Water on the brain)	
	Muscular dystrophy	
	Dwarfism	
	Spina Bifida	
PLACE AN **'X'**	**ALLERGIES**	**List yourself and the member(s) from your maternal or paternal side of your family who have or had each impairment**
	Eczema or other skin conditions	
	Hay fever	
	Milk allergy	
	Drug allergy(s)	
	Other	
PLACE AN **'X'**	**EYE, EAR, NOSE AND THROAT DISORDERS**	**List yourself and the member(s) from your maternal or paternal side of your family who have or had each impairment**
	Farsighted	
	Nearsighted	
	Different color eyes	
	Night blindness	
	Glaucoma	
	Blindness	
	Other visual problems	
	Sinus or nasal problems	
	Ear infections	
	Deafness	
	Other ear problems	
	Teeth problems	
	Gum disease	
	Other	
PLACE AN	**CIRCULATORY DISORDERS**	**List yourself and the member(s) from your maternal or paternal side of your**

'X'		**family who have or had each impairment**
	Hypertension (high blood pressure)	
	Heart murmurs	
	Heart attack (coronary)	
	Hemophilia (free bleeder)	
	Leukemia	
	Stroke	
	Anemia	
	Sickle cell anemia or trait	
	Heart Surgery	
	Any other heart or circulatory problems	
PLACE AN **'X'**	**RESPIRATORY AND DIGESTIVE DISORDERS**	**List yourself and the member(s) from your maternal or paternal side of your family who have or had each impairment**
	Asthma	
	Bronchitis	
	Cystic fibrosis	
	Sudden infant death syndrome	
	Frequent pneumonia	
	Other respiratory disorders	
	Ulcers	
	Colitis	
	Gall bladder problem	
	High Cholesterol	
	Obesity	
	Anorexia/Bulimia	
	Colon Cancer	
	Other Digestive Disorders	
PLACE AN **'X'**	**URINARY TRACT CONDITIONS**	**List yourself and the member(s) from your maternal or paternal side of your family who have or had each impairment**
	Bladder Problems	
	Kidney problems	
PLACE AN **'X'**	**DEVELOPMENTAL DISORDERS, MENTAL, BEHAVIORAL, AND NERVOUS DISORDERS.**	**List yourself and the member(s) from your maternal or paternal side of your family who have or had each impairment**
	Speech problems	
	Learning disability	
	Retardation: mental or physical	
	Other developmental disorders	
	Diagnosed schizophrenia	
	Diagnosed manic depressive	
	Alcoholism or heavy drinking	
	Drug abuse	
	Other mental or behavioral disorders	

	Multiple sclerosis	
	Lou Gehrig's disease	
	Seizures or convulsions	
	Huntington's disease	
	Epilepsy	
	Migraine headaches	
	Other nervous system disorders	
PLACE AN **'X'**	**MISCELLANEOUS DISORDERS**	**List yourself and the member(s) from your maternal or paternal side of your family who have or had each impairment**
	Diabetes	
	Arthritis	
	Gouty arthritis	
	Rheumatoid arthritis	
	Hodgkin's disease	
	Cysts, lumps, or growths	
	Tumors	
	HIV/AIDS	
	Others	
PLACE AN **'X'**	**FEMININE DISORDERS**	**List yourself and the member(s) from your maternal or paternal side of your family who have or had each impairment**
	Endometriosis	
	Menstrual problems	
	Problem pregnancies	
	Other problems	
	What age did your period begin?	
	What age did your period begin?	

Please provide this confidential information concerning your drug and medical history. Check no only if you have never used the substance before.

DRUG AND ALCOHOL USAGE	NO	MONTH(S) IF DURING PREGNANCY	YEAR(S) IF PRIOR TO PREGNANCY	FREQUENCY, AND AMOUNT
ASPRIN				
ANTIOBIOTICS				
ANTIHISTIMINES – TYPES				
HORMONES – TYPES				
CORTISONE (ACTH, ETC)				
DIET PILLS – TYPES				
SLEEPING PILLS –				

TYPES				
NERVE PILLS/ TRANQUILIZERS				
MEDICINES FOR CANCER – TYPE				
HEART/BLOOD PRESSURE PILLS – TYPE				
THALIDOMIDE				
MEDICINE FOR NAUSEA – TYPE				
MEDICINE FOR CONVULSIONS				
NOSE DROPS				
ALCOHOL				
AMPHETAMINES TYPES				
BARBITUATES				
COCAINE				
HEROIN				
LSD				
MARIJUANA				
CIGARETTES				

Florida law allows the prospective parents to pay the reasonable living, legal, medical, psychological and psychiatric expenses of the Gestational Surrogate that are directly related to the prenatal, intrapartal and postpartal periods. Please state the approximate total amount you desire to be compensated (not including medical screening and care, psychological screening/counseling, or legal fees). Perhaps reference to your monthly living expenses, calculated over a 10-month period, will assist you in arriving at a reasonable living expense figure.

$_____.

SURROGATE AGREEMENT

I, the undersigned prospective Surrogate, under penalty of perjury, represent that the forgoing information contained in and/or attached to this Surrogacy Profile (including but not limited to the Medical Information and the Budget) is true and accurate.

I acknowledge that the intended parents and other parties will rely on this information in making a determination to proceed. I hereby agree that this form and the information contained herein may be disclosed in its entirety to prospective intended parents, their physicians and specialists, and their attorney(s), and I expressly absolve and release the Law Offices of Jeanne T. Tate and its attorneys and employees from all liability in connection with such disclosure.

I authorize the Law Offices of Jeanne T. Tate to conduct criminal and child abuse background screening of me, directly or through Heart of Adoptions, Inc., and I authorize the release of my personal information and agree to complete any necessary forms and finger printing for such purposes.

I further understand that any false statement herein may be viewed as perjury and in violation of the penal laws of my state and may subject me to criminal and/or civil penalties under the law.

_____

STATE OF _____
COUNTY OF _____

The foregoing instrument was sworn to and subscribed before me this ___ day of _____, 20__, by_____, who is personally known to me or who has produced _____ as identification.

_____

Notary Public

_____

(Print, Type or Stamp Name)