SURROGATE QUESTIONNAIRE

Submit to NAFG 600 Third Avenue, 15th Floor New York, NY 10016

PLEASE RETURN WITH THIS FORM: 1) A COPY OF YOUR CURRENT DRIVER'S LICENSE
2) A COPY OF YOUR SPOUSE'S/PARTNER'S DRIVER'S LICENSE
3) RECENT PHOTOGRAPH(S) OF YOU, YOUR SPOUSE/PARTNER, AND YOUR CHILDREN

Date ________________ Name (first, middle, last) ____

Home Phone ______________________ Address ____

Work Phone ______________________ ____

Cell Phone ______________________ ____

E-mail Address ____

Occupation ___________________ Work Address ____

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Date of Birth ______________________ Social Security Number ______________________________

Marital Status: single ☐ married ☐ divorced ☐ widowed ☐

If married:

Your maiden name ____

Husband's name ____

Date of marriage ____

Husband's occupation _________________ Husband's date of birth ___________________

If you have been divorced, please provide the dates of your marriage(s) and divorce(s), and the name(s) of your ex-spouse(s) ____

If you have a secondary residence, please specify:

____

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Please list all your past addresses from the last ten years:

If you are currently unemployed, how are you financially supported?

If you are currently employed, please indicate start date of current job and provide a brief history of your past employment:

Please tell us how you heard of our program, and why you are interested in being a surrogate.

Have you informed your spouse, children, other family members, etc. of your interest in becoming a surrogate? Are they supportive?

MEDICAL / PHYSICAL / PERSONAL HISTORY

Height ______________________ Weight ______________________

Please list the dates of all your previous pregnancies (including abortions and miscarriages, if any), and the ages and names of your children:

Are your children currently living with you?

Are you currently taking any medications or have any illnesses? If so, please specify:

If you had any illnesses or prescribed any drugs in the past five years, please specify:

Do you have health insurance? If so, please specify name and policy number: ______________________

Do you see a gynecologist regularly? If so, please indicate doctor's name, address, and phone number:

Do you have regular menstrual periods? ______________________

Are you currently using birth control? If so, please specify method: ______________________

Do you currently or have you ever been treated for any sexually transmitted diseases?
If so, please give dates and description.

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Please describe your diet and exercise routine: ______________________________

____

____

Do you smoke? If so, please indicate how much: ______________________________

____

Do you you live in a smoke-free household? ______________________________

If you drink alcoholic beverages, please specify how often: ______________________________

____

Do you take any recreational drugs? If so, please specify: ______________________________

____

How many sexual partners have you had in the past six months? ______________________________

Have you been a surrogate or egg donor before? If so, please specify and provide dates:

____

Please describe, to the best of your ability, your religious and ethnic background:

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____

Have you ever been arrested or convicted of a crime? If so specify and provide dates:

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Please describe the level of your education and degree dates:

____

____

Do you plan on having any more children of your own? ______________________________

Would you be willing to travel for medical procedures related to your surrogacy? ______________________________

____

Massachusetts 92 State Street, 7th Floor, Boston MA 02109 Tel: 1-800-710-1677; 617-557-4300 Fax: 617-557-4301 www.assistedfertility.com
New York 600 Third Avenue, 15th Floor, New York NY 10016 Tel: 212-207-1900 Fax: 212-207-3099 inquiry@assistedfertility.com

FAMILY MEDICAL HISTORY

Please let us know if there is any history or cancer, diabetes, mental illness, birth defects, heart disease, or any other conditions in your family.

Relative	Age (if living)	Age at Death	Illnesses during Lifetime and Cause of Death
Father			
Mother			
Siblings			
Children			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

Please list the names and contact information for three people, unrelated to you, whom we may contact as character references:

____

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____

____

____

____

Would you be willing to serve as a surrogate for a family of a different race, religion, or ethnic background from your own? ____

Would you be willing to serve as a surrogate for an unmarried couple as well as a married couple? Single parent or same sex parents? Please specify any preference you may have.

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____

By signing below, I verify that all information above is complete and accurate. I understand that any false statement made by me 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.

______________________________ ______________

SIGNATURE DATE

AUTHORIZATION FOR RELEASE OF INFORMATION

To: NAFG and any of its affiliates, including but not limited to medical doctors and personnel, medical facilities, mental health professionals, social workers, and attorneys

I, ____, authorize NAFG to conduct any necessary background checks, including but not limited to criminal, financial, and medical records, pertaining to me.

I acknowledge that other interested parties, including but not limited to intended parents, attorneys, medical personnel, etc., will rely on this information. I understand that any false statement made by me 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.

This authorization shall remain valid for two years from the date thereof. A copy shall have the same force as the original.

_________________________ DATE

_________________________ SIGNATURE OF APPLICANT

_________________________ DATE OF BIRTH

_________________________ SOCIAL SECURITY NUMBER