

## SURROGATE QUESTIONNAIRE

Submit to NAFG 148 East 74th Street New York, NY 10021

- 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 \_\_\_\_\_

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:

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

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

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

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

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

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

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**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:

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Are your children currently living with you?

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

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

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

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

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Do you have regular menstrual periods? \_\_\_\_\_

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

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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: \_\_\_\_\_

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

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Do you live in a smoke-free household? \_\_\_\_\_

If you drink alcoholic beverages, please specify how often: \_\_\_\_\_

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

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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:

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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:

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

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

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### FAMILY MEDICAL HISTORY

Please let us know if there is any history of 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