Surrogacy Candidate Screening Form

Arkansas Fertility & Gynecology
9101 Kanis Road, Suite 300
Little Rock, Arkansas 72205

First Name Last Name Birth Date Age

Address City State Zip Code

US citizenship status Social Security Number Green Card or Visa information

Driver's License # State

Mobile telephone # E-mail Address

Highest Level of Education College Major / Minor / Area of interest / Future plans for education

Your occupation Your employer & location

Marital Status Maiden Name # of marriages # of divorces

Are you currently legally separated? What is the date of the legal judgment of separation?

Have you or your partner filed for divorce? Date of finalization

Partner's first and last name Birth Date Social Security Number

Length of current relationship Date of marriage

HOME LIFE

What is your type of residence? You _____your residence. How long at your current residence?

How many people are living in your household? # of adults # of children

Name	Age	Relationship

Please answer if any of the following apply to you, your partner, or anyone living in your household:

	YES	NO
Smoke tobacco or e-cigarettes,	☐	☐
Drink alcohol in excess	☐	☐
Use illicit or prescription drugs illegally	☐	☐
Currently receiving state assistance (welfare)	☐	☐
Filed for bankruptcy	☐	☐
Been arrested	☐	☐
Involved in any legal cases or cases that are pending	☐	☐
Convicted of a misdemeanor	☐	☐
Convicted of a felony	☐	☐
Lost custody of a child	☐	☐
Placed a child for adoption	☐	☐
Treated for or received counseling for alcohol or substance abuse	☐	☐
Been admitted to a psychiatric facility	☐	☐
Suffer from of been diagnosed with schizophrenia	☐	☐
Suffer from or been diagnosed with bipolar disorder	☐	☐
Suffer from or been diagnosed with post Traumatic Stress Disorder	☐	☐
A registered sex offender	☐	☐

If you answered “YES” to any of the above, please explain in detail:

PREGNANCY HISTORY

Please choose the number that you have had of the following:

Pregnancies Vaginal Deliveries C-section Deliveries Abortions Ectopics (tubal)

Miscarriage (< 12 weeks) Miscarriage (12-20 weeks) Miscarriage (> 20 weeks) Fetal Demise

Have you ever had any of the following:

Condition	YES	NO
Premature delivery (before 34 weeks)	☐	☐
Stillbirth	☐	☐
Pre-term labor	☐	☐
Preeclampsia (pregnancy induced hypertension)	☐	☐
Gestational diabetes	☐	☐
Placenta previa	☐	☐
Premature rupture of membranes (PROM)	☐	☐
Post partum hemorrhage	☐	☐
Post partum depression	☐	☐

Please fill out the applicable information below.

Pregnancy #1

Outcome Date # weeks # born Birth weight(s) Complications

Pregnancy #2 ☐ Biological ☐ Surrogate

Outcome Date #weeks # born Birth weight(s) Complications

Pregnancy #3 ☐ Biological ☐ Surrogate

Outcome Date #weeks # born Birth weight(s) Complications

Pregnancy #4 ☐ Biological ☐ Surrogate

Outcome Date #weeks # born Birth weight(s) Complications

List any additional pregnancy information at the end of the screening form in the space provided.

PERSONAL FEATURES

Race If "Other" please describe
Hispanic

Parent's ethnic background. Please check all that apply.

☐ African ☐ British ☐ Chinese ☐ European ☐ German ☐ Irish
☐ Italian ☐ Japanese ☐ Jewish ☐ Mexican ☐ Scottish ☐ Swiss
☐ Mediterranean ☐ Indian (Middle Eastern) ☐ Indian (Native American) ☐ Other

If "other" please describe

Height Weight BMI Body Build

CLINICAL INFORMATION

Do you SMOKE? ☐ YES ☐ NO

Have you ever smoked? ☐ YES ☐ NO

If "yes" when?

Are you exposed to 2nd hand smoke? ☐ YES ☐ NO

Do you DRINK alcohol? ☐ YES ☐ NO

If "yes" how often?

Are you currently using a method of birth control? ☐ YES ☐ NO

If "yes" what method are you using?

Are you currently on ANY medications? *This includes both prescription and over the counter medications.* ☐ YES ☐ NO

If "yes" please provide more information below. *Include birth control pills, Ortho-Evra patch, Nuva Ring, etc.*

Name of Medication	Daily dosage	Diagnosis (Reason for medication)	Any additional information

Have you ever had surgery? *(This includes c-sections)* ☐ YES ☐ NO

If "yes" please provide more information below.

Year	Procedure (Type of surgery)	Diagnosis (Reason for surgery)	Outcome / Complications Any additional information

MEDICAL HISTORY

Have you ever been diagnosed with or treated for any of the following conditions?
Check all that apply.

- ☐ NONE
- ☐ Allergies – Drug
- ☐ Allergies - Seasonal
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma – childhood
- ☐ Asthma – current
- ☐ Bipolar disease
- ☐ Birth defects
- ☐ Bleeding disorder
- ☐ Cancer
- ☐ Chromosomal abnormality
- ☐ Clubfeet
- ☐ Congenital heart disease
- ☐ Congenital hip dislocation
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Gastrointestinal disorder
- ☐ Hearing problems
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Human organ transplant
- ☐ Human tissue transplant
- ☐ Hydrocephalus
- ☐ Kidney problems
- ☐ Kidney stones
- ☐ Migraine headaches
- ☐ Neurofibromatosis
- ☐ Schizophrenia
- ☐ Sickle cell disease
- ☐ Skin problems
- ☐ Skin rashes
- ☐ Substance abuse
- ☐ Thalassemia
- ☐ Thyroid disease
- ☐ Other:

Please describe any of the above conditions that you have checked. Include the age at which you were diagnosed or treated, any treatment that you received, and the physician providing your care.

GYNECOLOGICAL HISTORY

How old were you when you started your first period?

How many days between periods?

How many days does your flow last?

Have you had any of the following? Check as many as necessary.

- ☐ Irregular cycles
- ☐ Bleeding between periods
- ☐ Bleeding after intercourse
- ☐ Pelvic adhesions
- ☐ Uterine adhesions
- ☐ Pain with periods
- ☐ Missed period(s)
- ☐ Breast discharge
- ☐ Infertility
- ☐ Endometriosis
- ☐ Polycystic ovaries
- ☐ PID (Pelvic Inflammatory Disease)
- ☐ Uterine fibroids

Have you ever had a mammogram? If "yes" please explain why, when, and the results

☐ YES ☐ NO

When was your most recent pap smear? Results

Have you ever had any of the following:

Condition	YES	NO	Date
Abnormal pap smear	☐	☐	
Colposcopy	☐	☐	
LEEP	☐	☐	
LEETZ	☐	☐	
Cryosurgery	☐	☐	
Cone procedure	☐	☐	

SCREENING QUESTIONS

Have you ever had a sexually transmitted disease?
☐ YES ☐ NO

If "yes" check all that apply

☐ HPV ☐ Herpes ☐ Chlamydia ☐ Gonorrhea ☐ Syphilis ☐ Genital warts

If "yes" what date(s):

Have you ever used marijuana?
☐ YES ☐ NO

Have you ever used cocaine?
☐ YES ☐ NO

Have you ever use heroine?
☐ YES ☐ NO

Have you ever used LSD?
☐ YES ☐ NO

Have you ever used methamphetamine?
☐ YES ☐ NO

Have you ever used ecstasy?
☐ YES ☐ NO

If "yes" to any of the questions above, please describe when and how often:

Have you ever used or are you using ANY prescription medication for reasons other than its medical purpose?
☐ YES ☐ NO

In the last 12 months have you been sexually active with anyone other than your partner listed on this form?
☐ YES ☐ NO

Have you ever been physically abused?
☐ YES ☐ NO

Have you ever been sexually abused or assaulted?
☐ YES ☐ NO

Have you ever had thoughts of or attempted suicide?
☐ YES ☐ NO

If you answered "YES" to any of the above questions, please explain:

TRAVEL

1. Between 1980 and today have you traveled to any of the following European countries? Check all that apply.

☐ None
☐ England ☐ France ☐ Isle of Man
☐ Wales ☐ Scotland ☐ United Kingdom
☐ Gibraltar ☐ Falkland Islands ☐ Channel Islands

Please provide the following information for any location that is marked above:

Location	Arrival Date	Departure Date	Total # of Days

2. Have you spent a total of 6 months or more associated with a military base in any of the following countries? Check all that apply.

☐ None
☐ Belgium ☐ Italy ☐ Portugal ☐ Turkey
☐ Germany ☐ Spain ☐ Greece ☐ The Netherlands

Please provide the following information for any location that is marked above:

Location	Arrival Date	Departure Date	Total # of Days

3. **During the last 6 months have you, or any sexual partner that you've had during the last 6 months, resided in or traveled to any of the locations listed below for ANY amount of time?**

This includes cruise ship travel, regardless of whether or not you disembarked from the ship at the port of call

☐ Cape Verde ☐ Mexico (any part of the country)

The Caribbean

☐ Aruba ☐ Dominican Republic ☐ Saint Martin
☐ Barbados ☐ Guadeloupa ☐ Saint Vincent & the Grenadines
☐ Bonaire ☐ Haiti ☐ Saint Maarten
☐ Cuba ☐ Jamacia ☐ Trinidad & Tobago
☐ Curaco ☐ Martinique ☐ US Virgin Islands
☐ Dominica ☐ Puerto Rico

Central America

☐ Costa Rica ☐ El Salvador ☐ Guatemala ☐ Honduras ☐ Nicaragua ☐ Panama

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Pacific Islands

☐ American Samoa ☐ Marshall Islands ☐ New Caledonia
☐ Samoa ☐ Fiji ☐ Tonga ☐ Kosrae (Federated States of Micronesia)

South America

☐ Bolivia ☐ Paraguay ☐ Brazil ☐ Ecuador ☐ Suriname
☐ Colombia ☐ Venezuela ☐ French Giuana ☐ Guyana

If you marked any of the boxes above, please give more detail about your travel in the boxes below.

Location	Traveler	Arrival Date	Departure Date	*For clinic use only*

Additional information that you would like to include:

FAMILY MEDICAL HISTORY

The following is related to the medical history of your family

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Have any family members ever been diagnosed with or treated for any of the following conditions?
Check all that apply.

- ☐ NONE
- ☐ Adrenoleukodystrophy
- ☐ Albinism
- ☐ Alport disease
- ☐ Alzheimer's disease
- ☐ Anxiety
- ☐ Bipolar disorder
- ☐ Bleeding disorder
- ☐ Bipolar disease
- ☐ Birth defects
- ☐ Bleeding disorder
- ☐ Blindness – childhood
- ☐ Blindness – adulthood
- ☐ Blood clots / clotting
- ☐ Chromosomal abnormality
- ☐ Cleft lip
- ☐ Cleft palate
- ☐ Clubfeet
- ☐ Colon polyps
- ☐ Color blindness
- ☐ Congenital heart problems
- ☐ Congenital hip dislocation
- ☐ Congestive heart failure
- ☐ CJD
- ☐ Crib death
- ☐ Cystic Fibrosis
- ☐ Deafness – childhood
- ☐ Deafness - adulthood
- ☐ Depression
- ☐ Developmental delay – physical
- ☐ Developmental delay – mental
- ☐ Diabetes
- ☐ Down Syndrome
- ☐ Dwarfism
- ☐ Early death (before age 35)
- ☐ Endometriosis
- ☐ Fibromyalgia
- ☐ Fragile X Syndrome
- ☐ Glactosemia
- ☐ Hemacromatosis
- ☐ Heart attack (before age 50)
- ☐ Heart attack (after age 50)
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Huntington's disease
- ☐ Hydrocephalus
- ☐ Hypospadias
- ☐ Infertility
- ☐ Joint disorder
- ☐ Kleinfelter's syndrome
- ☐ Manic disorder
- ☐ Marfan's syndrome
- ☐ Menopause (before age 40)
- ☐ Mental retardation
- ☐ Multiple sclerosis
- ☐ Muscular Dystrophy
- ☐ Neural tube defect(s)
- ☐ PKU
- ☐ Polycystic kidney disease
- ☐ Polycystic ovarian disease
- ☐ Retinitis pigmentosis
- ☐ Retinoblastoma
- ☐ Rheumatoid arthritis
- ☐ Schizophrenia
- ☐ Sickle cell anemia
- ☐ SIDS
- ☐ Suicide
- ☐ Tay-Sachs disease
- ☐ Thalassemia
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Unexplained death (any age)
- ☐ Cancer
  - ☐ Breast ☐ Ovarian
  - ☐ Colon ☐ Uterine
  - ☐ Other:
- ☐ Other condition not listed above:

Please include as much information as you can in the boxes below.

Condition / Disease	Relation	When diagnosed (age, year, etc.)

FAMILY HISTORY

If any member of your family is listed as deceased, give their age at the time of death in the "Age" box and explain their cause of death.

If you are unsure of a family member's age, you can estimate. Enter "40s" if you know that they are between 40 - 50 years old.

Do you have any siblings? If "yes" how many?

☐ YES ☐ NO

Sibling #1 Age Health issues

Sibling #2 Age Health issues

Sibling #3 Age Health issues

Sibling #4 Age Health issues

*If you have more than 4 siblings use the space at the end of this section to enter the additional information.

MOTHER'S FAMILY

Mother Age Health issues / Cause of death

Does your mother have siblings? If "yes" how many?

☐ YES ☐ NO

Sibling #1 Age Health issues

Sibling #2 Age Health issues

Sibling #3 Age Health issues

Sibling #4 Age Health issues

*If your mother has more than 4 siblings use the space at the end of this section to enter the additional information.

Maternal Grandmother Age Health issues / Cause of death

Maternal Grandfather Age Health issues / Cause of death

FATHER'S FAMILY

Father Age Health issues / Cause of death

Does your father have siblings? If "yes" how many?
☐ YES ☐ NO

Sibling #1 Age Health issues

Sibling #2 Age Health issues

Sibling #3 Age Health issues

Sibling #4 Age Health issues

*If your father has more than 4 siblings use the space at the end of this section to enter the additional information.

Paternal Grandmother Age Health issues / Cause of death

Paternal Grandfather Age Health issues / Cause of death

Additional Information:

Pregnancy

Your sibling(s)

Mother's sibling(s)

Father's sibling(s)

TRAITS, CHARACTERISTICS, AND GOALS

Describe your personality and character.

How would others describe you?

How would you rate your every day stress level? (1 lowest and 10 highest)

☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Do you stress out easily? ☐ YES ☐ NO

What causes the most stress in your life and how do you deal with it?

What are your personal goals and future plans for life? *(education, occupation, etc.)*

What are your hobbies, interests, and talents?

Is there a specific activity that you like to participate in? Why do you like this activity more than others?

What are some specific traits, characteristics, or goals that you have which make you stand out from others?

Please include any additional information about yourself that you would like for the intended parents to know.

THE SURROGACY PROCESS

Why do you want to become a surrogate?

Briefly explain your understanding of the surrogacy process.

Do you feel as though you fully understand of the time constraints and the amount of time that this process can take?
☐ YES ☐ NO

How does your spouse / partner feel about your decision to become a surrogate?

What do you and your spouse / partner plan to tell your family and friends about your decision to become a surrogate? How do you think that they will feel?

What do you plan to tell your children about your surrogate pregnancy? How do you think that they will react?

Please explain the support system that you will have during the surrogacy process from family, friends, co-workers, etc.

SURROGACY MEDICAL TREATMENT

Please answer each question and explain your answer in the space provided. There is no 'wrong' answer.
Definitions and descriptions of the test with * are on the last page of this form.

Would you consent to undergo a *Nuchal Translucency Test?
☐ YES ☐ NO

Would you consent to an *Amniocentesis?
☐ YES ☐ NO

Would you consent to a termination of the pregnancy due to medical reasons if recommended by the treating physician(s)?
☐ YES ☐ NO

Would you consent to *selective reduction if recommended by the treating physicians?
☐ YES ☐ NO

PREGNANCY AND CHILDBIRTH

Please answer each question and explain your answer in the space provided. There is no 'wrong' answer.

What are your expectations for a surrogate pregnancy?
Describe how you believe that you will feel physically and emotionally.

Do you or your spouse / partner have any concerns about complications during the surrogacy process?
☐ YES ☐ NO

Are you willing to see a specific OB upon request of your intended parents or by the treating physician?
☐ YES ☐ NO

Are you willing to have your delivery at a specific hospital?
☐ YES ☐ NO

Are you comfortable with the intended parents accompanying you to your doctor's visits?
☐ YES ☐ NO

What are your expectations for childbirth? (vaginal delivery, c-section, medications, etc.)

If there is any additional information that you would like to add about your surrogate pregnancy and/or childbirth, please us the space below.

THE INTENDED PARENTS

Please share your thoughts about the type of intended parents you wish to help

Is there anyone that you would not be surrogate for?

What qualities would you consider to be the most important for intended parents to have?

What concerns would you have about an intended parent?

What contact would you like to have with the intended parent during the surrogacy process?

What kind of relationship would you like to have with the intended parents after the birth?

What kind of contact and relationship would you like to have with the child(ren) after birth?

Is there a specific couple that you are involved with now and are planning to become their surrogate? If so, how are you related? How long have you known the intended parents? Did you offer to be their surrogate or was it their request?

Please answer the following questions. If you've answered "NO" to any question, please explain in the box below.

During the cycle:	**YES**	**NO**
I can and will discontinue the use of birth control (except in the case of a tubal ligation or partner with a vasectomy)	☐	☐
I will abstain from intercourse for the duration of the cycle as instructed by the treating physician(s)	☐	☐
I have one or more support persons to assist me during the cycle, including transportation and medication injections	☐	☐
I have a reliable source of transportation in order to arrive at my appointments on time	☐	☐
I have a source of childcare that can be relied upon during my appointment time	☐	☐

I have the knowledge of and the ability to complete the following:	**YES**	**NO**
Self injectable medications	☐	☐
Early morning appointments	☐	☐
Frequent blood testing and ultrasounds	☐	☐
Psychological evaluation	☐	☐
Criminal background check	☐	☐
Commitment during the time frame set for a surrogacy cycle.	☐	☐

Please use the space below to write a message to the intended parents who are searching for their perfect surrogate.

By signing this agreement electronically or physically in the space below, I hereby attest that the information that I have provided in the 19 previous pages of this screening form is accurate and true to the best of my knowledge.

Signature Date