



New Orleans, Louisiana
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Gestational Carrier Questionnaire

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 _____

Email 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:

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 carrier.

Have you informed your spouse, children, other family members, etc. of your interest in becoming a carrier? 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.

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 carrier or egg donor before? If so, please specify and provide dates:

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

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

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?

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.

AUTHORIZATION FOR RELEASE OF INFORMATION

To: Beginning Families 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 Beginning Families 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.

_____ Signature of Applicant

_____ Date

_____ Social Security Number

_____ Date of Birth