

JACQUELYNE GORTON, MSN, JD
NURSE ATTORNEY

Surrogate Health History and Background

First name only: Angela

City of Residence Windsor

Are you currently employed? Occupation: _____ No

Do you own a credit card? no (we follow Dave Ramsey's FPU Debt Free plan)

How long have you been employed at your current place of business? N/A

How many hours per day _____ per week _____

What days of the week do you work? (i.e. M-F, Sat, Sun) _____

How much is your gross hourly rate? _____

Marital Status

Marital Status: Married Single Divorced Legally Separated Widowed

If not married, are you currently involved in a committed relationship? Yes _____ No _____

Have you and/or your partner ever had any problems with the Law? Yes _____ No

Describe circumstances of charges & date(s) of occurrence: _____

Have you and/or your partner ever had any financial problems and/or filed for bankruptcy?

Yes _____ No Please explain nature of & date(s) of occurrence: _____

Partners' occupation: Juvenile Correctional Counselor What is your partner's gross hourly? \$20 - \$30

Insurance Information

Are you currently covered by a Health Insurance Plan? name _____ no

Physical Characteristics:

Date of Birth: 08/15/84 Age: 26 Race: El Salvadorian

Height 5'1" Weight: 140lbs Eye Color: brown Hair Color: brown

Hair (Check one) Complexion (Check one)

curly
 wavy
 straight

fair
 medium
 dark

Body type/bone structure: _____ small medium _____ large Blood Type: _____

Personal Characteristics:

Ethnic Origin Ancestry EUROPEAN Religion Born Into CHRISTIAN

How long have you lived at your current address? 4 YEARS

How long did you live at your last address? 2 YEARS

Education: (check one)

Completed High School / School Attended WINDSOR HIGH SCHOOL

Some College / School Attended SANTA ROSA JUNIOR COLLEGE - RN PROGRAM

Completed Junior College / School Attended: _____

Completed 4 Year College / School Attended: _____

Advanced Degree in _____ / School Attended: _____

Other (Please Specify) _____

Fertility History:

Have you been pregnant before: yes no How many children born? 2

Dates of Therapeutic Abortions: N/A Dates of Spontaneous Abortions: N/A

For each child, please write date of birth, type of delivery (vaginal, c-section), sex, and any special health problems

Date of Birth	Type of Delivery	Sex	Health Problems	Birth Weight
12/11/06	VAGINAL	FEMALE	N/A	4lb 13oz
07/16/09	VAGINAL	MALE	N/A	7lb 7oz

Did you have problems with the pregnancy (ex. Premature, toxemia, gestational diabetes)? Yes No

If yes, please describe problem, treatment, and outcome N/A

Is your partner the father of your children? Yes No

Are you Rh-? Yes No If yes, provide the dates of Rhogam injections? _____

Have you ever been told that you were infertile? Yes No

If yes when? _____ On what basis? _____

Is there any history of fertility problems in your family (difficulty conceiving or miscarriage)? Yes No

If yes, please explain: My older sister has been dx'd with early menopause

Did your parents have difficulty conceiving? No

Do any of your siblings have fertility problems? My older sister has been dx'd with early menopause

Do any of your blood relatives have fertility problems? Not that I know of

Did your mother take diethylstilbestrol (DES) or any other prescription drug when she was pregnant with you?

Yes ___ No X If yes, please explain. _____

Have you ever been a Surrogate Mother before? ___ Yes X No

Were you a ___ Gestational Carrier -OR- ___ Traditional (artificial insemination) Carrier

If so, when? _____ Where? _____

Describe Pregnancy _____

Was it successful? _____

Are your menstrual periods regular: Yes X No _____

How long is your cycle? (count 1st day of your period as day 1) 28 DAYS

1st day of last menstrual period: 01/24/11

Type of birth control used: OCP

Personal Health History:

Do you currently have allergies? Yes X No _____

If yes, are they due to ___ food X drugs ___ environment ___ other

Please list specific substances and reaction(s) produced, below:

Substance	Reaction
SULFA	HIVES

Toothaches or dental infections? Yes ___ Describe with dates _____ No X

Your diet is: ___ vegetarian X non-vegetarian ___ poor ___ good X excellent

How much exercise do you get? ___ none ___ occasional X regular

What type of exercise? AEROBIC WALKING 5XWEEK (about a 20 minute mile)

Do you smoke cigarettes? Yes ___ No X If yes, approximate number of cigarettes per day: _____

Does your partner smoke? Yes ___ No X If yes, approximate number of cigarettes per day _____

Do you drink alcoholic beverages? Yes ___ Number of drinks: _____ / _____ Type _____
No X Week / Month

Do you or have you ever used illegal or non-prescribed drugs? THC in HS (2000) a couple of times
 Please list drug names, even if they may now be considered illegal:

1) _____ Dates taken _____ Dosage: _____
 2) _____ Dates taken _____ Dosage: _____

Do you drink caffeinated beverages such as coffee, tea, colas? NO

If so, approximate number of cups per day: _____

Are you currently taking any medication prescribed by your doctor? Yes X No _____

If so, please indicate medication, dosage, and condition prescribed for below:

Medication	Dosage	For/Condition
ORTHO CYCLEN	T1 PO QD	Contraception

Have you ever had surgery? Yes X No _____

If yes, please explain: I had my gallbladder removed 11/2009, a few months after I delivered my son

Have you ever been hospitalized? Yes _____ No X

If yes, please explain: _____

Have you ever had a blood transfusion? Yes _____ No X

If yes, please explain: _____

Have you ever had major radiation or x-ray exposure? Yes _____ No X

If yes, please explain: _____

Have you completed the 3 Hepatitis B injections? Yes X No _____ Injection Dates 03/2005

Have you ever been treated for syphilis? Yes _____ No X

If yes, when? _____ How many times? _____ Date(s): _____

Have you ever been treated for gonorrhea? Yes _____ No X

If yes, when? _____ How many times? _____ Date(s): _____

Have you or any of your sexual partners ever had:

NSU (non-specific urethritis) _____yes Xno _____self _____partner when? _____

Chlamydia _____yes Xno _____self _____partner when? _____

Venereal Warts _____yes Xno _____self _____partner when? _____

Herpes _____yes Xno _____self _____partner when? _____

Other STD's? ___ yes ___X___ no ___ self ___ partner when? _____

Have you ever had any major illnesses such as amoebic dysentery, hepatitis, pneumonia, mononucleosis, etc? Yes ___ No ___X___ If yes, please explain: _____

Any current, chronic medical problems, conditions? If yes, please explain.
_____NONE_____

Psychiatric Health:

Have you ever been in the care of a Counselor or Mental Health Professional? Yes ___ No ___X___

If yes, when? _____

For what reason? _____

List All name(s) of Counselor(s) or Mental Health Professional(s):

Name: _____ Phone Number: (____) _____

Name: _____ Phone Number: (____) _____

Name: _____ Phone Number: (____) _____

Have had any psychiatric hospitalizations? Yes ___ No ___X___ When? _____

Diagnosis: _____

Are you currently taking any prescription drugs for psychiatric reasons? NO

1. Name and Dosage: _____ How Often? _____

2. Name and Dosage: _____ How Often? _____

Personal Health: Work History/Exposure:

What is your current or most recent occupation? I am a stay at home mom

Please list all jobs you have had in the past five years, and your possible exposure to chemicals, drugs, and gasses. Please consider carefully

Job Duties	Dates of Employment		Exposed to which drugs, chemicals, or gasses
	Year Began	Year Ended	
Scheduler for Sutter Residency Scheduling/office work	03/2005	06/2009	none

In the past six months, have you been exposed to any of the following in your living environment, or while involved in hobbies? If yes, please check the appropriate item below and give dates and how often exposed. Please consider each carefully.

Exposures	When (dates)	Duration, How Often
Toxic Chemicals	n/a	
Sprays	n/a	
Fumes/Exhaust	n/a	
Radiation	n/a	
Flea Powders/Sprays	n/a	
Lead/Lead Products	n/a	
Asbestos/Asbestos Products	n/a	
Cleaning Solutions/Solvents	2xMonth	At home while cleaning. I'm careful about ventilation.
Other		

Family Health History:

How many blood siblings in your immediate family, including yourself? 3

How many males? 0 How many females? 3

Have twins or multiple births occurred in your family? Yes X No

If yes, what relation to you? 1st Cousins

Please describe your family members by the following physical characteristics:

	Eye Color	Hair Color	Complexion	Height	Body Type	Vision
Mother	brown	brown	Med	5'3"	Med	Stigmatism
Father	brown	brown	Dark	5'5"	Med	Stigmatism
Maternal Grandmother	brown	brown	Fair	5'1"	Med	Good
Maternal Grandfather	brown	brown	Med	5'5"	Med	Good
Paternal Grandmother	brown	brown	Fair	5'3"	Small	Good
Paternal Grandfather	brown	brown	Med	5'4"	Med	Good

Please list below at what age members of your family died and what was the cause of their death? Please be as specific as possible.

	Age, if Living	Age at Time of Death	Cause of Death
Maternal Grandmother	87		
Maternal Grandfather		88	Natural causes
Paternal Grandmother	70		
Paternal Grandfather	75		
Mother	54		
Father	50		
Brother			
Brother			
Brother			
Sister	33		
Sister	22		
Sister			

Do you have any brothers or sisters who died in infancy or childhood? NO

If yes, what was the cause? _____

Are there any known genetic diseases that run in your family? Yes ___ No X

If yes, what are they? _____

Has anyone in your family, including yourself, experienced recurring and/or chronic physical symptoms that have not been evaluated by a physician? (Please include those symptoms that you may not consider serious) Yes ___ No X Please explain: _____

Please look through the following list of medical problems and indicate which ones you or one of your relatives have had. Where appropriate, please indicate their relationship to you. For example, if your paternal grandfather had a stroke, put 'PGF' in the box under 'Grandparents' for that condition. Please consider each condition carefully for each member of your family.

Heart:	You	Mother	Father	Sibling	Grandparents	Aunt/ Uncle	Cousin
Stroke					PGF/MGF		
Heart Attack							
Heart Disease -- from Birth							
Heart Disease -- Other							
Hardening of the arteries							

Blood:	You	Mother	Father	Sibling	Grandparents	Aunt/ Uncle	Cousin
Anemia							
Sickle-cell anemia							
Hemophilia or other bleeding problem -----							
Leukemia							
Immune deficiency							
Other blood disorder							

Respiratory (lungs):	You	Mother	Father	Sibling	Grandparents	Aunt/ Uncle	Cousin
Hay fever							
Asthma							
Emphysema							
Tuberculosis							
Lung Cancer							
Pneumonia							
Other Lung Disease							

Gastro-Intestinal	You	Mother	Father	Sibling	Grand- parents	Aunt/ Uncle	Cousin
Ulcer of the stomach or Duodenum							
Gall Stones	GB Rem oved	GB Removed			MGM GB Removed		
Hepatitis A (infectious)							
Hepatitis B (serum)							
Other Liver Disease							
Colon Cancer							
Ulcerative Colitis							
Crohn's Disease							
Cystic Fibrosis							
Intestinal Cancer							
Any other cancer or problem of the digestive system							

Metabolic/ Endocrine	You	Mother	Father	Sibling	Grand- parents	Aunt/ Uncle	Cousin
Diabetes					PGF		
Hypo-glycemia							
Thyroid Cancer							
Goiter							
Adrenal Dysfunction or disorder							
Hyperactivity							

Urinary:	You	Mother	Father	Sibling	Grand- parents	Aunt/ Uncle	Cousin
Kidney Disease					MGM 1 Removed		
Other Disease of the Urinary Tract							

Rectal Disorder							
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Genital/ Reproductive System:	You	Mother	Father	Sibling	Grand- parents	Aunt/ Uncle	Cousin
Undescended Testicle							
Hypo-Spadias							
Prostrate Cancer							
Uterine Fibroids							
Ovarian Cysts							
Cancer of the Cervix							
Cancer of the Ovaries							
Neurological:	You	Mother	Father	Sibling	Grand- parents	Aunt/ Uncle	Cousin
Migraines							
Mental Retardation							
Senility before Age 50							
Multiple Sclerosis							
Cerebral Palsy							
Epilepsy							
Hydro-cephalus							
Disorders of the Spinal Chord							
Huntington's Chores							
Gaucher's Disease							
Wilson's Disease							
Tay Sachs							
Other Diseases of the Nervous System							

Mental Health:	You	Mother	Father	Sibling	Grand- parents	Aunt/ Uncle	Cousin
Schizophrenia							
Manic Depression							
Clinical Depression							
Other Mental Health Disorders requiring Hospitalization							
Muscles/Bones/ Joints	You	Mother	Father	Sibling	Grand- parents	Aunt/ Uncle	Cousin
Other Chronic Muscle Disease							
Lupus							
Deformity of the Spine							
Osteoporosis							
Dwarfism							
Heredity low back disease							
Arthritis							
Gout							
Sight/Sound/ Smell:	You	Mother	Father	Sibling	Grand- parents	Aunt/ Uncle	Cousin
Deafness before the age of 60							
Deformity of the Ear				Older Sister			
Cataracts before the age of 50							
Blindness							
Color Blindness							
Glaucoma							
Deviated Septum							
Any other sight, sound, smell disorder							

Skin:	You	Mother	Father	Sibling	Grand- parents	Aunt/ Uncle	Cousin
Acne							
Eczema							
Skin Cancer							
Pigmentation Disorders							
Other Disorders of the Skin							

Other:	You	Mother	Father	Sibling	Grand- parents	Aunt/ Uncle	Cousin
Alcoholism						MU's	
Drug Abuse, Misuse or Addiction							
Eating Disorder							
Breast Cancer							
Any other cancer not mentioned above							
Any other condition not mentioned							

Why do you want to be a Surrogate Mother? I have wanted to help a couple complete their family for a very long time (over 10 years). I can't think of a better way to help someone.

Please describe your previous pregnancies. Both of my pregnancies were great. I felt great. I loved being pregnant. I was healthy and so were both of my children.

If you are married or in a committed relationship, have you discussed Surrogacy with your husband or partner? If so, what was his/her reaction?

Yes! My husband and I have been discussing the possibility of surrogacy in our family for a number of years. We've been keeping an open dialogue about when a good time would be. We are both feeling that our family is in a good place now that our family is complete.

Have you discussed Surrogacy with any of your family and friends? If so, what was their reaction?

I've spoken with my parents and sisters. My mom thinks the process is too painful (for anyone) to endure. My father is ambivalent. My sisters are supportive. My best friend is supportive and is going through the process for her brother in-laws currently.

Have you discussed Surrogacy with your children? If so, what was their reaction? If not, how do you plan to handle it with them?

Not yet. I've started talking with them about helping others in a very special way. We've also been talking about how happy they make us. The next thing I will talk with them about is how some people can't have babies, and how we can help someone else be as happy as we are with our family.

Who would provide you with support (emotional, childcare, injections) during the medical procedure and pregnancy? Emotional Support - My husband, family, and best friend. My mother in-law and sister in-law help me with my children. My husband and/or best friend Cristina will help with the injections.

The ability to get to medical appointment in the Bay Area and in your community is crucial.

Do you drive? Yes No Do you have a car? Yes No Make and Year Chevy Malibu 2002

What is your primary means of transportation? I drive myself wherever I need to go.

If your primary transportation is unavailable, what will you use as an alternate? My husbands car

How would you feel about meeting the child born as a result of this surrogacy in future years?

I would be willing/happy to meet the child born from the surrogacy, although, I would be equally as happy with Christmas cards.

Is it acceptable for the prospective parents to attend doctor's office visits and participate throughout the pregnancy process? Yes No Undecided

Is it acceptable for the prospective parents to be in the delivery room for the birth?

Yes No Undecided

If the treating physician prescribes it, will you undergo an amniocentesis to diagnose genetic defects (including Down's Syndrome)? Yes No

If pre-natal tests indicate that the fetus had a serious birth defect and the couple wanted to abort, would you be willing to go through with the abortion? How would you feel about it?

Yes. I would be sad, but I understand about the IP rights.

Would you undergo a selective reduction (salt injected into embryo(s) through the belly at 12th week) if you become pregnant with more than twins? Yes No

How would you feel about it? It's suboptimal. I'd like to be matched with a family that is ok with twins (to minimize the need for selective reduction).

Will you be willing to sign a parentage order so that the intended parents' names will go on the birth certificate rather than your name and the name of your partner? Yes No

What do you plan to use your fee for? For savings. To fully fund our "Emergency Fund" and for my kids college fund.

In your own words, please describe your personality and character:

I am a loving caring person. I like to help people. I am responsible, but I like to have fun.

What are your hobbies, interests, and talents? I like to do crafts. I like learning and working on new projects. Right now I am making a blanket for my dad.

If you could pass a message on to the couple you would be a Surrogate for, what would that message be?

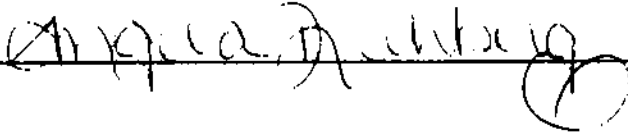
I'm so excited to help bring you the love and joy that comes with a child. I am excited for you and what is to come.

Is there anything else you would like to say?

I am very excited to embark on this journey.

Thank you for taking the time to complete this application!

I understand that any significant misrepresentation or omission is grounds for dismissal from the surrogacy program and that I can then be held financially responsible for any lab, medical, or psychological costs involved in furtherance of the proposed surrogate carrier arrangement. I declare that all of the following information and statements made regarding myself and my family's health history are true and correct. The Following Surrogate Candidate Health History and Background form has been completed under penalty of perjury under the laws of the State of California.

Signature:  Date: 2/1/11