



Hair (Check one)

curly  
 wavy  
 straight

Complexion (Check one)

fair  
 medium  
 dark

Body type/bone structure:  small  medium  large Blood Type: A-

**Personal Characteristics:**

Ethnic Origin Ancestry: Black/Filipino Religion Born Into: \_\_\_\_\_

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

How long did you live at your last address? less than 1 yr

**Education:** (check one)

Completed High School / School Attended: American Legion H.S. GED  
 Some College / School Attended: \_\_\_\_\_  
 Completed Junior College / School Attended: \_\_\_\_\_  
 Completed 4 Year College / School Attended: \_\_\_\_\_  
 Advanced Degree in \_\_\_\_\_ / School Attended: \_\_\_\_\_  
 Other (Please Specify) \_\_\_\_\_ GED and Trade School \_\_\_\_\_

**Fertility History:**

Have you been pregnant before: yes  no  How many children born? 3

Dates of Therapeutic Abortions: \_\_\_\_\_ Dates of Spontaneous Abortions: \_\_\_\_\_

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
11-20-2005	vaginal	female	none	7lbs 11 oz
01-25-2008	Vaginal Surrog	male	none	8lbs 14oz
09-27-2009	Vaginal Surrog	male	none	9lbs

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

If yes, please describe problem, treatment, and outcome \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is your partner the father of your children? Yes \_\_\_ No \_\_\_

Are you Rh-? Yes  No \_\_\_ If yes, provide the dates of Rhogam injections? 11/20/05, 1/25/08, 9/27/09

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: \_\_\_\_\_

Did your parents have difficulty conceiving? \_\_\_no\_\_\_\_\_

Do any of your siblings have fertility problems? \_\_\_no\_\_\_\_\_

Do any of your blood relatives have fertility problems? \_\_\_no\_\_\_\_\_

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

Yes \_\_\_ No  If yes, please explain: \_\_\_\_\_

Have you ever been a Surrogate Mother before?  Yes \_\_\_ No

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

If so, when? 2007/2008, 2009 Where? \_\_\_ Sacramento /SF bay area

Describe Pregnancy \_\_\_ Pregnancy is a very empowering and natural expression of ones connection to nature. It really puts into perspective your place in life and the roles you play throughout your life. It can be difficult to endure, but it is also very calming to experience.

Was it successful? All my labors and deliveries were successful

Are your menstrual periods regular: Yes  No \_\_\_\_\_

How long is your cycle? (Count 1<sup>st</sup> day of your period as day 1) 3-5 days

1st day of last menstrual period: Jul 5, 2011

Type of birth control used: abstinence

### Personal Health History:

Do you currently have allergies? Yes  No \_\_\_

If yes, are they due to: \_\_\_ food  drugs \_\_\_ environment \_\_\_ other

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

Substance	Reaction
Vicodin	Chest pains

Toothaches or dental infections? Yes \_\_\_ Describe with dates No

Your diet is: \_\_\_vegetarian  non-vegetarian \_\_\_poor  good \_\_\_excellent

How much exercise do you get? \_\_\_ None  occasional \_\_\_ regular

Whattypeofexercise?walkingandhomevideoworkouts/yoga\_\_\_\_\_

Do you smoke cigarettes? Yes \_\_\_ No x If yes, approximate number of cigarettes per day: \_\_\_\_\_

Does your partner smoke? Yes \_\_\_ No \_\_\_ If yes, approximate number of cigarettes per day: \_\_\_\_\_

Do you drink alcoholic beverages?: Yes x Number of drinks: 0 / 2 Type: \_\_\_\_\_  
No \_\_\_\_\_ Week / Month

Do you or have you ever used illegal or non-prescribed drugs? \_\_\_ Yes \_\_\_  
Please list drug names, even if they may now be considered illegal:

1) marijuana Dates taken teen years Dosage: \_\_\_\_\_  
2) \_\_\_\_\_ Dates taken \_\_\_\_\_ Dosage: \_\_\_\_\_

Do you drink caffeinated beverages such as coffee, tea, colas? \_\_\_\_\_ yes \_\_\_\_\_

If so, approximate number of cups per day: \_\_\_\_\_ 0-2 \_\_\_\_\_

Are you currently taking any medication prescribed by your doctor? Yes \_\_\_ No x

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

Medication	Dosage	For/Condition

Have you ever had surgery? Yes \_\_\_ No x

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Have you ever been hospitalized? Yes x No \_\_\_

If yes, please explain: only for labor and delivery \_\_\_\_\_  
\_\_\_\_\_

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 x No \_\_\_

If yes, please explain: I had a positive PPD once and had a chest X-ray done which came back clean

Have you completed the 3 Hepatitis B injections? Yes x No \_\_\_ Injection Dates completed in 2004

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

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

Have you or any of your sexual partners ever had:

NSU (non-specific urethritis) \_\_\_yes no \_\_\_self \_\_\_partner when? \_\_\_\_\_

Chlamydia \_\_\_yes no \_\_\_self \_\_\_partner when? \_\_\_\_\_

Venereal Warts \_\_\_yes no \_\_\_self \_\_\_partner when? \_\_\_\_\_

Herpes \_\_\_yes no \_\_\_self \_\_\_partner when? \_\_\_\_\_

Other STD's? yes \_\_\_no \_\_\_self \_\_\_partner when? \_\_\_2000 HPV\_\_\_

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

Any current, chronic medical problems, conditions? If yes, please explain. No

#### Psychiatric Health:

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

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  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? \_\_\_\_\_Dental Assistant\_\_\_\_\_

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	
Assisting Dr. and other staff, taking x-rays, cleaning/sterilizing instruments and equipment	2004	2011	Exposed to hospital grade disinfectants and germicides


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		
Sprays		
Fumes/Exhaust		
Radiation		
Flea Powders/Sprays		
Lead/Lead Products		
Asbestos/Asbestos Products		
Cleaning Solutions/Solvents	various	Briefly during routine housework
Other		

**Family Health History:**

How many blood siblings in your immediate family, including yourself? \_\_\_\_\_ 4 \_\_\_\_\_

How many males? \_\_\_2\_\_\_ How many females? \_\_\_2\_\_\_

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

If yes, what relation to you? \_\_\_\_\_

Please describe your family members by the following physical characteristics:

	Eye Color	Hair Color	Complexion	Height	Body Type	Vision
<b>Mother</b>	br	blk	med	5'	unk	poor
<b>Father</b>	br	blk	drk	5'11	unk	poor
<b>Maternal Grandmother</b>	br	blk	med	Unk	unk	poor
<b>Maternal Grandfather</b>	br	blk	med	Unk	unk	unk
<b>Paternal Grandmother</b>	br	blk	drk	Unk	unk	unk
<b>Paternal Grandfather</b>	br	blk	drk	Unk	unk	unk

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
<b>Maternal Grandmother</b>			
<b>Maternal Grandfather</b>			
<b>Paternal Grandmother</b>			
<b>Paternal Grandfather</b>			
<b>Mother</b>	60		
<b>Father</b>		55	Heart failure
<b>Brother</b>		16	Gun shot
<b>Brother</b>	26		
<b>Brother</b>	28		
<b>Sister</b>	32		
<b>Sister</b>			
<b>Sister</b>			

Do you have any brothers or sisters who died in infancy or childhood?

If yes, what was the cause?      \_my \_16 year old brother died of a gunshot wound as a teenager\_\_\_\_\_

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   x   No \_\_\_\_\_ Please explain\_ I have joint and muscle pains in my left wrist and shoulder, brother has chronic back pain, and my sister has rheumatoid arthritis. \_\_\_\_\_

Please look through the following list of medical problems and indicate which ones you or one of your relatives has 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.

<b>Heart:</b>	<b>You</b>	<b>Mother</b>	<b>Father</b>	<b>Sibling</b>	<b>Grand- parents</b>	<b>Aunt/ Uncle</b>	<b>Cousin</b>
Stroke							
Heart Attack							
Heart Disease -- from Birth							
Heart Disease -- Other							
Hardening of the arteries							

<b>Blood:</b>	<b>You</b>	<b>Mother</b>	<b>Father</b>	<b>Sibling</b>	<b>Grand- parents</b>	<b>Aunt/ Uncle</b>	<b>Cousin</b>
Anemia	slight						
Sickle-cell anemia							
Hemophilia or other bleeding problem -----							
Leukemia							
Immune deficiency							
Other blood disorder							

<b>Respiratory (lungs):</b>	<b>You</b>	<b>Mother</b>	<b>Father</b>	<b>Sibling</b>	<b>Grand- parents</b>	<b>Aunt/ Uncle</b>	<b>Cousin</b>
Hay fever							
Asthma				2 brothers			
Emphysema							
Tuberculosis							
Lung Cancer							
Pneumonia							
Other Lung Disease							

<b>Gastro-Intestinal:</b>	<b>You</b>	<b>Mother</b>	<b>Father</b>	<b>Sibling</b>	<b>Grand- parents</b>	<b>Aunt/ Uncle</b>	<b>Cousin</b>
Ulcer of the stomach or Duodenum							
Gall Stones							
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							

<b>Metabolic/ Endocrine:</b>	<b>You</b>	<b>Mother</b>	<b>Father</b>	<b>Sibling</b>	<b>Grand- parents</b>	<b>Aunt/ Uncle</b>	<b>Cousin</b>
Diabetes						Pu M great-aunt	
Hypo-glycemia							
Thyroid Cancer							
Goiter							
Adrenal Dysfunction or disorder							
Hyperactivity							

<b>Urinary:</b>	<b>You</b>	<b>Mother</b>	<b>Father</b>	<b>Sibling</b>	<b>Grand- parents</b>	<b>Aunt/ Uncle</b>	<b>Cousin</b>
Kidney Disease							
Other Disease of the Urinary Tract							

Rectal Disorder							
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<b>Genital/ Reproductive System:</b>	<b>You</b>	<b>Mother</b>	<b>Father</b>	<b>Sibling</b>	<b>Grand- parents</b>	<b>Aunt/ Uncle</b>	<b>Cousin</b>
Undescended Testicle							
Hypo-Spadiasis							
Prostrate Cancer							
Uterine Fibroids		x					
Ovarian Cysts							
Cancer of the Cervix							
Cancer of the Ovaries							
<b>Neurological:</b>	<b>You</b>	<b>Mother</b>	<b>Father</b>	<b>Sibling</b>	<b>Grand- parents</b>	<b>Aunt/ Uncle</b>	<b>Cousin</b>
Migraines	x	x		x		Ma/Mu	
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							

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

Skin:	You	Mother	Father	Sibling	Grand-parents	Aunt/ Uncle	Cousin
Acne				sister			
Eczema				brother			
Skin Cancer							
Pigmentation Disorders					mgm		
Other Disorders of the Skin				brother		Ma's Mu's	

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

Why do you want to be a Surrogate Mother? Pregnancy was such a relatively easy thing for me and I see no reason not to do it for someone who has difficulty with it. \_\_\_\_\_

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Please describe your previous pregnancies. All of my pregnancies were relatively easy. There were no complications or fears. I didn't have any weird cravings in the middle of the night, and my mobility was not hindered. I did not have any post partum symptoms and I returned to my pre-pregnancy weight relatively soon afterwards.

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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?

N/A

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

I have been a surrogate multiple times and my immediate family has not ever objected to any of the choices I have made in my life. They recognize that I am my own person and capable of doing the right thing for myself. \_\_\_\_\_

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

My daughter understands that I would be carrying a baby for another person. She remembers that I have done it before and we talk about it analytically rather than emotionally. I am very open and honest with her and clearly explain the science of it all, and that the child is not ours to keep.

Who would provide you with support (emotional, childcare, injections) during the medical procedure and pregnancy?  my family and friends, and paid providers will be there for emotional support and child care. I have always been perfectly fine with giving myself the injections and will continue to do so.

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  Make and Year  2000 Dodge Grand Caravan \_\_\_\_\_  
What is your primary means of transportation?  my personal vehicle \_\_\_\_\_  
If your primary transportation is unavailable, what will you use as an alternate?  I can take the train and bus in the bay area \_\_\_\_\_

How would you feel about meeting the child born as a result of this surrogacy in future years?  
I don't feel that this would be an issue.

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?  
 If the prospective parents wanted that it would be totally up to them. A late term abortion would be undesirable and sad for me, but as I have no plans to raise the child personally, it wouldn't really affect me over much.

Would you undergo a selective reduction (salt injected into embryo(s) through the belly at 12<sup>th</sup> week) if you become pregnant with more than twins? Yes  No   
How would you feel about it?  I have no feelings about that at all. \_\_\_\_\_

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? \_\_\_\_\_paying off debt.

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

I am honest, flexible and easy-going. I work hard and I don't get stuck in the past. \_

What are your hobbies, interests, and talents? books, movies, crafts, and baking

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

I have grown three very healthy babies in my body, so you can rest assured that while I am responsible for their well being I will do the absolute best by them.

Is there anything else you would like to say?

**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: \_\_\_\_\_ Ross-Anna McKissack \_\_\_\_\_ Date: \_\_\_\_\_ 07/14/2011 \_\_\_\_\_