

JACQUELYNE GORTON, MSN, JD
NURSE ATTORNEY

Surrogate Health History and Background

First name only: Tracy

City of Residence Santa Rosa

Are you currently employed? Occupation: medical assist No

Do you own a credit card? no x yes Name of card (NOT number) RCU, Best Buy, Citi financial

How long have you been employed at your current place of business? 4.5 yrs

How many hours per day 8 per week 40

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

How much is your gross hourly rate? \$19.50

Marital Status

Marital Status: x 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 x

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 x No Please explain nature of & date(s) of occurrence: Civil lawsuit in 2003, settled outside of court

Partners' occupation: Retail Sales manger What is your partner's gross hourly? \$14.67

Insurance Information

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

Physical Characteristics:

Date of Birth: 8-9-84 Age: 26 Race: Caucasian

Height: 5'5" Weight: 142 Eye Color: Blue Hair Color: Brown

Hair (Check one) curly wavy x straight
Complexion (Check one) x fair medium dark

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

Personal Characteristics:

Ethnic Origin Ancestry: German + Irish Religion Born Into: _____

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: Maria Carrillo High School
- Some College / School Attended: 2 semester chico state university 2002
Empire College (med Assisr program) 2004-2006
Santa Rosa Junior college 2011
- _____ 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: ∅ 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
<u>11-13-03</u>	<u>Vaginal</u>	<u>male</u>	<u>none</u>	<u>6 lbs 3oz</u>
<u>8-7-08</u>	<u>Vaginal</u>	<u>female</u>	<u>none</u>	<u>6lbs 12oz</u>

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

If yes, please describe problem, treatment, and outcome At end of term with each pregnancy I showed some signs of pre-eclampsia but I delivered by the next day and had no physical problems.

Is your partner the father of your children? Yes No _____ July 2003, Nov 2003 +

Are you Rh-? Yes No _____ If yes, provide the dates of Rhogam injections? 4/2008

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: Mother had 1 ectopic pregnancy and 1 miscarriage at the age of 37 and 38 yrs old.

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 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: 2/16/11

Type of birth control used: mirena IUD (will switch to ocp's soon)

Personal Health History:

Do you currently have allergies? Yes X No ~~X~~

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

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

Substance	Reaction
<u>Sulfa</u>	<u>Rash</u>
<u>Compazine</u>	<u>muscle spasms</u>

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

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

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

What type of exercise? hikes, riding bikes, playing with kids + on feet at work

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 X No ___ Number of drinks: 2 / 1 Type: Beer
Week / Month

Do you or have you ever used illegal or non-prescribed drugs? never

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? yes, coffee

If so, approximate number of cups per day: 1

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 X No ___

If yes, please explain: Achilles tendon repair 2002

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 _____

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 X no ___ self ___ partner when? _____

Chlamydia ___ yes X no ___ self ___ partner when? _____

Venereal Warts ___ yes X no ___ self ___ partner when? _____

Herpes ___ yes ___ no X self ___ partner when? _____

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

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. _____

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? N

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? Medical 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	
<u>Medical assistant</u>	<u>2006</u>	<u>Current</u>	
<u>Study coordinator</u>	<u>2010</u>	<u>Current</u>	
<u>Office Secretary</u>	<u>2003</u>	<u>2006</u>	

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		
Other		

Family Health History:

How many blood siblings in your immediate family, including yourself? 2

How many males? 1 How many females? 1

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

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
Mother	hazel	Brown	Fair	5'5"	med	Contacts
Father	hazel	Brown	Fair-med	5'11"	med	far sighted
Maternal Grandmother	hazel	Brown	Fair	4'11"	petite	glasses
Maternal Grandfather	green	white	fair	5'7"	med	
Paternal Grandmother	hazel	Brown	fair-med	5'6"	med	
Paternal Grandfather	hazel	Brown	fair-med	5'9"	med	glasses

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	81		
Maternal Grandfather	83		
Paternal Grandmother	80		
Paternal Grandfather	80		
Mother	57		
Father	59		
Brother	29		
Brother			
Brother			
Sister			
Sister			
Sister			

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

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	Grand- parents	Aunt/ Uncle	Cousin
Stroke							
Heart Attack							
Heart Disease -- from Birth							
Heart Disease -- Other							
Hardening of the arteries							

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

Respiratory (lungs):	You	Mother	Father	Sibling	Grand- parents	Aunt/ Uncle	Cousin
Hay fever		X		X		X	X
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							
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						X	
Hypo-glycemia							
Thyroid Cancer							
Goiter							
Adrenal Dysfunction or disorder							
Hyperactivity							

Urinary:	You	Mother	Father	Sibling	Grand- parents	Aunt/ Uncle	Cousin
Kidney Disease							
Other Disease of the Urinary Tract							
Rectal Disorder							

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							
Cataracts before the age of 50		X					
Blindness							
Color Blindness							
Glaucoma							
Deviated Septum							
Any other sight, sound, smell disorder							

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

Other:	You	Mother	Father	Sibling	Grand- parents	Aunt/ Uncle	Cousin
Alcoholism							
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 had 2 great pregnancies and why not share such a gift with someone else.

Please describe your previous pregnancies. Wonderful! I loved every minute, no problems with my health or my 2 children. I've even called myself "a lean mean baby making machine."

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, he admits it would be "weird" but supports me 100% and that's why I love him.

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

All my friends and co-workers love the idea, they believe I would be perfect for it. My mother has her reservations as any mom would, but after a nice discussion about it she says she supports my decision.

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 2 yr old would not understand but I did talk to my 7 yr old son. He was interested in the reasons why - I explained that sometimes no matter how much two people love each other, they're bodies won't allow them to make a baby, so they ask someone like me (who has had babies) to help them and its a really great thing to help others. I'm sure we'll need more conversations along the way. Who would provide you with support (emotional, childcare, injections) during the medical procedure and pregnancy? My husband, family, friends and co-workers. Co-workers will help inj (they're all qualified medical assistants)

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 2006 Explorer No

What is your primary means of transportation? myself

If you primary transportation is unavailable, what will you use as an alternate? husband's truck or one of my parents vehicles

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

I would love it!

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
of course!

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 ok because its not my decision to make. But of course it would be hard on everyone involved.

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? I would be fine.

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? Pay credit cards and to buy our first home!

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

Smart, funny, responsible, loving, caring, not always as punctual as I would like to be, motivated, quiet (at times), reserved, outgoing with friends & family, hardworking, well liked

What are your hobbies, interests, and talents? Sports (hockey, soccer), sewing, currently attending school to learn Spanish, cooking,

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

I commend you for everything you've been through to get to this point and I would love nothing more than to give you the wonderful gift of becoming a parent.

Is there anything else you would like to say?

I'm ready and waiting, so let's do this! :)

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: *J. Clum* Date: 2/26/11