**When filling out form below, to save your filled info to disk & continue to edit you must update Acrobat Reader to version XI. Versions X and lower will not allow for saving. DOWNLOAD FREE READER HERE. OR fill out form in browser all at once & print. Saving to disk you can print from there too.

JACQUELYNE GORTON, MSN, JD
NURSE ATTORNEY

Surrogate Health History and Background

First name only:

City of Residence:

Are you currently employed? Occupation: No:

Do you own a credit card? No. Yes. Name of card (NOT number):

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

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 been involved in any civil and/or criminal proceedings involving any arrests? Yes. No.

If yes, list date, type of proceeding, name of court & outcome:

Have you and/or your partner ever had any financial problems and/or filed for bankruptcy? Yes. No.

If yes, please explain nature of & date(s) of occurrence:

Partner's occupation: What is your partner's gross hourly?

Insurance Information

Are you currently covered by a Health Insurance Plan? Name: No.

Physical Characteristics:

Date of Birth: Age: Race:

Height: Weight: Eye Color: Hair Color:

Hair (Check one):
- ☐ Curly
- ☐ Wavy
- ☐ Straight

Complexion (Check one):
- ☐ Fair
- ☐ Medium
- ☐ Dark

Body type/bone structure: ☐ Small ☐ Medium ☐ Large Blood Type:

Personal Characteristics:

Ethnic Origin Ancestry: Religion Born Into:

How long have you lived at your current address?

How long did you live at your last address?

Education: (check one)

- ☐ Completed High School / School Attended:
- ☐ Some College / School Attended:
- ☐ 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?

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

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?

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?

Do any of your siblings have fertility problems?

Do any of your blood relatives have fertility problems?

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? Where?

Describe Pregnancy (ies):

Successful Delivery (ies)?

Are your menstrual periods regular: Yes ☐ No ☐

How long is your cycle? (Count 1st day of your period as day 1):

1st day of last menstrual period:

Type of birth control used:

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

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

What type of exercise?

Do you smoke cigarettes? Yes. ☐ No. ☐ 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. ☐ No ☐ Number of drinks per: / Type:
Week / Month

Do you or have you ever used illegal or non-prescribed drugs? ☐ Yes. ☐ No.

Please list drug names, even if they may now be considered illegal:

1) Dates taken: Dosage:

2) Dates taken: Dosage:

3) Dates Taken: Dosage:

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

If yes, approximate number of cups per day:

Are you currently taking any medication prescribed by your doctor? Yes. ☐ No. ☐

Ifyes, please write name of medication, dosage, and condition prescribed for below:

Medication	Dosage	For/Condition

Have you ever had surgery? Yes. ☐ No. ☐

If yes, please explain:

Have you ever been hospitalized? Yes. ☐ No. ☐

If yes, please explain:

Have you ever had a blood transfusion? Yes. ☐ No. ☐

If yes, please explain:

Have you ever had major radiation or x-ray exposure? Yes. ☐ No. ☐

If yes, please explain:

Have you completed the 3 Hepatitis B injections? Yes. ☐ No. ☐ 3 Injection Dates:

Have you ever been treated for syphilis? Yes. ☐ No. ☐

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?

Have you ever had any major illnesses, such as amoebic dysentery, hepatitis, pneumonia, mononucleosis?

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?

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?

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

Job Duties	Dates of Employment		Exposed to which drugs, chemicals, or gasses
	Year Began	Year Ended	

In the past 6 (six) months, have you been exposed to any of the following? If yes, please check the appropriate item below and give dates and how often exposed.

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?

How many males? How many females?

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
Mother						
Father						
Maternal Grandmother						
Maternal Grandfather						
Paternal Grandmother						
Paternal Grandfather						

List at what age members of your family died and what was the cause of their death? Name the condition or disease that caused the death if possible.

	Age, if Living	Age at Time of Death	Cause of Death
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Mother			

continued next page

	Age, if Living	Age at Time of Death	Cause of Death
Father			
Brother			
Brother			
Brother			
Sister			
Sister			
Sister			

Do you have any brothers or sisters who died in infancy or childhood? Yes. ☐ No. ☐

If yes, what was the cause?

Are there any known genetic diseases that run in your family? Yes. ☐ No. ☐

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? (Include symptoms that you may not consider serious.)

Yes. ☐ No. ☐ If yes, please explain:

PLEASE IDENTIFY WHICH BLOOD RELATIVES HAD ANY OF THE MEDICAL PROBLEMS CHARTED BELOW. FOR EXAMPLE, IF YOUR MOTHER'S SISTER HAD A STROKE, YOU WOULD WRITE "MA" (MATERNAL AUNT) UNDER THE COLUMN LABELED *AUNT/UNCLE* AND ACROSS FROM THE "STROKE COLUMN."

MA=Maternal Aunt / MU=Maternal Uncle / PA=Paternal Aunt / PU=Paternal Uncle / MC=Maternal Cousin / PC=Paternal Cousin MGM=Maternal Grandmother / MGF=Maternal Grandfather / PGM=Paternal Grandmother / PGF=Paternal Grand Father

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							
Asthma							
Emphysema							
Tuberculosis							

continued on pext page

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							
Hypo-glycemia							
Thyroid Cancer							
Goiter							
Adrenal Dysfunction or disorder							
Hyperactivity							

Urinary:	**You**	**Mother**	**Father**	**Sibling**	**Grand-parents**	**Aunt/ Uncle**	**Cousin**
Kidney Disease							

continued next page

Other Disease of the Urinary Tract							
Rectal Disorder							

Genital/ Reproductive System:	**You**	**Mother**	**Father**	**Sibling**	**Grand-parents**	**Aunt/ Uncle**	**Cousin**
Undescended Testicle							
Hypo-Spadiasis							
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 Hospital-Ization							
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							
Blindness							
Color Blindness							
Glaucoma							
Deviated Septum							
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							
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?

Please describe your previous pregnancies with dates of each delivery.

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?

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

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

Who would provide you with support (emotional, childcare, injections) during the medical procedure and pregnancy?

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: No. ☐

What is your primary means of transportation?

If you primary transportation is unavailable, what will you use as an alternate?

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

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? Yes. ☐ No. ☐ How would you feel about it?

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?

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?

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

What are your hobbies, interests, and talents?

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

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: Date:

JACQUELYNE GORTON, MSN, JD
NURSE ATTORNEY

Authorization for Publication of Surrogate Information on Jackie Gorton Nurse Attorney's Website

Please complete form either electronically or handwritten and bring it to your initial appointment with our office.

I, _____, have been advised by Jackie Gorton Nurse Attorney ("JGNA") that if I am accepted to be an surrogate carrier in JGNA's surrogacy program, that JGNA Publishes information about JGNA's surrogate on JGNA's website for potential and actual Intended Parent Clients to view.

I agree to the following:

JGNA may publish information including a photographs of my family and me (as provided by me); my first name ; my age; height and weight; my national/ethnic ancestry; my educational background (all as provided by me) and my complete profile (as provided by me) on JGNA's website as managed by JGNA.

Said information will be provided to Intended Parent Clients on JGNA's website. All of the above information pertaining to me shall be identified as *Surrogate Online Surrogate Application.*

I hereby authorize the publication on JGNA's website as identified above of my *Surrogate Online Surrogate Application* for online viewing. I understand that I have the right to revoke this authorization for publication of my *Surrogate Online Surrogate Application* at any time, by written notice to JGNA (who shall delete all information about me from JGNA's website within two (2) business days after receipt of my written notice. I have received a copy of this Authorization for Publication of Surrogate Information.

Dated: _____ _____

Name of Surrogate

25 Biscayne Court • San Rafael, CA 94901
(415) 485-1969 • Fax: (415) 485-1113
E-mail:info@jackiegortonnurseattorney.com • Website: www.jackiegortonnurseattorney.com

JACQUELYNE GORTON, MSN, JD
NURSE ATTORNEY

Authorization for Use and/or Disclosure of Patient Health Information

I hereby authorize: _____,
Name of Disclosing Party

_____
Address

_____ **CA** _____
City State ZIP

Ph _____

To disclose to:

Jackie Gorton
Name of Recipient

25 Biscayne Court
Address

San Rafael CA 94901
City State ZIP

Records and Information Pertaining to:

_____ _____ _____
Patient' Name (List Other Names Used) Medical Record No. Date of Birth

_____ _____
Address Telephone Number

DURATION: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here _____ (date).

REVOCATION: I understand that the recipient may not lawfully further use or disclose health information unless another authorization is obtained from me or unless such use or disclosure is specifically required by law.

SPECIFY Check any, initial and/or sign which type of information to be disclosed.

RECORDS:

- ☐ **Medical Information** _____ **(initial)**
- ☐ **Psychiatric Information** _____ **(initial)**
- ☐ **Drug/Alcohol Information** _____ **(initial)**
- ☐ **Genetic Records** _____ **(initial)**
- ☐ **Results of an HIV Test** _____ **(initial)**

Specify records to be disclosed:

The recipient may use the health information authorized on this form for the following purposes: Medical Evaluation to be Surrogate Carrier

A copy of this authorization is as valid as the original.

Member/Patient has a right to a copy of this authorization.

_____ _____ _____
Date Signature if signed by Other than Member/Patient, Indicate Relationship

25 Biscayne Court • San Rafael, CA 94901
(415) 485-1969 • Fax: (415) 485-1113
E-mail:info@jackiegortonnurseattorney.com • Website: www.jackiegortonnurseattorney.com

Surrogate Contact Sheet

First Name: _____ Middle Initial_____ Last Name: _____

Address: _____

_____

Phone: Day: _____Evening: _____

Cell: _____ E-Mail address _____

May Leave Detailed Messages: yes _____ no _____

Employer Name: _____

Employer Address: _____

Employer Phone: _____

How Long? _____

Social Security No.: _____

Driver's License #_____

Spouse/Partner Information (if applicable)

Name:_____ Birth Date _____

Address _____

Phone _____

Social Security # _____

Driver's License # _____

Occupation _____

Employer's Name: _____

Employer's Address: _____

Employer's Phone: _____ How Long? _____

Your Insurance Information

Name of Insurance Plan: _____

Name of primary insured: _____

Other Questions

Have you and/or your partner ever had any problems with the Law? Y ___ N ___

Have you and/or your partner ever had any financial problems? Y ___ N ___

Please list arrests, convictions, sentences, court hearings, etc.

Emergency Contact other than spouse (for example; parents)

Name_____

Relationship to you**:**_____

Address:_____

_____

Phone: _____

Alternate Phone:_____

I understand that any significant misrepresentation or omission is grounds for dismissal from the surrogate program and that I can then be held financially responsible for any lab, medical or psychological costs involved in furtherance of the proposed surrogacy.

_____ _____

Signature of Surrogate Carrier: **Date**

_____ _____

Signature of Partner (if applicable)**:** **Date**