

COOPER INSTITUTE FOR ADVANED REPRODUCTIVE MEDICINE
7500 BEECHNUT, SUITE 308
HOUSTON, TEXAS 77074
TEL. 713-771-9771 FAX. 713-771-9773

SURROGATE PERSONAL INFORMATION

Today's Date: _____/_____/_____

You're Name: _____, _____, _____
Last First Middle

Partner's name: _____, _____, _____
Last First Middle

Address: _____

City State Zip Code

Home #: _____ - _____ - _____ Work: _____ - _____ - _____

Cell #: _____ - _____ - _____ Partner's #: _____ - _____ - _____

Date of Birth: _____/_____/_____ Age: _____ SS: _____ - _____ - _____

Current OB/GYN: _____
Name Phone

Current Doctor (General): _____
Name Phone

Donor #: _____

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Surrogate Application Form

Today's Date: _____/_____/_____

Date of Birth: _____/_____/_____

Age: _____

Days from beginning of one menstrual cycle to the next: _____

Have you ever had a hysterosalpingogram (HSG) performed? Yes No If yes, please give dates and results:

Date	Performed by	Results

Have you had previous fertility treatment? Yes No **EXCLUDING IVF**, please list and describe:

PREGNANCY DATA

Please list any pregnancies and detailed information below:

Date	Outcome	Infertility TX (Indicate type)		# of Months Needed to Conceive	Type of delivery	Sex		With Current Partner	
		Y	N			M	F	Y	N
		Y	N			M	F	Y	N
		Y	N			M	F	Y	N
		Y	N			M	F	Y	N
		Y	N			M	F	Y	N

Donor #: _____

CHARACTERISTICS

Height: _____ Weight at 21? _____ Current Weight: _____

Body Frame: Small Medium Large

Natural Hair Color: Black Lt. Brown Brown Dk. Brown Auburn Red
 Lt. Blonde Blonde Dk. Blonde

Hair (All that apply): Wavy Straight Curly Thin texture Premature Gray (at what age_____)

Eye Color: Blue Gray Green Hazel Brown Black

Skin Tone: Fair Light Medium Dark Lt. Brown Dk. Brown Ebony
 Freckled Rosy Olive Lt.Olive Dk. Olive Birthmarks

Race: _____ Mother: _____ Father: _____

Ethnicity: _____

Blood Type: A Pos A Neg B Pos B Neg AB Pos AB Neg O Pos
 O Neg Unsure

Right Handed: _____ Left Handed: _____ Ambidextrous: _____

Marital Status: Single Married Separated Divorced Widowed

Duration of relationship with partner: _____

Education: Completed grade School: Y N Completed High School: Y N GPA _____

Currently in College, pursuing degree in _____ GPA _____

Completed College, degree in _____ GPA _____

Currently pursuing advanced degree in _____

Advanced Degree in _____

Occupation: _____

Vision (without corrective lenses): Poor Fair Good Excellent

Do you wear corrective lenses? Yes No

For What problems? Near sighted Far sighted Other _____

Hearing (without corrective device): Poor Fair Good Excellent

Teeth: Poor Fair Good Excellent

Diet: Vegetarian Non-Vegetarian Diet (nutrition): Poor Average Good

Donor #: _____

Please describe your family members' characteristics:

Relation	Eye Color	Hair Color	Height	Weight	Ethnic Origin	Age L/D	Cause of Death
Mother							
Father							
Maternal Grandmother							
Maternal Grandfather							
Paternal Grandmother							
Paternal Grandfather							
Siblings							

If you or anyone in your family has had any of the following conditions, check yes and describe below:

Yes	No		Yes	No	
—	—	1. Down's syndrome or Known Chromosomal Disorder	—	—	21. Skin Disease: Eczema/ Psoriasis
—	—	2. Mental Retardation	—	—	22. Coffee-colored spots on the skin
—	—	3. Seizure Disorder	—	—	23. Early Death (before age 50)
—	—	4. Muscular Dystrophy or Multiple Sclerosis	—	—	24. Cystic Fibrosis
—	—	5. Premature Senility (Before age 50)	—	—	25. Arthritis (before age 50)
—	—	6. Deafness (before age 50)	—	—	26. Drug Addiction
—	—	7. Blindness	—	—	27. Hemophilia
—	—	8. Cataracts (before age 40)	—	—	28. Chronic Anemia
—	—	9. Schizophrenia or Manic Depression	—	—	29. Sickle Cell Anemia
—	—	10. Serious Birth Defects	—	—	30. Elevated Cholesterol Levels
—	—	11. Minor Birth Defects	—	—	31. Early Heart Attack/ Stroke (before age 50)
—	—	12. Cleft Lip and/or Cleft Palate	—	—	32. Alcoholism
—	—	13. Club Foot	—	—	33. Allergies
—	—	14. Open Spine or Water on the Brain	—	—	34. Asthma
—	—	15. Congenital Heart Problems	—	—	35. Heart Disease
—	—	16. Congenital Hip Problems	—	—	36. High Blood Pressure
—	—	17. Two or More Miscarriages or Stillborns	—	—	37. Cancer: type and location
—	—	18. Diabetes Mellitus	—	—	38. Tay Sachs
—	—	19. Thyroid Disease	—	—	39. Sickle Cell Trait
—	—	20. Polycystic Kidney Disease	—	—	40. B-Thalassemia
					41. A- Thalassemia

Donor #: _____

If you answered YES to any of the above questions, please answer the following:

Question #	Specific Relation or Family Member	Condition	Age of onset
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

42. Do you or have you ever used recreational drugs? Yes No

If YES, please specify: Cigarettes/Cigars Alcohol Marijuana Cocaine
 Heroin Crack IV Drugs Amphetamines
 LSD Other _____

Indicate frequency: _____

If you or anyone in your family had any of the following conditions, check yes and describe below.

Yes	No		Yes	No	
___	___	43. Liver Disease	___	___	44. Lung Disease
___	___	45. Appendicitis	___	___	46. Crohn's Disease
___	___	47. Color Blind	___	___	48. Huntington's Chorea
___	___	49. Sarcoidosis	___	___	50. Lupus
___	___	51. Tuberculosis	___	___	52. Hepatitis A, B, or C
___	___	53. Ulcers	___	___	54. Colitis
___	___	55. Alzheimer's	___	___	56. Osteoporosis
___	___	57. Gout	___	___	58. Cerebral Palsy
___	___	59. Dwarfism	___	___	60. Migraines
___	___	61. Wilson's Disease	___	___	62. Glaucoma
___	___	63. Goiter	___	___	64. Leukemia
___	___	65. Emphysema	___	___	66. Dyslexia
___	___	67. Skin Cancer: Melanoma	___	___	68. Kidney/ Gall Stones
___	___	69. Hodgkin's Disease			

If you answered YES to any of the above questions, please answer the following:

Question #	Specific Relation or Family Member	Condition	Age of onset
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you had any surgery (s)? Yes No If "YES" please list surgeries performed and date:

1. _____
2. _____
3. _____
4. _____

Have you had any hospitalizations not mentioned above: _____

Donor #: _____

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

If yes, explain: _____

Please indicate date of testing and results of the following, also, list any treatment:

Test	Date Performed	Results (circle one)		Treatments
		Immune	Non-immune	Vaccinated?
Rubella Immunity				
Chlamydia Culture		Positive	Negative	
Mycoplasmma Culture		Positive	Negative	
Pap Smear		Normal	Abnormal	
Mammogram		Normal	Abnormal	

HIGH RISK QUESTIONNAIRE

- Have you ever donated blood or any blood products? Yes No
- Have you ever had yellow jaundice, liver disease, and hepatitis? Yes No
- Have you ever had a positive test for hepatitis? Yes No
- Have you ever had radiation or chemotherapy? Yes No
- Have you had a major illness or surgery in the last 12 months? Yes No
- Have you ever had a blood transfusion? Yes No
- Have you had an organ or tissue transplant? Yes No
- Have you had an accidental needle stick? Yes No
- Have you been in close contact with anyone with hepatitis? Yes No
- Have you had a positive test for syphilis? Yes No
- Have you been treated for syphilis or gonorrhoea? Yes No
- Have you had sex with anyone who has taken money for sex? Yes No
- Since 1977, have you taken money or drugs for sex? Yes No
- Have you had sex with anyone who has taken money for sex? Yes No
- Have you had sex with a male who has had sex with another male? Yes No

Psycho-Social Questionnaire

What do you hope to achieve by volunteering in the Surrogacy program (emotionally, financially, etc.)? _____

What message would you like passed on to the person/family who chose you as a Surrogate? _____

What helped you decide to become a Surrogate? _____

Donor #: _____

How would you describe yourself? Please include a description of your personality and temperament: _____

Describe your philosophy of life: _____

YOU'RE FAMILY:

Describe the following:

Family member	Education	Occupation	Intellectual Academic Achievements	Artistic Achievements
Mother				
Father				
Sister(s): _____ _____ _____	_____ _____ _____	_____ _____ _____	_____ _____ _____	_____ _____ _____
Brother(s): _____ _____ _____	_____ _____ _____	_____ _____ _____	_____ _____ _____	_____ _____ _____

YOU'RE CHILDREN:

Describe the following:

Personality	Artistic Ability	Intelligence	Distinguishing Characteristic(s)
1.			
2.			
3.			
4.			

YOU'RE CHILDHOOD:

Describe yourself as a child (personality, health, happiness, etc.). _____

What was it like growing up in your family? _____

Donor #: _____

What religion did you belong to as a child? _____

What was your earliest memory as a child? _____

What problems did you have as a child (health, allergies, learning, social, etc.)? _____

WHEN I WAS A CHILD:

My favorite thing to do was: _____

At home I was expected to do: _____

My parents were strict about: _____

My parents taught me to value: _____

What I loved most about my father was: _____

What I loved most about my mother was: _____

My favorite relatives were: _____

I loved to visit: _____

In comparison to others I was: _____

YOUR TEENAGE YEARS:

Describe yourself as a teenager: _____

Describe your achievements: _____

Did you do poorly in anything: _____

Donor #: _____

WHEN I WAS A TEENAGER:

My favorite subject(s) was: _____

My worst subject(s) was: _____

The activities I was involved in were: _____

The most important influence on me was: _____

In comparison to others I was: _____

I liked to go: _____

I traveled to: _____

I was talented in: _____

My ambition was to: _____

ADULTHOOD:

Religion: How religious are you now? Very Moderately Not at all

Are you an: Atheist Agnostic

Activities: How athletic are you? Very Average Not Athletic

Do you exercise? Regularly Occasionally Not at all

What types of exercise or physical activity do you enjoy? _____

Do you have musical ability? _____

What other skills or talents do you have (painting, writing, reading, ability at games, crossword puzzles, handicraft, etc)?

Please describe in detail. _____

Describe any special interests you have (Girl Scout leader, fund raiser, pet owner, volunteer activities, etc.). _____

What physical, artistic, intellectual, or social abilities do you feel best about? _____

What have been your achievements as an adult? _____

Donor #: _____

AUTHORIZATION FORM

I, _____, have completed the physical profile, genetic/medical history, and psychosocial history forms. I have answered the above questions honestly and to the best of my knowledge and ability. I understand that this information will be used and relied on by the IVF Program and by its recipients. I have not knowingly nor intentionally given false or misleading information. I understand that knowingly or intentionally providing false information will not only be a cause for my disqualification as a surrogate, but will also allow the IVF program to bring lawsuit for a recipient in order to recover damages they might have incurred. I understand that by signing this application I give the IVF Program permission to have my photograph viewed by potential recipients.

PLEASE INCLUDE A RECENT PHOTOGRAPH OF YOURSELF; THIS IS FOR PROGRAM USE ONLY AND WILL ONLY BE VIEWED BY OUR STAFF AND THE POTENTIAL RECIPIENT. ALL PERSONAL INFORMATION (NAME, ADDRESS, TELEPHONE #, ETC.) WILL REMAIN ANNONOMOUS.

DATE: ____/____/____

SIGNATURE: _____

DATE: ____/____/____

PARTNER'S SIGNATURE: _____

Donor #: _____