



Woman to Woman  
FERTILITY CENTER

## SURROGACY PROGRAM

### CONFIDENTIAL APPLICATION FORM

**Please print clearly in blue or black ink. Fill out completely, thoroughly, and truthfully, potential recipients will be reading this application (identifying information will be masked). Use extra paper if necessary.**

Date of application: \_\_\_\_/\_\_\_\_/\_\_\_\_/  
Month Day Year

Application No \_\_\_\_\_  
W.W.F.C. information)

### PERSONAL INFORMATION

\_\_\_\_\_  
Last name First name Middle name

Maiden name : \_\_\_\_\_ Age: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Spouse's name : \_\_\_\_\_ Age: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Present address: \_\_\_\_\_  
(Street) (City, State) (Zip)

Phone: Home # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Cell # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email Address: \_\_\_\_\_

Marital Status : Married:  Single:  Separated:  Divorced:  Widowed:

S. S. Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Driver's License No: \_\_\_\_\_ State: \_\_\_\_\_

U.S. Citizen: Yes  No  Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_  
(Street) (City, State) (Zip)

Spouse's occupation: \_\_\_\_\_ Business Phone No: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Spouse's employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_  
(Street) (City, State) (Zip)

In case of emergency: Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_

Have you or your spouse declared bankruptcy in the last seven years : Yes  No

Do you have a credit card which can be used for expenses that we reimburse : Yes  No

Dates of all marriages: \_\_\_\_\_

Dates of all divorces: \_\_\_\_\_

City, County, and State of all marriages: \_\_\_\_\_

Medical insurance: Yes  No

Insurance company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Present or past Physician : \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City, State) (Zip)

**PERSONAL CHARACTERISTICS**

Height: \_\_\_\_ Ft \_\_\_\_ In Weight: \_\_\_\_\_ Lbs Eye color: \_\_\_\_\_ Hair color: \_\_\_\_\_

Hair:	Complexion:	Body Type
Curly <input type="checkbox"/>	Fair <input type="checkbox"/>	Small <input type="checkbox"/>
Wavy <input type="checkbox"/>	Medium <input type="checkbox"/>	Medium <input type="checkbox"/>
Straight <input type="checkbox"/>	Dark <input type="checkbox"/>	Large <input type="checkbox"/>

Ethnic background Maternal: \_\_\_\_\_ Paternal \_\_\_\_\_

Religion born into: \_\_\_\_\_ Race : \_\_\_\_\_

Education: (check one)

Completed grade school  Completed high school

Currently in college pursuing degree in \_\_\_\_\_

Completed college degree in \_\_\_\_\_

Name of College or University? \_\_\_\_\_

Currently pursuing advance degree in \_\_\_\_\_

Advance degree in \_\_\_\_\_

Name of College or University? \_\_\_\_\_

**FERTILITY HISTORY**

Number of pregnancies : \_\_\_\_\_ Dates of pregnancies : \_\_\_\_\_

Number of miscarriages : \_\_\_\_\_ Dates of miscarriages : \_\_\_\_\_

Number of abortions : \_\_\_\_\_ Dates of abortions : \_\_\_\_\_

Number of stillbirths : \_\_\_\_\_ Dates of each stillbirth : \_\_\_\_\_

Number of children : \_\_\_\_\_

First name	Age	Sex	Birthdate	Health / Problems
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Are your menstrual periods regular : Yes  No

How long is your monthly cycle : \_\_\_\_\_ days How many days does your period usually last : \_\_\_\_\_ days

How old were you when you first started your period ? \_\_\_\_\_

Have you ever been a surrogate before : Yes  No

If yes; when : \_\_\_\_\_ Name of IVF Clinic : \_\_\_\_\_

Was it successful: Yes  No  If yes, number of child(ren) born: \_\_\_\_\_

Describe each of your pregnancies: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Full term: Yes  No

Any complications: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever been told you were infertile : Yes  No

If yes; when : \_\_\_\_\_ On what basis: \_\_\_\_\_  
\_\_\_\_\_

Birth control method used: \_\_\_\_\_

Is there any history of fertility problems in your family ( conceiving or miscarriages ) : Yes  No

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

Did your mother take diethylstilbestrol (DES) or any prescription drug while she was pregnant with you or any of your siblings :

Yes  No

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

**PERSONAL HEALTH HISTORY**

Do you smoke cigarettes : Yes  No  If yes, how many : \_\_\_\_\_

Anyone in your household smoke : Yes  No  If yes, how many : \_\_\_\_\_

Do you drink alcohol : Yes  No  If yes, how much : \_\_\_\_\_

Are you using marijuana now : Yes  No  If yes, how often: \_\_\_\_\_

Have you ever used illegal or unprescribed drugs : Yes  No

If yes, what drugs and how often : \_\_\_\_\_

Are you using illegal or unprescribed drugs now: Yes  No

If yes, what drugs and how often : \_\_\_\_\_

Have you ever had any problems with the law : Yes  No

Please list any arrests, convictions, sentences, etc. : \_\_\_\_\_

Have you ever had an eating disorder : \_\_\_\_\_

Have you had any therapy with a psychiatrist or any other mental health professional : Yes  No

If yes, when and why : \_\_\_\_\_  
\_\_\_\_\_

Have you ever had any psychiatric hospitalization : Yes  No

If yes, please be specific : \_\_\_\_\_

Have you ever had any problems with drug or alcohol abuse : Yes  No

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

Do you currently have any allergies : Yes  No

If yes, are they to: Food  Drugs  Environment  Other \_\_\_\_\_

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

Substance	Reaction
_____	_____

As per above, please describe any childhood allergies you have outgrown :

\_\_\_\_\_

How is your vision (without glasses) : Poor  Fair  Good  Excellent

Do you wear glasses : Yes  No  Your vision is about: 20 / \_\_\_\_\_

Are you : Nearsighted  Farsighted  Other : \_\_\_\_\_

Do you have normal hearing : Yes  No  Blood type : \_\_\_\_\_

What is the condition of your teeth : Poor  Fair  Good

Your diet is : Vegetarian  Non - vegetarian

How would you describe your diet : Poor  Average  Excellent

How much exercise do you do : None  Occasionally  Regularly  Athlete

What type of exercise : \_\_\_\_\_

Have you ever had surgery : Yes  No

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

Have you ever had any hospitalization not already mentioned : Yes  No

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

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

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

Have you ever been treated for syphilis : Yes  No  If yes, when \_\_\_\_\_

How many times : \_\_\_\_\_ When was the last time : \_\_\_\_\_

Have you ever been treated for gonorrhea : Yes  No  If yes, when \_\_\_\_\_

How many times : \_\_\_\_\_ When was the last time : \_\_\_\_\_

Have you or any of your sexual partners had:

	<u>Myself</u>		<u>Partner</u>		<u>When</u>
NSU (non-specific urethritis)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Chlamydia	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Venereal warts	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Herpes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Other sexually transmissible diseases	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____

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 : Yes  No

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

**PERSONAL HEALTH : WORK HISTORY / EXPOSURE**

What is your current or most recent occupation : \_\_\_\_\_

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

Jobs / Duties	Dates of employment		Exposed to which drugs, chemicals, gases.
	Began	Ended	

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

Exposed to	When (dates)	How often (daily, weekly, monthly)
Toxic chemicals		
Sprays		
Fumes / Exhaust		
Radiation		
Flea powders / sprays		
Lead / lead products		
Asbestos / asbestos products		

**FAMILY'S EDUCATIONAL INFORMATION**

	Completed High School	Completed College	Major
Father			
Mother			
Sibling			
Sibling			
Sibling			

Profession of Father: \_\_\_\_\_

Profession of Mother: \_\_\_\_\_

Profession of Siblings: \_\_\_\_\_

Profession of Siblings: \_\_\_\_\_

Profession of Siblings: \_\_\_\_\_

**FAMILY HEALTH HISTORY**

Please describe your family members by the following physical characteristics:

	Eye color	Hair color	Complexion	Height	Body type	Vision
Mother						
Father						
M.G.M.						
M.G.F.						
P.G.M.						
P.G.F.						

How many blood siblings are in your immediate family : (including yourself): \_\_\_\_\_

Have twins or multiple births occurred in your family : Yes  No

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

Please list below at what age members of your family died and the cause of their death.

	Age (if living)	Age (at time of death)	Cause of death
Grandfather (paternal)			
Grandmother (paternal)			
Grandfather (maternal)			
Grandmother (maternal)			
Father			
Mother			
Brothers 1.			
2.			
3.			
Sisters 1.			
2.			
3.			

Has any member of your family, including yourself, had a problem or defect at birth of any of the following body systems:

- |                                     |                              |                             |                    |                              |                             |
|-------------------------------------|------------------------------|-----------------------------|--------------------|------------------------------|-----------------------------|
| Bones, muscles, joints, limbs       | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Blood circulation  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Gastrointestinal system             | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Diabetes           | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Nervous system, brain, spinal cord  | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Respiratory system | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Organ (heart, lungs, kidney, etc.)  | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Genital / urinary  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Metabolic (hormones, enzymes, etc.) | Yes <input type="checkbox"/> | No <input type="checkbox"/> |                    |                              |                             |

If yes to any of the above, please explain the specific defect in each case.

Birth defect	Who	How did it happen	Circumstances
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

If yes, please explain what was the cause : \_\_\_\_\_  
 \_\_\_\_\_

Are there any known genetic diseases or conditions that run in your family. Yes  No

If yes, please explain 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

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

Look through the following list of medical problems and indicate which ones you or one of your relatives have had. Please consider each condition carefully for each family member.

Check ( √ ) all that apply.

**Condition.**

<b>Heart</b>	You	Mother	Father	Sibling	Grandparents	Aunt/Uncle	Cousins
Stroke							
Heart attack							
Heart disease							
from birth							
other: _____							
Hardening of arteries							
High blood pressure							
Congenital Heart Malformation							
Other: _____							

<b>Blood</b>	You	Mother	Father	Sibling	Grandparents	Aunt/Uncle	Cousins
Anemia							
Sickle cell							
Hemophilia							
Leukemia							
Immune deficiency							
A- or B-Thalassemia							
Tay-Sachs							
Hemoglobin disorder							
Hereditary hypercholesterolemia							
Other: _____							

<b>Respiratory</b>	You	Mother	Father	Sibling	Grandparents	Aunt/Uncle	Cousins
Hay fever							
Asthma							
Emphysema							
Tuberculosis							
Lung cancer							
Pneumonia							
Other: _____							

**Condition.**

<b>Gastro intestinal</b>	You	Mother	Father	Sibling	Grandparents	Aunt/Uncle	Cousins
Ulcer							
Gall stones							
Hepatitis A							
Hepatitis B							
Liver disease							
Colon cancer							
Ulcerative colitis							
Crohn's disease							
Cystic fibrosis							
Intestinal cancer							
Multiple Polyposis of colon							
Other: _____							

<b>Endocrine/Glandular</b>	You	Mother	Father	Sibling	Grandparents	Aunt/Uncle	Cousins
Juvenile Diabetes Mellitus							
Cystic Fibrosis							
Other: _____							

<b>Urinary</b>	You	Mother	Father	Sibling	Grandparents	Aunt/Uncle	Cousins
Kidney disease							
Rectal disorder							
Other: _____							

<b>Genital / Reproductive</b>	You	Mother	Father	Sibling	Grandparents	Aunt/Uncle	Cousins
Undescended testicle							
Hypospadiasis							
Prostate cancer							
Uterine fibroids							
Ovarian cysts							
Cancer of cervix							
Cancer of ovaries							
Other: _____							

<b>Mental health</b>	You	Mother	Father	Sibling	Grandparents	Aunt/Uncle	Cousins
Schizophrenia							
Manic depressive							
Psychosis							
Other: _____							

**Condition**

<b>Muscles/Bones/Joints</b>	You	Mother	Father	Sibling	Grandparents	Aunt/Uncle	Cousins
Muscular dystrophy							
Marfan's Syndrome							
Multiple Sclerosis							
Chronic muscledisease							
Rheumatoid Arthritis							
Lupus							
Deformity of spine							
Spina bifida							
Congenital hip dislocation							
Osteoporosis							
Dwarfism							
Low back pain							
Club foot							
Gout							
Other: _____							

<b>Sight/Sound/Smell/Mouth</b>	You	Mother	Father	Sibling	Grandparents	Aunt/Uncle	Cousins
Cleft lip or palette							
Deafness before age of 60							
Deformity of the ear							
Cataracts before age of 50							
Blindness							
Retinoblastoma							
Retinitis Pigmentosa							
Color blindness							
Glaucoma							
Deviated septum							
Other: _____							

<b>Skin</b>	You	Mother	Father	Sibling	Grandparents	Aunt/Uncle	Cousins
Acne							
Eczema							
Skin cancer							
Albinism							
Pigmentation disorders							
Other: _____							

<b>Nervous System</b>	You	Mother	Father	Sibling	Grandparents	Aunt/Uncle	Cousins
Neuro fibromatosis							
Epilepsy							
Huntington's disease							
Other: _____							

**Condition**

<b>Other</b>	You	Mother	Father	Sibling	Grandparents	Aunt/Uncle	Cousins
Alcoholism							
Drug abuse							
Breast cancer							
Other condition: _____							

**PERSONAL AND MOTIVATIONAL**

In your own words, describe your personality and character: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What are your hobbies, interests, and talents: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you plan on having any (more) children? \_\_\_\_\_

If you could pass on a message to the child you are carrying for the couple, what would that message be:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Why do you want to be a surrogate mother : \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How do you feel about aborting a fetus in the case of medical defects or medical recommendation : \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How do feel about reducing the pregnancy in the case of multiple fetuses : \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Would you participate in this procedure for an infertile couple ONLY : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Would you work with a couple with children :                      Yes  No

Are you willing to work with a single woman or man :                      Yes  No

Please, share your reasons for your preference : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you foresee any possible emotional reactions or problems you might have during the surrogate parenting process ?. (testing, injections, or delivery). \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you discussed surrogacy with your family and do they approve ?. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If not, when do you plan on discussing it with them ?. \_\_\_\_\_  
\_\_\_\_\_

Who would you have to provide you with emotional support during the entire procedure. (e.g. husband, parents, relatives, friends, etc.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is your spouse or companion aware of your interest in the program, and if so, how does he feel about you participation ?. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Would you expect or desire emotional support from the couple ?. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What reassurance can we give the prospective parents of a child that you will not change your mind : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To what extent is payment for this service a necessary requirement for you : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please state your fee \_\_\_\_\_ What will your fee be used for ? \_\_\_\_\_

Please rate from 1 to 10 how important the following factors were to you in making your decision to be a surrogate mother ( 1=least important; 10=most important).

\_\_\_\_\_ I like being pregnant but don't want more children of my own.

\_\_\_\_\_ I need the money very much.

\_\_\_\_\_ I think people who want children should have them.

\_\_\_\_\_ Giving someone else a child would make me very happy.

\_\_\_\_\_ Other (please explain ) : \_\_\_\_\_

How did you become aware of the Woman to Woman Fertility Center :

- Newspaper advertisement Specify: \_\_\_\_\_
- Newspaper / magazine article Specify: \_\_\_\_\_
- Friend / acquaintance Name: \_\_\_\_\_
- Other \_\_\_\_\_

**I verify that the statements made and information provided in this Application are true and correct.**

**This Application is executed under penalty of perjury under the laws of the State of California.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Include pictures of yourself and children (if applicable) and a copy of your Drivers License and Social Security Card with your completed application.**

**Please Mail or Fax completed Application to:**

**Woman to Woman Fertility Center, Inc.**  
**383 Diablo Road, Suite 100**  
**Danville, CA 94526**  
**Phone (925) 820-9495 Fax (925) 820-3885**  
**Email: wwfc@compuserve.com**



*Woman to Woman*  
FERTILITY CENTER

**AUTHORIZATION FOR RELEASE OF INFORMATION**

(Civil Code section 56.10)

**TO: ANY PHYSICIAN, MEDICAL FACILITY, PSYCHIATRIST, PSYCHOLOGIST, OR OTHER HEALTH CARE OR MENTAL HEALTH PROFESSIONAL:**

YOU ARE HEREBY AUTHORIZED to release to Woman to Woman Fertility Center any and all medical, psychological, psychiatric, or health information pertaining to me, or to my pregnancy, or to the child expected to be born on or about \_\_\_\_\_ which is now or in the future may be in your possession or under your control.

Woman to Woman Fertility Center is expressly authorized hereby to copy, or receive copies of, any records or documents pertaining to me or the information specified above, and to distribute said copies to \_\_\_\_\_ ( Prospective Parents) or to any other Prospective Parents and to any other interested physician, psychiatrist, psychologist or health care or mental health professional who requires the information for purposes of medical or psychological assessment or treatment.

The information may be used in, or in connection with, the surrogate parenting agreement I entered into with the Prospective Parents identified above or with other Prospective Parents.

This authorization shall remain valid for two years from the date hereof.

I have been advised of my right to receive a copy of this Authorization.

I have received a copy of this Authorization. \_\_\_yes \_\_\_no

Dated: \_\_\_\_\_

\_\_\_\_\_  
Surrogate

**HUSBAND/PARTNER SUPPORT FORM**

I am \_\_\_\_\_, the husband/partner of \_\_\_\_\_.  
I can/cannot attend the initial interview that you have scheduled for my wife/partner on \_\_\_\_\_.

I am supportive of my wife's/partner's decision to be a surrogate mother to help an infertile couple have a child.

I am not supportive of my wife's/partner's decision to be a surrogate mother to help an infertile couple have a child.

**I am willing to have an HIV test.**

The reasons for my decision are as follows (in no order of importance):

- 1. \_\_\_\_\_  
\_\_\_\_\_
- 2. \_\_\_\_\_  
\_\_\_\_\_
- 3. \_\_\_\_\_  
\_\_\_\_\_
- 4. \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature