**CONTACT INFORMATION**

**Date:** **Name:**

First MI Last

**Home Street Address:**

**City, State, Zip:** ,

**Telephone:** ( ) ( ) ( )

Home Cell Work

**Email:**

**What is the best time to reach you? What is your preferred method of contact?**

**PERSONAL CHARACTERISTICS**

**Date of Birth:** **Current Age:**

**Height:** ft. inches **Weight (lbs.):**

**What is your Race (circle one):** Caucasian African-American Hispanic/Latina Other (specify)

**Marital Status (circle one):** Single (partner) Single (no partner) Married Divorced

**Children (circle one):** No Yes How many? What are their ages?

**MEDICAL HISTORY**

**Have you had any medical illnesses? (circle one):** No Yes (explain in box below)

|  |  |  |  |
| --- | --- | --- | --- |
| **Date** | **Medical Illness** | **Diagnosis** | **Medications** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Have you had any surgeries? (circle one):** No Yes (explain in box below)

|  |  |  |
| --- | --- | --- |
| **Year of Surgery** | **Type of Surgery** | **Complications?** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Have you ever been hospitalized? (circle one):** No Yes (explain in box below)

|  |  |  |
| --- | --- | --- |
|  **Year of Hospitalization** | **Reason of Hospitalization** | **Complications?** |
|  |  |  |
|  |  |  |
|  |  |  |

**If you have previously been pregnant, please list information about each pregnancy below:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date** | **Conception (spontaneous or with treatment?)** | **Pregnancy complications** | **Gestational age at delivery** | **Weight of baby** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Are you currently taking any medications, prescriptions or over-the-counter? (Other than those previously listed) (circle one)** No Yes (explain)

|  |  |
| --- | --- |
| **Medication** | **Condition Under Treatment** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Do you have any current allergies (circle one):** No Yes If yes, what type? Drug Food Environment

 Other (explain)

**For each allergy, please describe the specific substance, type of reaction(s) and the age when first noticed:**

|  |  |  |
| --- | --- | --- |
| **Substance** | **Reaction** | **Age** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Have you ever had a blood transfusion? (circle one):** No Yes (explain)

**Have you had any major radiation or x-ray exposure? (circle one):**  No Yes (explain)

**Have you every smoked cigarettes or used other tobacco products? (circle one):**  No Yes (explain)

Age when began using tobacco? Age when stopped using tobacco?

**Do you smoke cigarettes currently? (circle one):**  No Yes # of packs per day:

**Have you ever drunk alcohol? (circle one):**  No Yes

Age when began using alcohol? Age when stopped using alcohol?

**Do you drink alcohol currently? (circle one):** No Yes # of drinks per week:

**How would characterize your diet/nutrition? (circle one):** Poor Average Good

**Do you follow a vegetarian diet? (circle one):** No Yes

**How much exercise do you get? (circle one):**  None Occasiona Regular

Type of Exercise? Days per Week:

**SEXUAL HISTORY**

**What is your sexual orientation? (circle one)** Heterosexual Homosexual Bisexual

**Have you been sexually active? (circle one)** No Yes

 Number of sexual partners you have had in the last six (6) months:

 Number of sexual partners your partner has had in the last six (6) months:

Please identify any infections that you or any of your sexual partners have had diagnosed. For each infection or behavior listed below, check “Yes” if either you or a partner has had the diagnosis, or “No” if neither you nor a partner has had the diagnosis. For any known infection, please indicate when you/your partner was diagnosed, and the outcome (e. g., resolved after treatment).

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Infection/Behavior** | Self Yes | Self No | Partner Yes | Partner No | **When** | **Outcome** |
| Non-specific urethritis (NSU) |  |  |  |  |  |  |
| Syphillis |  |  |  |  |  |  |
| Gonorrhea |  |  |  |  |  |  |
| Chlamydia |  |  |  |  |  |  |
| Venereal Warts |  |  |  |  |  |  |
| Herpes |  |  |  |  |  |  |
| Hepatitis |  |  |  |  |  |  |
| Other sexually-transmitted infections |  |  |  |  |  |  |
| Use of intravenous (I.V.) drugs |  |  |  |  |  |  |

**ENVIRONMENTAL EXPOSURES**

In the table below, please check “No” or “Yes” to indicate whether you have been exposed to any of the listed substances in your living or work environment. If yes, provide details on the type and time of the exposure.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Substance** | **Exposure No** | **Exposure Yes** | **When (Years)** | **Frequency** | **Type or Source of Exposure** |
|  Toxic Chemicals |  |  |  |  |  |
| Sprays |  |  |  |  |  |
| Fumes/Exhaust |  |  |  |  |  |
| Radiation |  |  |  |  |  |
| Insecticides |  |  |  |  |  |
| Lead/Lead Products |  |  |  |  |  |
| Asbestos/Asbestos Products |  |  |  |  |  |
| Cleaning Solutions |  |  |  |  |  |
| Recreational Drugs |  |  |  |  |  |

**EXPOSURE TO INFECTIOUS DISEASES/AGENTS**

Because of recent medical events, we are required to ask the following questions regarding certain activities that could result in exposure to infectious agents. We must ask these questions to protect you, our patients, and ourselves. For each, please circle “No” or “Yes”.

1. Since 1977, have you lived in or traveled to any country outside of the United States? No Yes

If no, please go directly to question #6

If yes, please complete questions #2-#5 below

1. Between 1980 and 1996, did you spend a total of six (6) months or more associated No Yes

with a U.S. military base in any of the following countries: Belgium, The Netherlands,

Germany, Spain, Portugal, Turkey, Italy or Greece?

If no, please go to question #3

If yes, please indicate when and where:

|  |  |
| --- | --- |
| **Dates of Travel** | **Country Traveled To:** |
|  |  |
|  |  |
|  |  |

1. Since 1980, have you lived in or traveled to Europe, including the United Kingdom No Yes

(includes England, Ireland, Scotland, Wales, the Isle of Man, the Channel Islands,

Gibraltar, or the Faulkland Islands)?

If no, please go to question #4

If yes, please complete questions #3a-3c, then continue with question #4

 3a. From 1980-1996, did you spend a total of three (3) months or more No Yes

 in the United Kingdom?

 3b. Since 1980, have you received a transfusion of blood, platelets, plasma, No Yes

cryoprecipitate or granulocytes in the United Kingdom?

 3c. Since 1980, have you spent time totaling five (5) years or more in Europe No Yes

(including time spent in the United Kingdom from 1980 to the present)?

1. Since 1977, have you been in Africa? No Yes

If no, please go to question #5

If yes, please complete questions #4a-4c, then continue with question #5

 4a. Were you born in or have you live in Cameroon, Central African Republic, No Yes

 Chad, Congo, Equatorial Guinea, Gabon, Niger , or Nigeria?

 If yes, please explain:

 4b. Have you received a blood transfusion or any other medical treatment with a No Yes

 Product made from blood in any of these African countries?

 If yes, please explain:

 4c. Have you had sex with anyone who, since 1977, was born in or lived in Africa? No Yes

 If yes, please explain:

1. In the past 3 years, have you been out of the U.S. or Canada? No Yes

If no, please go to question #6

If yes, please complete questions #5a-5d, then continue with question #6

 5a. Have you been to any location where infection with malaria is possible? No Yes

 5b. Have you traveled to Southeast Asia (China, Vietnam, Thailand, Cambodia)? No Yes

 5c. Did you contract any disease(s) from your foreign travel? No Yes

 If yes, please explain:

 5d. In the past year, have you been exposed to anyone who has traveled to Southeast No Yes

 Asia (China, Vietnam, Thailand, Cambodia)?

 If yes, please explain:

1. In the past five (5) years, have you ever injected drugs for a non-medical reason, including No Yes

Intravenous, intramuscular, or subcutaneous injection?

 If yes, please explain:

1. Do you take or have you ever taken any concentrated products derived from blood or No Yes

blood substances for treatment of a clotting disorder or other disease?

 If yes, please explain:

1. In the past five (5) years, have you had sex in exchange for drugs or money? No Yes

If yes, please explain:

1. In the past twelve (12) months, have you given money or drugs to anyone to have sex No Yes

with you?

 If yes, please explain:

1. In the past twelve (12) months, have you had sex with anyone who would answer “yes” No Yes

to questions #6, #7, #8 or #9?

 If yes, please explain:

1. Females: In the past twelve (12) months, have you had sex with a man who has had sex No Yes

with another man during the past five (5) years?

 If yes, please explain:

1. In the past twelve (12) months, have you had sex with a person known or suspected to No Yes

have HIV, or active Hepatitis B or Hepatitis C?

 If yes, please explain:

1. In the past twelve (12) months, have you been exposed to anyone with known or No Yes

suspected HIV, Hepatitis B and/or Hepatitis C infected blood due to an injection, contact

with an open wound, non-intact skin, or mucous membrane?

 If yes, please explain:

1. In the past twelve (12) months, have you been in close contact (e.g. sharing kitchen and No Yes

bathroom) with a person having active viral hepatitis?

 If yes, please explain:

1. In the past year, have you had a tattoo, ear or skin piercing, or acupuncture? No Yes

If yes, please explain:

1. After the age of 11, have you ever had viral hepatitis? No Yes

If yes, please explain:

1. Have you had a recent smallpox vaccination or had close contact with the vaccination No Yes

site of anyone else (e.g. touching the vaccination site, the bandages covering the site, or

handling bedding or clothing that has been in contact with an un-bandaged vaccination site?

 If no, please go to question #18

 If yes, please complete questions #17a-#17c, then continue with question #18

17a. If you received the vaccination, did the scab fall off the skin by itself? No Yes

 If no, please explain:

17b. If you had close contact with the vaccination site of another person, have you No Yes

 had any new skin rash or sore since the contact?

 If yes, please explain:

17c. Did you have any illness or complications from your vaccination or from your No Yes

 close contact with someone who had the vaccination?

 If yes, please explain:

1. In the past four (4) weeks, have you had any shots or vaccinations? No Yes

If yes, please describe the type of shot or vaccination you received:

1. Have you ever been diagnosed with West Nile Virus? No Yes

If yes, please explain:

1. In the past week, have you had a headache and fever? No Yes

If yes, please explain:

1. In the past forty-eight (48) hours, have you had a blood transfusion or other No Yes

intravenous infusion before your blood was drawn for tests to determine your eligibility

to be a donor?

 If yes, please explain:

1. In the past twelve (12) months, have you had a positive syphilis test? No Yes

If yes, please explain:

1. In the past twelve (12) months, have you had or been treated for syphilis or gonorrhea? No Yes

If yes, please explain:

1. Have you ever received or had intimate contact (e.g. exchanged body fluids, including No Yes

sharing toothbrushes and razors) with someone who has received organs or cells from

non-human sources?

 If yes, please explain:

1. Have you ever received growth hormone, bovine (beef) insulin, or had a dura mater No Yes

(brain covering) graft?

 If yes, please explain:

1. Have you or any of your blood relatives ever had Creutzfeldt-Jakob disease No Yes

(e.g. mad cow disease or a similar illness)?

 If yes, have you had the geneti test for CJD and, if so, what was the result?

1. In the past twelve (12) months, have you been in jail for more than three (3) days No Yes

in a row?

 If yes, please explain:

**DETAILED FAMILY MEDICAL HISTORY**

In the table below, please identify any health conditions that have been diagnosed in members of your family. If you do not already know details of your family health history, please ask someone who can provide you with the information. For each of the listed conditions, please write an “X” or a description (e.g. brother, MGM) to identify which, if any, member(s) of your family was diagnosed with the condition. If the condition has not been diagnosed in any member of your family (to the best of your knowledge), leave the row blank.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **CONDITION** | **YOU** | **MOTHER** | **FATHER** | **SIBLING** | **MGM/MGF/****PGM/PGF** | **AUNT/UNCLE** | **COUSIN** |
| Heart/Cardiovascular |  |  |  |  |  |  |  |
| Stroke |  |  |  |  |  |  |  |
| Heart Attack |  |  |  |  |  |  |  |
| Heart Disease from Birth |  |  |  |  |  |  |  |
| Other Heart Disease |  |  |  |  |  |  |  |
| Hardening of the Arteries |  |  |  |  |  |  |  |
| High Blood Pressure |  |  |  |  |  |  |  |
| High Cholesterol |  |  |  |  |  |  |  |
| Blood/Hematologic |  |  |  |  |  |  |  |
| Anemia |  |  |  |  |  |  |  |
| Sickle Cell Anemia |  |  |  |  |  |  |  |
| Hemophilia/Other Bleeding Disorder |  |  |  |  |  |  |  |
| Leukemia |  |  |  |  |  |  |  |
| Lymphoma |  |  |  |  |  |  |  |
| HIV Infection |  |  |  |  |  |  |  |
| Other Blood Disorder |  |  |  |  |  |  |  |
| Lung/Respiratory |  |  |  |  |  |  |  |
| Hay Fever/Environmental Allergy |  |  |  |  |  |  |  |
| Asthma |  |  |  |  |  |  |  |
| Emphysema |  |  |  |  |  |  |  |
| Tuberculosis |  |  |  |  |  |  |  |
| Lung Cancer |  |  |  |  |  |  |  |
| Pneumonia |  |  |  |  |  |  |  |
| Other Lung Diseases |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **CONDITION** | **YOU** | **MOTHER** | **FATHER** | **SIBLING** | **MGM/MGF/****PGM/PGF** | **AUNT/UNCLE** | **COUSIN** |
| Gastro-Intestinal |  |  |  |  |  |  |  |
| Ulcer of Stomach or Duodenum |  |  |  |  |  |  |  |
| Gall Stones |  |  |  |  |  |  |  |
| Hepatitis |  |  |  |  |  |  |  |
| Cirrhosis |  |  |  |  |  |  |  |
| Other Liver Disease |  |  |  |  |  |  |  |
| Color Cancer |  |  |  |  |  |  |  |
| Ulcerative Colitis |  |  |  |  |  |  |  |
| Crohn’s Disease |  |  |  |  |  |  |  |
| Cystic Fibrosis |  |  |  |  |  |  |  |
| Intestinal Cancer |  |  |  |  |  |  |  |
| Developmental Disorder of Stomach and/or Intestine |  |  |  |  |  |  |  |
| Pyloric Stenosis |  |  |  |  |  |  |  |
| Rectal Disorder |  |  |  |  |  |  |  |
| Other Problem of Digestive System |  |  |  |  |  |  |  |
| Metabolic/Endocrine |  |  |  |  |  |  |  |
| Diabetes |  |  |  |  |  |  |  |
| Hypoglycemia |  |  |  |  |  |  |  |
| Thyroid Cancer |  |  |  |  |  |  |  |
| Goiter |  |  |  |  |  |  |  |
| Other Thyroid Disease |  |  |  |  |  |  |  |
| Adrenal Disorder/ Dysfunction |  |  |  |  |  |  |  |
| Hyperactivity |  |  |  |  |  |  |  |
| Urinary |  |  |  |  |  |  |  |
| Kidney Disease |  |  |  |  |  |  |  |
| Other Disease/ Disorder of the Bladder/Urethra/ Ureter |  |  |  |  |  |  |  |
| Genital/Reproductive |  |  |  |  |  |  |  |
| Undescended Testicle |  |  |  |  |  |  |  |
| Ambiguous Genitals |  |  |  |  |  |  |  |
| Hypospadius |  |  |  |  |  |  |  |
| Uterine Fibroids |  |  |  |  |  |  |  |
| Endometriosis |  |  |  |  |  |  |  |
| Ovarian Cysts |  |  |  |  |  |  |  |
| Cancer of Cervix/Uterus |  |  |  |  |  |  |  |
| Ovarian Cancer |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **CONDITION** | **YOU** | **MOTHER** | **FATHER** | **SIBLING** | **MGM/MGF/****PGM/PGF** | **AUNT/UNCLE** | **COUSIN** |
| Reproductive Outcomes |  |  |  |  |  |  |  |
| Two or More Miscarriages |  |  |  |  |  |  |  |
| Stillbirth |  |  |  |  |  |  |  |
| Death of a Newborn |  |  |  |  |  |  |  |
| Neonatal Jaundice |  |  |  |  |  |  |  |
| Neurological |  |  |  |  |  |  |  |
| Migrane |  |  |  |  |  |  |  |
| Mental Retardation |  |  |  |  |  |  |  |
| Cerebral Palsy |  |  |  |  |  |  |  |
| Epilepsy/Seizures |  |  |  |  |  |  |  |
| Hydrocephalus |  |  |  |  |  |  |  |
| Spina Bifida/ Neural Tube Defect |  |  |  |  |  |  |  |
| Other Disease of the Nervous System |  |  |  |  |  |  |  |
| Mental Health |  |  |  |  |  |  |  |
| Schizophrenia |  |  |  |  |  |  |  |
| Manic Depression/ Bipolar Disorder |  |  |  |  |  |  |  |
| Other Mental Health Disorder Requiring Hospitalization |  |  |  |  |  |  |  |
| Muscle/Bone/Joints |  |  |  |  |  |  |  |
| Chronic Muscle Disease |  |  |  |  |  |  |  |
| Loss of Muscle Coordination |  |  |  |  |  |  |  |
| Lupus |  |  |  |  |  |  |  |
| Congenital Abnormalities |  |  |  |  |  |  |  |
| Cleft lip/palate |  |  |  |  |  |  |  |
| Congenital hip problems |  |  |  |  |  |  |  |
| Club feet |  |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **CONDITION** | **YOU** | **MOTHER** | **FATHER** | **SIBLING** | **MGM/MGF/****PGM/PGF** | **AUNT/UNCLE** | **COUSIN** |
| Other |  |  |  |  |  |  |  |
| Alcoholism |  |  |  |  |  |  |  |
| Drug abuse, misuse of addiction |  |  |  |  |  |  |  |
| Breast Cancer |  |  |  |  |  |  |  |
| Any other cancer not mentioned |  |  |  |  |  |  |  |
| Any other condition not mentioned |  |  |  |  |  |  |  |

**Please use the space below to provide any further relevant information about family health conditions or to provide any further relevant information about your suitability as a gestational carrier.**

**AFFIRMATION**

**My signature below affirms that the information I have provided above is true, complete, and accurate to the best of my knowledge.**

**Donor Signature Date**

**REVIEW (Program Use Only)**

**I have reviewed the information contained on this form and have determined that the donor is (check one):**

|  |  |
| --- | --- |
|  | **QUALIFIED to continue with the screening process to determine eligibility** |
|  | **NOT QUALIFIED to continue with the screening process to determine eligibility because:** |

**Physician Name (Print) Physician Signature Date**