

LAW OFFICES OF CHARLOTTE H. DANCIU
SURROGATE AND EGG DONOR QUESTIONNAIRE
202 N. Swinton Ave.
Delray Beach, FL 33444
561-330-6700/1-800-395-5449

IDENTIFYING INFORMATION: DATE: _____

Name: _____ PHONE NUMBERS:
Address: _____ Home: (____) _____
Work: (____) _____
Cell: (____) _____

E-mail Address: _____ Date of Birth: _____
Social Security No.: _____ Age: _____
Occupation: _____ Blood Type: ____ (+) or (-)
Driver's License #: _____

Marital Status: _____ If Married, How
Maiden Name: _____ Long: _____

Husband's Name: _____ Date of Birth: _____
Social Security No.: _____ Age: _____
Occupation: _____
Driver's License #: _____

Do you have Health Insurance: _____ Name/#: _____
Previous Egg Donor: YES _____ NO _____ Previous Surrogate: YES _____ NO _____
Results (IF KNOWN) _____

* YOU MUST SUPPLY THREE CHARACTER REFERENCE LETTERS:

REFERENCES:

NAME (NOT RELATED): ADDRESS: TELEPHONE#:

* PLEASE ENCLOSE A RECENT PHOTO of yourself and any children you may have. We suggest a photo of which you have duplicates, as we cannot guarantee its return.

* Are you interested in being: _____ a surrogate mother or _____ an egg donor

* On a separate sheet of paper, please explain why you wish to be a Surrogate Mother or an Egg Donor

PHYSICAL CHARACTERISTICS:

Age: _____ Date of Birth: _____ Height: _____ Weight: _____

Eye Color: _____ Natural Hair Color: _____

	Eye Color	Hair Color	Complexion	Height	Body Types
Mother:	_____	_____	_____	_____	_____

Father: _____

Body Type/Bone Structure: _____ Small _____ Medium _____ Large

Natural Hair type: _____ Curly _____ Wavy _____ Straight

Premature Greying? _____ Yes _____ No If Yes, At What Age: _____

Skin Color (Check all that apply) : _____ Fair _____ Medium _____ Olive _____ Light Brown
_____ Dark Brown _____ Ebony _____ Freckled _____ Rosy

Birthmarks: _____

Vision (without corrective lenses): _____ Poor _____ Fair _____ Good _____ Excellent

Do you wear corrective lenses? _____ For What Problem? _____

Age you first wore glasses: _____

Hearing: (without corrective aids): _____ Poor _____ Fair _____ Good _____ Excellent

Do you wear corrective aids? _____ For What Problem? _____

Age you first wore an aid? _____

Teeth: _____ Poor _____ Fair _____ Good _____ Excellent

Any Abnormalities? _____ Orthodontic Work? _____

If Yes, please explain: _____ At What Age: _____

BACKGROUND:

Race: _____ Ethnic Origin: _____

Mother: _____ Father: _____

ATHLETIC ACTIVITY:

_____ Athletic _____ Active _____ Average _____ Inactive

What physical activities do you engage in? _____

Have you excelled in any physical activities? _____ Please explain: _____

MANUAL DEXTERITY:

_____ Dexterous _____ Average _____ Clumsy

_____ Right Handed _____ Left Handed _____ Ambidextrous

MUSICAL ABILITY:

_____ Musical _____ Average _____ Tone Deaf

Please describe any musical abilities or talents: _____

SKILLS/TALENTS:

Please describe any skills or talents that you have (e.g. painting, writing, crafts): _____

EDUCATION:

_____ Completed Grade School

_____ Completed High School (GPA _____) Year: _____

_____ GED, Year: _____

_____ Currently in College, pursuing a degree in: _____
GPA: _____ Year: _____
Name of College or University: _____

_____ Completed College, Degree in: _____
GPA: _____ Year: _____
Name of College of University: _____

_____ Currently pursuing an advance degree in: _____
GPA: _____ Year: _____
Name of College of University: _____

_____ Hold an advanced degree in: _____
GPA: _____ Year: _____
Name of College of University: _____

_____ Technical and Specialized School, Certification or Degree in: _____

_____ Any awards or any non-degree seeking classes taken: _____

TESTING SCORES: SAT: _____ ACT: _____ GRE: _____ MAT: _____
LSAT: _____ MCAT: _____

REPRODUCTIVE HEALTH:

Age at first period: _____ Cycles: _____ Regular _____ Irregular

Interval between periods: _____

Please describe any problems or special circumstances having to do with your reproductive health (Failure to Conceive, Menstrual problems, Ovarian Cysts, etc.): _____

Pregnancy History:

* Please indicate in the outcome column if it was a vaginal delivery, C-section, Ectopic, Miscarriage of Termination.

	Year	Outcome	Wks. Gestation	Weight of Baby	Complications?
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____

Birth Control Method Now used: _____ For How Long: _____

HEALTH:

Do you smoke cigarettes? _____ Yes _____ No How many packs per day? _____

Do you drink Alcoholic beverages? ____Yes ____ No How often? _____

Do you now, or have you ever, used mind-altering drugs? ____Yes ____ No

If yes, please explain: _____

List prescription and non-prescription medications that you take regularly: _____

Do you have any allergies? ____Yes ____No If Yes, please explain:_____

Do you have any medical illnesses? (Asthma, Diabetes, Seizure Disorders, etc.): _____

How is your nutrition? ____Poor ____Average ____Good ____ Excellent

Describe your nutritional habits, likes and dislikes: _____

Are you a vegetarian? ____ Yes ____ No

MEDICAL HISTORY:

Have you had any surgeries? _____

Please list any surgeries you have had and the dates:

1. _____

2. _____

3. _____

Have you had a blood transfusion? _____ How long ago? _____

Have you had major radiation or x-ray exposure? _____

Please describe any other health issues that you have had:_____

Have you been immunized for: (X as many as known)

- () Diphtheria
- () Polio
- () Influenza (flu)
- () Small pox
- () Measles, regular
- () Tetanus
- () Mumps
- () Whooping Cough
- () Rubella
- () None of the above
- () Other (please specify): _____

FAMILY HEALTH HISTORY:

	AGE (if alive)	AGE (at death)	Medical problems or cause of death
Mother:			
Father:			
Brothers:			
Sisters:			
Maternal Grandmother:			
Maternal Grandfather:			
Paternal Grandmother:			
Paternal Grandfather:			
Children:			

FAMILY MEDICAL HISTORY:

Please read the following list of medical problems carefully and indicate which ones you or one of you relatives have had. Please consider each condition for each family members:

Medical Problems	You	Mother	Father	Siblings	Grand-parents	Other Family	Describe
1. HEART							
A. Stroke							
B. Heart Attack							

Medical Problems	You	Mother	Father	Siblings	Grand-parents	Other Family	Describe
C. Heart disease							
1. From birth							
2. Other							
D. Hardening of arteries							
E. High Blood Pressure							
2. BLOOD							
A. Anemia							
B. Sickle-cell							
C. Hemophilia Other Bleeding							
D. Leukemia							
E. HIV							
F. Other Blood Disease							
3. RESPIRATORY							
A. Hayfever							
B. Asthma							
C. Emphysema							
D. Tuberculosis							
E. Lung Cancer							
F. Pneumonia							
G. Other Lung Disease							
4. GASTRO-INTESTINAL							
A. Ulcer of stomach or duodenum							
B. Gallstone							
C. Hepatitis A							
D. Hepatitis B							
E. Other Liver Disease							
F. Colon Cancer							
G. Ulcerative colitis							
H. Crohn's Disease							
I. Cystic Fibrosis							
J. Intestinal Cancer							
K. any other cancer problems of digestive system							
5. METABOLIC ENDOCRINE							

Medical Problems	You	Mother	Father	Siblings	Grand-parents	Other Family	Describe
A. Diabetes Mellitus							
B. Hypoglycemia							
C. Thyroid Cancer							
D. Thyroid Disease							
E. Goiter							
F. Adrenal Dysfunction or Disorder							
G. Hyperactivity							
6. URINARY							
A. Kidney Disease							
B. Other disease of Urinary Tract							
C. Rectal Disorder							
7. GENITAL REPRODUCTION							
A. Undescended Testicle							
B. Hypospadiasis							
C. Prostate							
D. Uterine Fibroids							
E. Ovarian Cancer							
F. Cancer of Ovaries Cervix, uterus							
8. NEUROLOGICAL							
A. Migraines							
B. Mental Retardation							
C. Senility before age 50							
D. Multiple sclerosis							
E. Cerebral Palsy							
F. Epilepsy							
G. Hydrocephalus (water on brain)							
H. Disorders of the Spinal Cord							
I. Huntington's chorea							
J. Gaucher's Disease							
K. Wilson's Disease							
L. Other Disease of the Nervous System							
9. MENTAL HEALTH							

Medical Problems	You	Mother	Father	Siblings	Grand-parents	Other Family	Describe
A. Schizophrenia							
B. Manic Depressive							
C. Other mental health problems requiring hospitalization							
10. MUSCULAR, BONES & JOINTS							
A. Muscular Dystrophy							
B. Other chronic Muscle Disease							
C. Lupus							
D. Deformity of spine							
E. Osteoporosis							
F. Dwarfism							
G. Hereditary Low Back Disease							
H. Arthritis							
I. Gout							

PSYCHO/SOCIAL:

Religion:

What religion were you born into? _____

What religion are you now? _____

Are you atheist? _____ Agnostic: _____

How religious are you now?

____Very ____Moderately ____Occasionally Attend ____Not at all

PLEASE GIVE A BRIEF DESCRIPTION OF YOURSELF AND YOUR PERSONALITY:

AUTHORIZATION FOR CHARLOTTE H. DANCIU, P.A. TO DISCLOSE
PROTECTED HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____ Social Security No.: _____

Address: _____

City: _____ State: _____ Zip: _____

I authorize Charlotte H. Danciu, P.A., to disclose the above-named individual's health information as described below.

The type and amount of information to be disclosed is as follows: (Include dates where appropriate)

ALL MEDICAL RECORDS

ALL MEDICAL RECORDS DURING MY PREGNANCY INCLUDING BIRTH, DELIVERY AND POST-PARTUM

I understand that this information may include, when applicable, information relating to sexually transmitted disease, Human Immunodeficiency Virus (HIV infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex) and any other communicable disease. It may also include information about behavioral or mental health services, and referral or treatment for alcohol and drug abuse (as permitted by 42 CFR Part 2).

This information may be disclosed to and used by the following person or organization.

Attorney(s) for adoptive parent(s) Adoptive parent(s)
Agency for adoptive parent(s) Court in connection with adoption, as necessary
Interstate Compact on the Placement of Children, as necessary
Other: _____

This disclosure and use is for the following purpose: Adoption matter

I understand that I have the right to revoke this authorization at any time, I understand that if I revoke this authorization I must do so in writing and present my written revocation to The Law Offices of Charlotte H. Danciu, P.A. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire one year from the signature date.

I understand that authorizing the disclosure of this health information is voluntary. I also understand that I may refuse to sign this authorization and that my refusal to sign will not effect my ability to obtain treatment, payment for services, or eligibility for benefits.

By signing this authorization, I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal privacy rules. I further understand I may request a copy of this signed authorization. A photostatic copy of this authorization shall serve in its stead.

Witness

Signature of individual or Legal Representative

Date: _____

Relationship of Representative: _____

Date: _____

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
TO THE LAW OFFICES OF CHARLOTTE H. DANCIU, P.A.

Patient's Name: _____ Social Sec. Number (if known): _____
Date of Birth: _____ Health Rec.# (if known): _____

1. I authorize the use or disclosure of the above named individual's health information as described below:
2. The following individual or organization is authorized to make the disclosure:

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

- | | |
|--|---|
| <input type="checkbox"/> problem list | <input type="checkbox"/> list of allergies |
| <input type="checkbox"/> medication list | <input type="checkbox"/> immunization records |
| <input type="checkbox"/> most recent discharge summary | <input type="checkbox"/> bills, invoices, itemized statements |
| <input type="checkbox"/> Most recent history and physical | <input type="checkbox"/> insurance claim forms |
| <input type="checkbox"/> laboratory results from (date) _____ to (date) _____ | |
| <input type="checkbox"/> x-ray and imaging records from (date) _____ to (date) _____ | |
| <input type="checkbox"/> consultation reports from (doctors' name) _____ | |
| <input type="checkbox"/> entire record from (date) _____ to (date) _____ | |
| <input type="checkbox"/> other _____ | |

4. I understand that the information may included information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual or organization:

The Law Offices of Charlotte H. Danciu, P.A.
202 N. Swinton Avenue, Delray Beach, FL 33444
for the purpose of: adoption matter.

6. I understand I have the right to revoke this authorization for my child at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to The Law Offices of Charlotte H. Danciu, P.A. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire _____ in six months.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact an attorney or The Law Offices of Charlotte H. Danciu, P.A.

Signature of Individual or Legal Representative

Date

Printed Name and Relationship of Representative

Signature of Witness

Date