Surrogate Mother Medical Profile. Sample

If you have ever had a miscarriage and or abortion when did it occur? **no**
Are you currently breastfeeding? **no**
If you have been pregnant before please fill out below:

Year	Sex of the child	Duration	Complications	Healthy?
2010	Male	41 weeks	no	yes
2012	Female	38 weeks	no	yes

Reproductive History:
Age of first period – **13**
Interval between periods – **29**
If you have menstrual cramps please describe – **no**
Do you have any bleeding in between your periods? **no**
When was your last Pap smear? **25.10.2017**
If you have had an abnormal pap smear when was it? **no**
Do you have discharge from one or both breasts? **no**
Have you ever had any of the following? **no**

		Data	Age	Treatment
Gonorrhea	**no**			
Chlamydia	**no**			
Condyloma (venereal warts)	**no**			
Syphilis	**no**			
Herpes	**no**			
Other	**no**			

Did your mother take DES when she was pregnant with you? **no**
If there is a history of infertility in your family, please describe – **no**
Whether you belong to the persons with an untraditional sexual orientation? **no**
Domestic position – **married**.

Contraceptive/ Sexual History:
What contraceptive have you used?

What method do you currently use?	**Condoms**
Which method does your partner currently use?	**Condoms**
Are you sexually active now?	**yes**
Is your relationship monogamous?	**yes**
How many partners have you had in the past year?	**1**

Personal Health History:

Do you currently have any allergies to:	**no**
Are you currently breastfeeding?	**no**
Has anyone in your family including yourself experienced recurring and of chronic physical symptoms that have not yet been evaluated by a physician? Please include those symptoms that you might not consider serious. If yes, please explain	**no**
How is your vision (without glasses) ?	**normal**
Do you wear glasses or contact lenses?	**no**
Do you have normal hearing?	**yes**

Please describe abnormal hearing	-
What is the condition of your teeth?	**normal**
If you ever wore braces or retainer, please describe	**no**
Are you vegetarian?	**no**
If you ever had surgery, please describe	**no**
If you ever had hospitalizations not previously mentioned, please describe	**no**
If you ever had any complications resulting from surgery, please describe	**no**
If you have or any member of your family had malignant hyperthermia or high fevers after surgery, injury or exercise, please describe	**no**
If you have had any major radiation or x-ray exposure, please describe	**no**
Have you ever lived in Chernobyl or the surrounding areas since 1986, please describe	**no**
Have you ever visited the exclusion zone, please describe	**no**
If you ever had a blood transfusion, when?	**no**
Have you got any tattoos?	**no**
Have you ever smoked cigarettes?	**no**
If you take any medications at the present time, what are they?	**no**
If you have ever been advised to have any diagnostic testing, hospitalization or surgery that was not completed, please explain	**no**
If you ever had any serious trauma, please explain	**no**
If you have gained or lost more than 10 pounds in the last year, please explain	**no**
If you have ever participated in mental health counselling, please explain	**no**
What kind of alcoholic beverages do you drink?	**no**
How many drink?	-
Do you consume?	**no**
Have you ever used intravenous drugs?	**no**
Have you ever been with a partner who may have used intravenous drugs?	**no**
Have you had or been treated for a substance, alcohol abuse, addiction problem?	**no**
If you have any legal cases pending against you, please explain	**no**

Family History:
Biological mother – 1975 – healthy
Biological father – 1975 – healthy
Biological maternal grandmother – 1950-2014 - accident
Biological maternal grandfather – 1952– healthy
Biological paternal grandmother – 1950 – healthy
Biological paternal grandfather – 1951 – healthy
Sibling:
Brother born in 1994 – healthy – has no children
Please describe twins or other multiple births that may have occurred in your family – **no**.

Medical Background:
Indicate if your grandparents, parents, siblings, children, aunts, uncles, cousins or other extended family members (blood relatives) have had or now have any of the following medical conditions listed below. Please note with aunts, uncles or cousins if on the maternal or paternal side of the family, appropriate give age at onset, treatment, medication etc.

Heart:			
Medical Problem	**Self**	**Family**	**If yes, please describe**
Stroke	**no**		

Heart attack	**no**		
Heart disease	**no**		
Heart murmur	**no**		
Hardening of the arteries	**no**		
High blood pressure	**no**		
High cholesterol	**no**		

Blood:			
Medical Problem	**Self**	**Family**	**If yes, please describe**
Anemia	**no**		
Sickle cell anemia	**no**		
Hemophilia or other bleeding problem	**no**		
Leukemia	**no**		
Immune deficiency	**no**		
Thalassemia	**no**		

Respiratory (Lungs):			
Medical Problem	**Self**	**Family**	**If yes, please describe**
Hay fever	**no**		
Asthma	**no**		
Emphysema	**no**		
Tuberculosis	**no**		
Lung cancer	**no**		
Pneumonia	**no**		
Cystic Fibrosis	**no**		
Other lung disease	**no**		

Gastrointestinal:			
Medical Problem	**Self**	**Family**	**If yes, please describe**
Ulcer of stomach or duodenum	**no**		
Gallstones	**no**		
Hepatitis A (infectious)	**no**		
Hepatitis B (serum)	**no**		
Hepatitis C	**no**		
Other liver disease	**no**		
Colon cancer	**no**		
Ulcerative colitis	**no**		
Crohn’s disease	**no**		
Intestinal cancer	**no**		
Cirrhosis	**no**		
Pyloric Stenosis	**no**		
Rectal disorder	**no**		
Any other problem of the digestive system	**no**		

Metabolic / Endocrine:			
Medical Problem	**Self**	**Family**	**If yes, please describe**

Diabetes mellitus	**no**		
Hypoglycemia	**no**		
Thyroid disease	**no**		
Thyroid cancer	**no**		
Goiter	**no**		
Pneumonia	**no**		
Adrenal dysfunction	**no**		
Phenyl ketonuris	**no**		

Urinary:			
Medical Problem	**Self**	**Family**	**If yes, please describe**
Kidney disease	**no**		
Kidney stones	**no**		
Other diseases of the urethra, bladder ureter	**no**		

Genital / Reproductive:			
Medical Problem	**Self**	**Family**	**If yes, please describe**
Undescended testicle	**no**		
Hypospadias	**no**		
Prostate cancer	**no**		
Uterine fibrosis	**no**		
Endometriosis	**no**		
Cervical cancer	**no**		
Ovarian cancer	**no**		
Ovarian cysts	**no**		
Uterine cancer	**no**		
Spontaneous abortion, miscarriage, stillbirth	**no**		
Early infant death	**no**		
Rectal disorder	**no**		
Premature menopause	**no**		
Ambiguous genitals	**no**		

Neurological:			
Medical Problem	**Self**	**Family**	**If yes, please describe**
Migraines	**no**		
Mental retardation	**no**		
Down's syndrome	**no**		
Turner's syndrome	**no**		
Fragile X	**no**		
Multiple sclerosis	**no**		
Cerebral palsy	**no**		
Epilepsy, seizures	**no**		
Hydrocephalus	**no**		
Spinal cord disorder	**no**		
Huntington's chorea	**no**		
Gaucher's disease	**no**		
Canavan's disease	**no**		
Tay Sach's	**no**		

Wilsons's disease	**no**		
Parkinson's disease	**no**		
Alzheimer's disease	**no**		
Senility before age 50	**no**		
Other disease of the nervous system	**no**		

Mental Health:			
Medical Problem	**Self**	**Family**	**If yes, please describe**
Schizophrenia	**no**		
Manic depression	**no**		
Depression	**no**		
Suicide	**no**		
Other mental health disorders requiring hospitalization	**no**		

Muscular / Bones / Joints:			
Medical Problem	**Self**	**Family**	**If yes, please describe**
Muscular dystrophy	**no**		
Other chronic muscle disease	**no**		
Lupus	**no**		
Deformity of spine / Spina Bifida	**no**		
Osteoporosis	**no**		
Dwarfism	**no**		
Rheumatoid arthritis	**no**		
Osteoarthritis	**no**		
Gout	**no**		
Cleft palate / Cleft Lip	**no**		
Marfan syndrome	**no**		

Sight / Sound / Smell:			
Medical Problem	**Self**	**Family**	**If yes, please describe**
Deafness before age 60	**no**		
Deformity of the ear	**no**		
Cataracts before age 50	**no**		
Blindness	**no**		
Colour blindness	**no**		
Deviated septum	**no**		
Glaucoma	**no**		
Retinitis Pigmentosa	**no**		
Any other sight / sound / smell disorder	**no**		

Skin:			
Medical Problem	**Self**	**Family**	**If yes, please describe**
Acne	**no**		
Eczema	**no**		
Skin cancer	**no**		
Pigmentation disorder	**no**		
Neurofibromatosis	**no**		
Other disorders of the skin	**no**		

Other:			
Medical Problem	**Self**	**Family**	**If yes, please describe**
Alcoholism	**no**		
Drug abuse, misuse or addiction	**no**		
Breast cancer	**no**		
Early death, before 50 years	**no**		
Any other cancer not mentioned	**no**		
Congenital hip problems	**no**		
Club feet	**no**		
Any other condition not mentioned	**no**		