

LAW OFFICES OF  
DIANE MICHELSEN  
3190 Old Tunnel Road  
Lafayette, CA 94549-4133  
(925) 945-1880/(800) 877-1880  
(925) 933-6807 (fax)

**\* Please include photos! \***  
**&**  
**Copy of Drivers License**

**EGG DONOR AND SURROGATE MOTHER APPLICATION**

Please complete this form as thoroughly as possible and indicate if you wish to become:

**Egg Donor:** \_\_\_\_\_ **Gestational Surrogate:** \_\_\_\_\_ **Traditional Surrogate:** \_\_\_\_\_

~~~~~  
**IDENTIFYING DATA**

Name: \_\_\_\_\_  
Last First Middle

Other Names  
You are Known By: \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_  
Street City State Zip

Own: \_\_\_\_\_ Rent: \_\_\_\_\_ How long at this address: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Cell Phone/Pager: ( ) \_\_\_\_\_ email address: \_\_\_\_\_

Driver's license # \_\_\_\_\_ Social Security # \_\_\_\_\_ Current job title: \_\_\_\_\_

Employer's Name: \_\_\_\_\_ How long? \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Address: \_\_\_\_\_ Wages/wkly \_\_\_\_\_ Hrly rate \_\_\_\_\_  
Street City State Zip

In case of emergency please call: \_\_\_\_\_

(Circle One)  
Married  Single  Living Together  Widowed  Divorced  Separated (Date) \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Please list names, dates and places of all marriages: \_\_\_\_\_

Please list names, dates and places of divorces: \_\_\_\_\_  
(use reverse side if necessary)

Spouse's or Partner's Information (if applicable)

Name: \_\_\_\_\_ Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address: \_\_\_\_\_ Home Phone No: ( ) \_\_\_\_\_

Occupation: \_\_\_\_\_ How long? \_\_\_\_\_ Work Phone No: ( ) \_\_\_\_\_

Employer's Name and address: \_\_\_\_\_

Driver's license # \_\_\_\_\_ Social Security # \_\_\_\_\_ Current job title \_\_\_\_\_

~~~~~  
**I understand that any significant misrepresentation or omission is grounds for dismissal from the surrogate program and that I can then be held financially responsible for any lab, medical or psychological costs involved in furtherance of the proposed surrogacy.**

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

Signature of Spouse: \_\_\_\_\_ Date: \_\_\_\_\_  
(if applicable)

**LAW OFFICES OF  
DIANE MICHELSEN**  
(925) 945-1880  
Surrogate Mother and  
Egg Donor Application

**PERSONAL INFORMATION**

Birthdate: \_\_\_\_\_ City/State of Birth: \_\_\_\_\_ U.S. Citizen: Yes \_\_\_\_\_ No \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Natural Hair Color: \_\_\_\_\_ Hair Texture: \_\_\_\_\_ Eyes: \_\_\_\_\_ Blood Type: \_\_\_\_\_  
(Circle one)

Religion: \_\_\_\_\_ American Indian Tribe: \_\_\_\_\_ Ethnicity/Heritage: \_\_\_\_\_ Right/Left handed

Education: High School \_\_\_\_\_ City/St \_\_\_\_\_ Yr. Grad \_\_\_\_\_ GED \_\_\_\_\_

College \_\_\_\_\_ City/St \_\_\_\_\_ Yrs. Attended \_\_\_\_\_ Degree \_\_\_\_\_ Major \_\_\_\_\_

Other training/talents? \_\_\_\_\_

Occupation: \_\_\_\_\_ How long? \_\_\_\_\_

Hobbies/Other Interests: \_\_\_\_\_

**LEGAL INFORMATION** (use reverse side if necessary)

Please list any arrests, convictions, sentences, or run-ins with the law, including drunk driving.  
Please include date, charge and disposition: \_\_\_\_\_

**INSURANCE INFORMATION**

Do you have medical insurance? \_\_\_\_\_ Carrier's name: \_\_\_\_\_ Maternity Benefit Coverage? \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: ( ) \_\_\_\_\_

Policy # \_\_\_\_\_ Policy in whose name? \_\_\_\_\_

**MEDICAL INFORMATION**

Are you currently under doctor's care? \_\_\_\_\_ If yes, for what reason? \_\_\_\_\_

Name and address of current physician: \_\_\_\_\_

Please list any current conditions you have now or have had in the past (e.g. cancer, endometriosis, Crohn's disease, etc.) \_\_\_\_\_

Please list any allergies or respiratory disorders (e.g. hay fever, asthma, cats, dust, etc.): \_\_\_\_\_

Any childhood allergies you may have outgrown? \_\_\_\_\_

Please list any developmental disorders (e.g. orthodontia, speech/learning disabilities): \_\_\_\_\_

Do you wear corrective lenses? \_\_\_\_\_ Pls specify nearsighted/farsighted \_\_\_\_\_

Have you ever been exposed to herbicides/toxic chemicals? **Yes No** (circle answer)

Please list any surgeries, dates, reasons, results: \_\_\_\_\_

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Egg Donor Application

Please list any prescribed drugs you are using:

- 1) Name and dosage \_\_\_\_\_ How often? \_\_\_\_\_  
2) Name and dosage \_\_\_\_\_ How often? \_\_\_\_\_  
3) Name and dosage \_\_\_\_\_ How often? \_\_\_\_\_

Do you currently: Smoke cigarettes? \_\_\_\_\_ How much? \_\_\_\_\_  
Use alcohol? \_\_\_\_\_ How much? \_\_\_\_\_  
Smoke marijuana? \_\_\_\_\_ How often? \_\_\_\_\_

Do you or have you ever used illegal or nonprescribed drugs? \_\_\_\_\_

Please list drug names, even if they may now be considered illegal:

- 1) \_\_\_\_\_ Dates taken \_\_\_\_\_ Dosage: \_\_\_\_\_  
2) \_\_\_\_\_ Dates taken \_\_\_\_\_ Dosage: \_\_\_\_\_

**FERTILITY & PREGNANCY HISTORY**

Are your menstrual periods regular? **Yes No** (circle answer)

How long between your monthly cycles? \_\_\_\_\_ days

How many days does your period last? \_\_\_\_\_ days

Have you ever donated eggs or been a surrogate before? **Yes No** (circle answer) If yes, describe:

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

Have you ever been told that you have an fertility problem? **Yes No** (circle answer)

Is there any history of fertility problems in your family (difficulty conceiving or miscarriages)? **Yes No** (circle answer) If yes, please explain: \_\_\_\_\_

Have you ever been treated for syphilis or gonorrhea? **Yes No** (circle answer)

Have you or any of your sexual partners had chlamydia, herpes, venereal warts, or any other sexually transmitted diseases? **Yes No** (circle answer) If yes, when: \_\_\_\_\_

Have you ever been refused as a blood donor? **Yes No** (circle answer)

No. of pregnancies: \_\_\_\_\_  
No. of miscarriages: \_\_\_\_\_ When? \_\_\_\_\_ No. of abortions: \_\_\_\_\_ When? \_\_\_\_\_  
No. of stillbirths: \_\_\_\_\_ When? \_\_\_\_\_ No. of live births: \_\_\_\_\_ When? \_\_\_\_\_  
No. of cesarean births \_\_\_\_\_ When? \_\_\_\_\_

Complications during any pregnancy? **Yes No** (circle answer) If yes, what Result? \_\_\_\_\_

List names and addresses of all previous obstetricians: (if applicable)

- 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_

**CHILDREN'S HEALTH HISTORY, ETC**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Health: \_\_\_\_\_ In whose custody? \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Health: \_\_\_\_\_ In whose custody? \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Health: \_\_\_\_\_ In whose custody? \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Health: \_\_\_\_\_ In whose custody? \_\_\_\_\_

Pediatrician and/or doctor's name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone No. ( ) \_\_\_\_\_

Please list any serious physical/mental illness of any child on reverse side (e.g. Down's Syndrome, Epilepsy, etc)

If child is deceased, please list date and cause on reverse side.

**FAMILY HISTORY & INFO**

Your Mother's age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Health condition: \_\_\_\_\_

Any serious physical/mental illness? \_\_\_\_\_ (If yes, please describe) \_\_\_\_\_

Your Father's age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Health condition: \_\_\_\_\_

Any serious physical/mental illness? \_\_\_\_\_ (If yes, please describe) \_\_\_\_\_

If they are deceased, please state when and how they died on reverse side.

Brothers/Sisters:

#1 Name: \_\_\_\_\_ Occupation: \_\_\_\_\_ Wght \_\_\_\_\_ Hgt \_\_\_\_\_

Health condition: \_\_\_\_\_

#2 Name: \_\_\_\_\_ Occupation: \_\_\_\_\_ Wght \_\_\_\_\_ Hgt \_\_\_\_\_

Health condition: \_\_\_\_\_

#3 Name: \_\_\_\_\_ Occupation: \_\_\_\_\_ Wght \_\_\_\_\_ Hgt \_\_\_\_\_

Health condition: \_\_\_\_\_

Any brothers or sisters who died during childhood or infancy? **Yes No** (circle answer)

If yes, please use reverse side to state how and when death occurred.

Any genetic or hereditary diseases or conditions which may run in your family? \_\_\_\_\_

Does anyone in your family (brothers, sisters, aunts, uncles, etc) have a serious physical or mental condition?

Relative: \_\_\_\_\_ Name of illness: \_\_\_\_\_

Relative: \_\_\_\_\_ Name of illness: \_\_\_\_\_

Relative: \_\_\_\_\_ Name of illness: \_\_\_\_\_

**PSYCHOLOGICAL INFORMATION**

Have you ever been under the care of a counselor or mental health professional?

**Yes No** (circle answer) If yes, when \_\_\_\_\_

For what reason? \_\_\_\_\_

List all name(s) of counselor(s) or mental health professional(s):

Name: \_\_\_\_\_ Phone Number: ( \_\_\_\_\_ ) \_\_\_\_\_

Name: \_\_\_\_\_ Phone Number: ( \_\_\_\_\_ ) \_\_\_\_\_

Name: \_\_\_\_\_ Phone Number: ( \_\_\_\_\_ ) \_\_\_\_\_

Have you had any psychiatric hospitalizations? **Yes No** (circle answer) When? \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Are you currently using prescribed drugs for psychiatric reasons? **Yes No** (circle answer)

1) Name and dosage: \_\_\_\_\_ How often? \_\_\_\_\_

2) Name and dosage: \_\_\_\_\_ How often? \_\_\_\_\_

Please answer the same questions for your children. (use reverse side if necessary)

Child's age: \_\_\_\_\_ Health condition: \_\_\_\_\_ Serious psychological/mental illness? \_\_\_\_\_

Child's age: \_\_\_\_\_ Health condition: \_\_\_\_\_ Serious psychological/mental illness? \_\_\_\_\_

SPACE FOR ADDITONAL ANSWERS/COMMENTS:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Also include with your completed application:**

- 1. A photocopy of your driver's license and/or passport**
- 2. A photocopy of your husband's driver's license and/or passport**
- 3. Recent photograph(s) of yourself and your children**

**YOUR PERSONAL PHILOSOPHY:**

Questions 1 - 16 are for both SURROGATE and EGG DONOR applicants.

1. Why do you want to be a surrogate and/or egg donor? \_\_\_\_\_  
\_\_\_\_\_
2. How much information do you have on these procedures? \_\_\_\_\_  
\_\_\_\_\_
3. To what extent is payment for services a necessary requirement for you? \_\_\_\_\_  
\_\_\_\_\_
4. What sort of financial payment do you expect to receive? \_\_\_\_\_
5. Do you foresee any emotional reactions or problems arising from being a surrogate or participating in the egg donor process?  
\_\_\_\_\_
6. Who would provide you with emotional support during the entire process (e.g. spouse, other relative, friend, etc.)? \_\_\_\_\_
7. How does your husband/significant other feel about your participation? \_\_\_\_\_  
\_\_\_\_\_
8. If you have other children, do you plan to explain your decision to them? How? \_\_\_\_\_  
\_\_\_\_\_
9. If you are currently employed, do you plan to tell your employer? \_\_\_\_\_ Why or why not? \_\_\_\_\_  
\_\_\_\_\_
10. How does your religious belief affect your decision? \_\_\_\_\_  
\_\_\_\_\_
11. How much involvement do you want with the intended parents and child? \_\_\_\_\_  
\_\_\_\_\_

**YOUR PERSONAL PHILOSOPHY (Continued):**

12. What date will you be available to begin the process? \_\_\_\_\_  
(Please indicate any specific dates when you may be out of state or have vacation plans.)

13. Do you own a car? \_\_\_\_\_ What means of transportation will be available to you for doctor appointments, lab work, psychological exam, etc? \_\_\_\_\_

14. Does anyone else live with you? \_\_\_\_\_ If so, what is your relationship? \_\_\_\_\_

Is it appropriate to leave messages regarding surrogacy/egg donation with them? \_\_\_\_\_

Please list any additional information which may be of interest or which has not been asked or addressed thus far. (Use reverse side if needed) \_\_\_\_\_

\_\_\_\_\_

15. Please indicate in which of the following situations you would participate as a donor or surrogate.

***Please circle answers:***

Married couple:	Yes	No
Single man:	Yes	No
Single Woman:	Yes	No
Unmarried couple:	Yes	No
Same sex partners:	Yes	No
Any age restrictions on intended parents:	Yes	No

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please discuss with significant other/spouse so we can learn more on your views in these situations. (Upon agreement, **both** parties must sign below.)

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
Applicant

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
Spouse/Significant Other

16. Are you currently working with any other surrogacy/egg donor programs? \_\_\_\_\_

Please list: \_\_\_\_\_

\_\_\_\_\_

17. Where did you hear about us? \_\_ Friend or acquaintance \_\_ Internet \_\_ Publication \_\_ Other

Name of friend, acquaintance, website, newspaper, magazine, etc. \_\_\_\_\_

*(If you are interested in being a surrogate applicant continue on through questions 18-26)*

**YOUR PERSONAL PHILOSOPHY (Continued):**

**Questions 18 - 26 are for surrogate applicants only.**

18. Would you be a surrogate via In Vitro Fertility (surrogate is medically implanted w/embryos and then carries the baby/babies to term)?

Yes / No     a. Embryos formed of intended parents genetic material?

Yes / No     b. Embryos formed of donor eggs and/or donor sperm?

19. Would you be a traditional surrogate artificially inseminated with sperm and then carries the baby/babies to term)? Yes / No (circle answer)

20. Are you willing to carry twins? \_\_\_\_\_

21. Would you agree to selective abortion if it is determined you are carrying **more** than two fetus/children? \_\_\_\_\_ Why or why not? \_\_\_\_\_

22. If the child you are carrying was determined to have abnormalities, would you consent to an abortion, if that is what the intended parents desire? \_\_\_\_\_ Why or why not? \_\_\_\_\_

23. Under what circumstances would you agree to an abortion? \_\_\_\_\_

24. What do you perceive as society's attitude with respect to surrogacy? \_\_\_\_\_

25. How would you wish to be described to the resulting child? \_\_\_\_\_

26. Is it acceptable for prospective parents to attend doctor's office visits and participate throughout the pregnancy process? **Yes No** (circle answer)

Comments: \_\_\_\_\_

**EGG DONOR/SURROGATE PROFILE**

Math skills and ability:	Excellent	Good	Average	Poor
Mechanical skills/ability	Excellent	Good	Average	Poor
Athletic skills/ability	Excellent	Good	Average	Poor

Favorite sports: \_\_\_\_\_

Musical ability: \_\_\_\_\_

Artistic ability: \_\_\_\_\_

Languages spoken: \_\_\_\_\_

How would you describe your personality:

Optimistic	1	2	3	4	Pessimistic
Assertive	1	2	3	4	Passive
Leader	1	2	3	4	Follower
Easy going	1	2	3	4	Rigid
Light hearted	1	2	3	4	Serious

What are your hobbies and interests?

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Other: \_\_\_\_\_

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**LAW OFFICES OF  
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(925) 945-1880  
Surrogate Mother and  
Egg Donor Application

I warrant, under penalty of perjury under the laws of the State of CA, that this information is complete and accurate to the best of my knowledge and belief.

I understand that any significant misrepresentation or omission is grounds for dismissal from the surrogate program and that I can be held financially responsible for any lab, medical, or psychological costs involved in furtherance of the proposed surrogacy.

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

Spouse's Signature (if applicable) \_\_\_\_\_ Date \_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF INFORMATION**

TO: ANY PHYSICIAN, ATTORNEY, MEDICAL PERSONNEL, MEDICAL FACILITY, EDUCATIONAL FACILITY, PSYCHIATRIST, PSYCHOLOGIST, OR MENTAL HEALTH PROFESSIONAL

RE: \_\_\_\_\_

YOU ARE HEREBY AUTHORIZED to release to Law Offices of Diane Michelsen any and all educational, psychological, psychiatric, or health information pertaining to me or my children which is now or in the future may be in your possession or under your control, including the results of any autoimmune deficiency testing or drug panel.

I authorize the Law Offices of Diane Michelsen to receive copies of and to copy any records or documents pertaining to me or my children. I authorize Law Offices of Diane Michelsen to release information pertaining to me or my children (including but not limited to HIV, drug and alcohol test results) to prospective Intended Parents, medical personnel, medical facilities, educational facilities, investigators, psychiatrists, psychologists, counselors, attorneys, or other parties as deemed prudent or necessary.

I acknowledge that other interested persons will rely on this information. I further understand that any false statement made by me may be viewed as perjury and in violation of the penal laws of my state and may subject me to criminal and/or civil penalties.

This authorization shall remain valid for two years from the date hereof. A copy shall have the same force as the original.

I have been advised of my right to receive a copy of this Authorization (pursuant to California Civil Code §§ 56.10, 56.11, 56.12) and have received a true copy thereof on this date.

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

\_\_\_\_\_  
Signature of Applicant

Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

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

\_\_\_\_\_  
Signature of Spouse

Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Revised 08/01

**PERSONAL HEALTH HISTORY:****NAME:****Describe your general health**

What Childhood Diseases have you had?

<input type="checkbox"/> Rubella (3 Day)	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Encephalitis	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Hayfever
<input type="checkbox"/> Rubeola (2 week)	<input type="checkbox"/> Roseola	<input type="checkbox"/> Meningitis	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Urinary/Bladder Infections
<input type="checkbox"/> Mumps	<input type="checkbox"/> Asthma	<input type="checkbox"/> Ear Rheumatic Fever	<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Other (Specify)				

Any Major Surgery?

 YES  NO If Yes, for what conditions/and what result

Are you a

 Twin  Triplet  Other multiple birth

Are you an

 Identical or  Fraternal Twin**FAMILY HISTORY:**

Were you or any member of your immediate family adopted?

 YES  NO If yes, please tell who

	YOUR BIOLOGICAL FATHER			YOUR BIOLOGICAL MOTHER		
Current age.....						
If deceased, age at death...						
Cause of death.....						
Height & Weight.....	Height	Weight		Height	Weight	
Hair color and texture.....						
Eye color.....						
Skin color.....						
Left or right handed.....						
Outstanding features.....						
Education completed.....						
Occupation.....						
Race/Ethnic Group.....	<input type="checkbox"/> White	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Black	<input type="checkbox"/> White	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Black
	<input type="checkbox"/> Asian	<input type="checkbox"/> Filipina	<input type="checkbox"/> Pacific Islander	<input type="checkbox"/> Asian	<input type="checkbox"/> Filipino	<input type="checkbox"/> Pacific Islander
	<input type="checkbox"/> American Indian	<input type="checkbox"/> Alaskan Native	<input type="checkbox"/> Other (specify)	<input type="checkbox"/> American Indian	<input type="checkbox"/> Alaskan Native	<input type="checkbox"/> Other (specify)
Nationality.....						
Religion.....						
How many brothers or sisters did she/he have?.....						
If any of your aunts/ uncles have died, give age at death and cause of death.....						
	YOUR FATHER'S PARENTS			YOUR MOTHER'S PARENTS		
	FATHER		MOTHER	FATHER		MOTHER
Age.....						
If deceased, age at death and cause of death.....						
Describe physical appearance.....						
Height & Weight.....	Height	Weight	Height	Weight	Height	Weight
Outstanding features.....						
Education completed.....						
Current or former occupation.....						

**FAMILY HISTORY: (Continued)**

**YOUR BROTHERS AND SISTERS**  
(If you have more than 4 siblings, please use additional paper)

	1		2		3		4	
Gender (Male or Female).....								
Age.....								
If deceased, age at death and cause.....								
Full or half sibling to you?.....	<input type="checkbox"/> FULL	<input type="checkbox"/> HALF	<input type="checkbox"/> FULL	<input type="checkbox"/> HALF	<input type="checkbox"/> FULL	<input type="checkbox"/> HALF	<input type="checkbox"/> FULL	<input type="checkbox"/> HALF
Height & Weight.....	Height	Weight	Height	Weight	Height	Weight	Height	Weight
Hair color and texture.....								
Eye color.....								
Skin color.....								
Hobbies and talents.....								
Last grade completed.....								
Presently in school?.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Occupation.....								
Marital status.....								
Number of children they have.....								
Health of their children.....								

**YOUR CHILDREN**

	CHILD #1		CHILD #2		CHILD #3		CHILD #4	
Indicate if son or daughter.....								
Birth date or age.....								
If deceased, age at death.....								
Cause of death.....								
Height & Weight.....	Height	Weight	Height	Weight	Height	Weight	Height	Weight
Hair color and texture.....								
Eye color.....								
Skin color.....								
Left or Right handed.....								
Grade in school.....								
Does this child live with you?.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Hobbies and talents.....								
General health.....								
Major surgery.....								
Health problems.....								

## HEALTH HISTORY OF YOU, YOUR PARENTS AND OTHER RELATIVES

Indicate by checking appropriate box if YOU or any RELATIVES (i.e., your parents, sisters, brothers, aunts, uncles, grandparents, other children born to you, etc.) have had or now have the medical conditions listed below. Indicate person's relationship to you. Please complete "Comments Section." If a medical condition resulted in death of a family member, indicate this and the person's approximate age at time of death in "Comments Sections."

MEDICAL CONDITION	Not Yes Yes - Relative			COMMENTS
	No	Known	Self (Specify relationship)	
<b>A. CONGENITAL IMPAIRMENTS</b>				
1. Clubfoot or any orthopedic problem (i.e., flat footed, etc.)				
2. Harelip (cleft lip) or cleft palate.				
3. Down's Syndrome				
4. Other chromosome abnormality				
5. Hydrocephalus				
6. Muscular Dystrophy				Parts of body involved? Age at onset?
7. Dwarfism				
8. Spina Bifida				
9. Congenital heart defect				
10. Sickle Cell Anemia				
11. Tay-Sachs disease				
<b>B. ALLERGIES</b>				To what allergies? What treatment or medication?
1. Eczema or other skin condition				
2. Hay fever or other allergy				
3. Drug allergy				To what drugs?
4. Food allergy				To what foods?
<b>C. EYE, DENTAL, EAR, AND DEVELOPMENTAL DISORDERS</b>				
1. Blindness, glaucoma, color blindness or other visual problems				
2. Corrective glasses or contact lenses				At what age were prescription lenses necessary?
Nearsighted <input type="checkbox"/>				
Farsighted <input type="checkbox"/>				
Astigmatism <input type="checkbox"/> (inability to focus)				
Strabismus <input type="checkbox"/> (crossed eyes)				
Other (explain) <input type="checkbox"/>				
3. Braces on teeth or other orthodontia work				If so, what orthodontic work and for how long?

**HEALTH HISTORY OF YOU, YOUR PARENTS AND OTHER RELATIVES (Continued)**

<b>MEDICAL CONDITION</b>	<b>No</b>	<b>Not Known</b>	<b>Yes Self</b>	<b>Yes, Relative (Specify relationship)</b>	<b>COMMENTS</b>
4. Deafness or other ear problems					Special education? If "Yes", indicate age at onset
5. Speech problems					
6. Learning disability					Any diagnosis? Hospitalization?
7. Disability: mental or physical					
<b>D. CIRCULATORY DISORDERS</b>					
1. Hemophilia					
2. Sickle Cell Anemia trait					
3. Hypertension (High blood pressure)					Age at onset? What treatment? Hospitalization?
4. Stroke					
5. Heart attack (coronary)					
6. Arthritis					What kind? Age at onset? What part of body?
7. Kidney disease					
<b>E. HORMONAL DISORDERS</b>					Age at onset? What treatment?
1. Diabetes					
2. Thyroid disorder					
3. Obesity (overweight)					
<b>F. RESPIRATORY DISORDERS</b>					Any (known) cause? What treatment?
1. Asthma					
2. Emphysema					Age at onset?
3. Tuberculosis					Age at onset? What kind? What part of body?
<b>G. MENTAL AND BEHAVIORAL DISORDERS</b>					Age at onset? What treatment? Hospitalization?
1. Diagnosed schizophrenia					
2. Diagnosed manic depressive / bi polar					
3. Other mental illness. Describe, using additional page, if necessary					
4. Alcoholism or heavy drinking					
5. Drug usage					Kind, amount, and when taken?

**HEALTH HISTORY OF YOU, YOUR PARENTS AND OTHER RELATIVES (Continued)**

MEDICAL CONDITION	Not Yes Yes - Relative			COMMENTS
	No	Known	Self (Specify relationship)	
<b>H. LYMPHATIC DISORDERS</b>				What kind? Age at onset? What part of body?
1. Cancer				
2. Tumors				
3. Cystic Fibrosis				
4. Hodgkins Disease				
<b>I. NERVOUS SYSTEM DISORDERS</b>				Parts of body involved? Age at onset?
1. Multiple Sclerosis				
2. Huntington's Disease				
3. Cerebral Palsy				
4. Seizures or convulsions				Age at onset? What treatment? Frequency?
5. Epilepsy				
<b>J. INFECTION, HOSPITALIZATION</b>				Diagnosis?
1. Repeated attacks of fever with known infection				
2. Repeated severe infection necessitating hospitalization				
3. Hospitalization, operation, or injury				What for? When?
4. HIV / AIDS				
<b>K. OTHER MEDICAL, OR HEALTH PROBLEMS</b>				