DIVISION OF DGA, INC.
1148 5th Avenue, #1B
New York, NY 10128
Phone/Fax: (212) 661-7177
Mobile: (917) 601-4919
Web: www.IndianEggDonors.com and www.surrogacy4all.com
Email: info@IndianEggDonors.com and info@surrogacy4all.com

# OB/GYN CLEARANCE FORM

Dear Physician:

Your patient, _____DOB_____, is interested in being a Surrogate Mother. Please fill out the following regarding their OB/GYN and General Health History. Every option filled out with "N/A", "Yes", or "No" Please:

☐ Has had a C-Section. If yes, how many? ____

Would you recommend VBAC? ____

☐ Has had an abnormal pap smear. If Yes, What were the abnormalities?

_____

_____

☐ Has had any pregnancy complications (Pre-eclampsia, Ectopic Pregnancy, Placenta Previa, Gestational Diabetes, Low Amniotic Fluid (oligohydramnios), Miscarriage, Abortion, Polyp(s), Premature labor and/or birth, Anemia at such a level that pregnancy is not safe, etc.). If Yes to any, please list details:

_____

_____

_____

_____

☐ Has had abnormal menstrual period(s). If Yes, please explain: _____

_____

☐ Has been on antidepressant or antipsychotic medication, in the care of a psychiatric Dr/Clinic, or any connection to a treatment center in the last 48 months.

☐ Has medical issue(s) that would put her or the pregnancy at risk. If Yes, please list issue(s) here: _____

_____

☐ Prescriptions and/or OTC that you are aware of the past 12 months please list here: _____

_____

I proclaim that the above is true to the best of my ability.

Signature: _____ Date: _____

Printed Name: _____

Clinic/Office Name: _____

Phone Number: _____ Fax: _____

Address: _____