















**Please choose a pseudonym for your profile: Vivi D**

**Date of Birth: 13/03/1989**

**Height: 175**

**Weight (lbs): 60kg**

**Hair Color: Light Brown**

**Eye Color: brown**

**Ethnic Origin: Italian**

**Maternal Heritage: Italian**

**Paternal Heritage: Italian**

**Blood Type: A+**

**Highest Level of education  
upper College major**

**What college(s) or university(ies) have you attended?  
Tuiuti Brazil**

**Do you have any athletic abilities? Please list:  
Gym and all king of Sports**

**What is your current occupation?  
Model**

**Please describe your personality:  
responsible, organized, cheerful, independent**

**Do you wear or have you worn eyeglasses? If yes, at what age did you start wearing them?  
No**

**Have you worn braces?  
No**

**Why do you want to become a donor?  
To be able to help people who would like to have a child and need help**

**Being a donor is a big responsibility. It requires going to several doctor's appointments, taking injections and having minor out-patient surgery. Do you feel prepared to commit to this process?  
Yes**

**Are you open to being matched with all types of families regardless of sexual preference, marital status, ethnicity or sex of the egg recipient?  
If no, please explain.  
Yes**

**If they request it, are you willing to meet your intended parents?  
No**

**Are you open to meeting the child in the future if that is requested?**



No

Are you open to exchanging future contact information with your intended Parents(s)?

No

Where did you grow up?

Pranchita - Paraná - Brazil

Do you have any siblings? If so, tell us about each of them:

No

Do you have any children? If so, tell us about each of them:

No

### Personal Health History

Any past or current medical problems (including surgeries, accidents, birth defects, depression, etc.)? If yes, please list:

No

Do you drink alcohol? If yes, how many drinks per week?  
on the weekends maybe around 2

Have you ever been pregnant? If yes, how many times and what was the outcome?

No

Have you ever been a donor before? If yes, did a pregnancy occur?

No

Are you currently taking any medication (for physical or mental health)? If yes, what medications are you on and why?

No

Are you taking any recreational drugs? If yes, what are you taking?

No

Do you smoke?

No

Are your menstrual cycles regular? If no, please explain:

Yes

## Family Medical History

Note: Medical history will be verified. Anything purposefully omitted may result in being dropped from the program. If any of the following has occurred in your family, please list which family member and explain:

Family Genetic History							
Biological Family Member	Sex	Age	Height	Eye Color	Hair Color	Deceased	Occupation
Father	M	54	176	Hazel	Hazel		Farmer
Mother	F	50	174	Hazel	Hazel		Farmer
Paternal Grandmother	F	73	168	Hazel	Hazel		Retired
Paternal Grandfather	M	78	178	Hazel	Hazel		Retired
Maternal Grandmother	F	68	168	hazel	hazel		Retired
Maternal Grandfather	M	68	160	hazel	Hazel		Retired
Sibling							
Sibling							
Sibling							
Sibling							

<b>Disease/Medical Condition</b>	<b>Check one</b>	<b>To Whom</b>	<b>Passed away?</b>		<b>Age of onset/ Medication</b>	<b>Age at the time of passing</b>
<b>Cancer</b>			Yes	No		
<b>Mental Retardation</b>			Yes	No		
<b>Autism / Asperger's</b>			Yes	No		
<b>Physical Malformation</b>			Yes	No		
<b>Paralysis or crippling disorders</b>			Yes	No		
<b>Alcohol or Drug Addiction</b>			Yes	No		
<b>Cystic Fibrosis</b>			Yes	No		
<b>Sickle Cell Anemia</b>			Yes	No		
<b>Lupus</b>			Yes	No		
<b>Miscarriages, still births, neonatal deaths</b>			Yes	No		
<b>High blood pressure, heart attacks or strokes</b>			Yes	No		
<b>Memory loss or dementia</b>			Yes	No		
<b>Osteoporosis</b>			Yes	No		
<b>Arthritis</b>			Yes	No		
<b>Allergies</b>			Yes	No		
<b>Blood diseases</b>			Yes	No		
<b>Diabetes (Specifically Type 1 or Type 2)</b>			Yes	No		
<b>Thyroid issues</b>			Yes	No		
<b>Learning disabilities</b>			Yes	No		
<b>Seizure or epilepsy</b>			Yes	No		

<b>Disease/Medical Condition</b>	<b>Check one</b>	<b>To Whom</b>	<b>Passed away?</b>		<b>Age of onset/ Medication</b>	<b>Age at the time of passing</b>
<b>Depression</b>			Yes	No		
<b>Panic attacks</b>			Yes	No		
<b>Schizophrenia</b>			Yes	No		
<b>Bipolar Disorder</b>			Yes	No		
<b>ADD or ADHD</b>			Yes	No		
<b>Age-related issues</b>			Yes	No		
<b>Kidney problems / diseases</b>			Yes	No		
<b>Reproductive problems: i.e. endometriosis, hysterectomies, late-term miscarriages, etc.</b>			Yes	No		
<b>Vision/Sight/Eye Problems</b>			Yes	No		