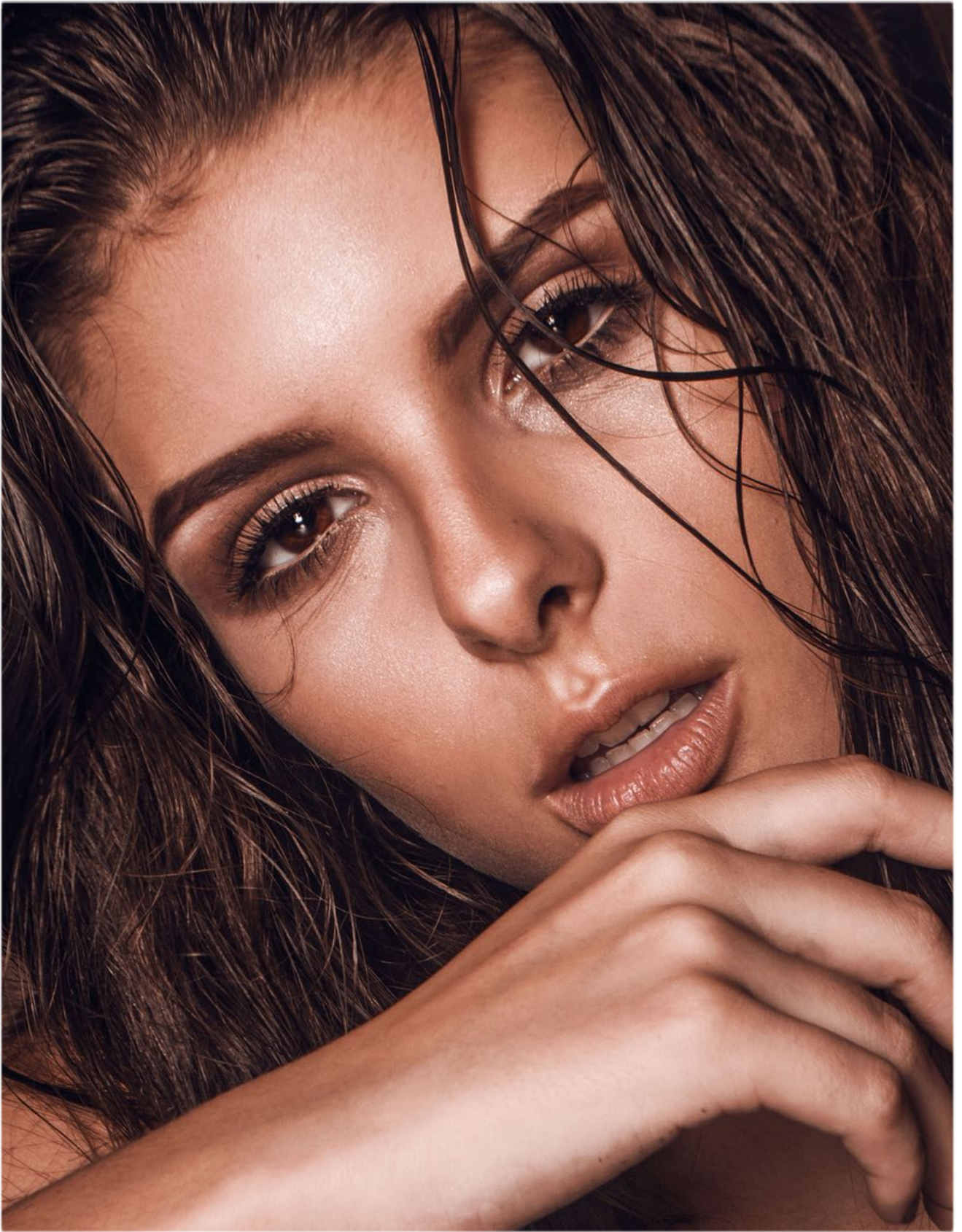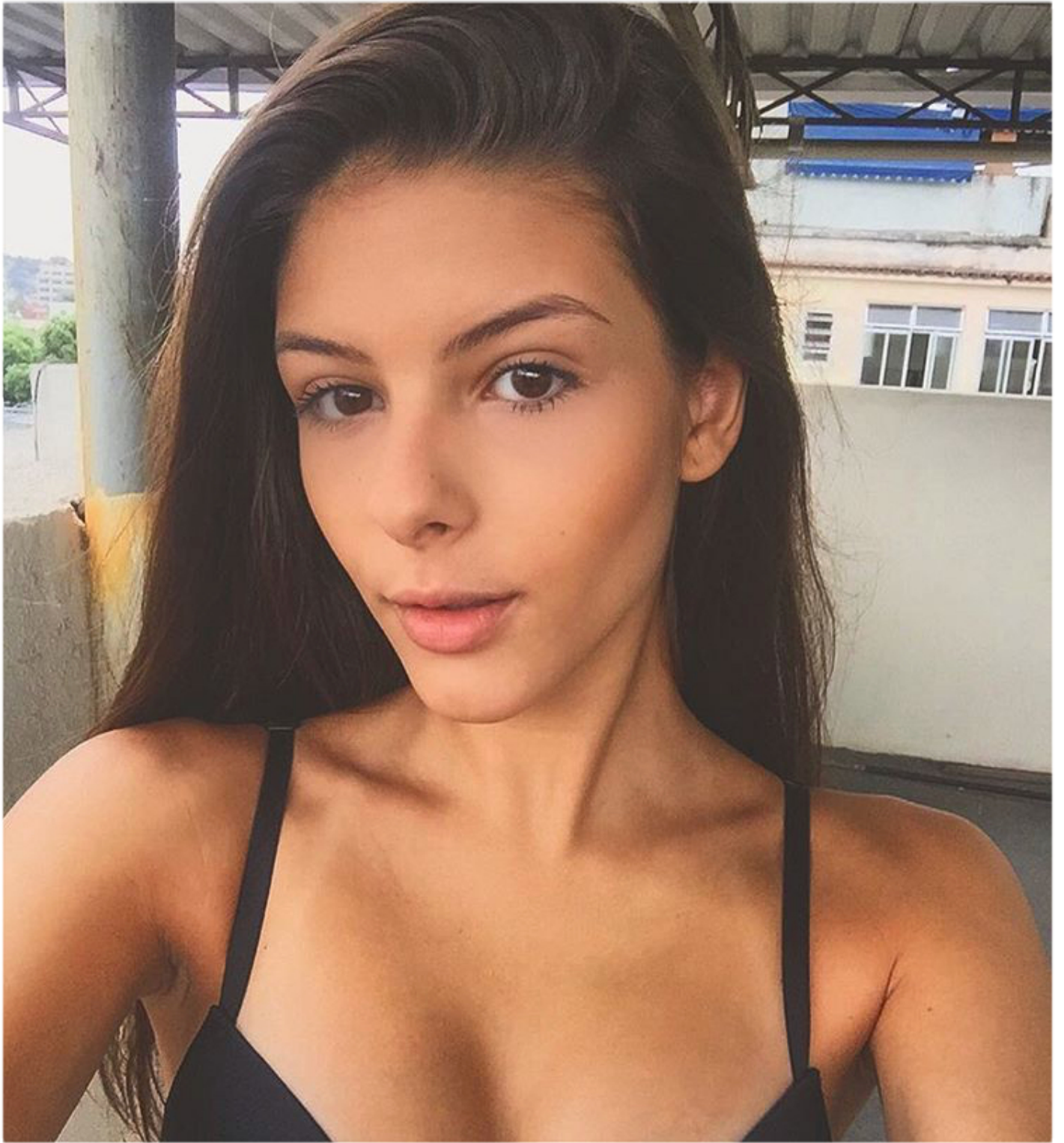*sexy dress from* VALENTINO

**Please choose a pseudonym for your profile:** Alexis

**Date of Birth:** 08/03/1997
**Height:** 1,76          **Weight (lbs):** 56kg
**Hair Color:** Hazel          **Eye Color:** Hazel
**Ethnic Origin:** Portuguese & Italian      **Maternal Heritage:** Portuguese
**Paternal Heritage:** Italian
**Blood Type:** A+

**Highest Level of education**
**College student**

**What college(s) or university(ies) have you attended?**
**UFRJ - Economics**

**Do you have any artistic abilities? Please List:**
**Paint and Sing**

**Do you have any athletic abilities? Please list:**
**all kind of sports**

**What is your current occupation?**
**Model and student**

**Please describe your personality:**
**Friendly and lovely.**

**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 help a woman have a child

**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?**
Rio Janeiro - Brazil

**Do you have any siblings? If so, tell us about each of them:**
one brother we are very close…

**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?**
I dont drink

**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?**
Never been

**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 | 184 | Honey | Blonde | | Businessman |
| Mother | F | 45 | 164 | Green | Blonde | | Physioterapeut |
| Paternal Grandmother | F | 68 | 165 | Green | Blonde | | Retired |
| Paternal Grandfather | M | 75 | 180 | Blue | Hazel | | Retired |
| Maternal Grandmother | F | 78 | 170 | Hazel | Hazel | | retired |
| Maternal Grandfather | M | 80 | 177 | Blue | Blonde | | Retired |
| Sibling | | | | | | | |
| Sibling | | | | | | | |
| Sibling | | | | | | | |
| Sibling | | | | | | | |

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

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