





















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

**Date of Birth: August 15, 1989**

**Height: 1.70 Weight (lbs): 119 IB**

**Hair Color: BROWN Eye Color: BROWN**

**Ethnic Origin: DESCENDING OF SPANISH**

**Maternal Heritage: BRAZILIAN Paternal Heritage: SPANISH**

**Blood Type: O-**

**Highest Level of education**

**College Major : LAW SCHOOL**

**What was your college GPA? A**

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

**FAAP (Fundação Armando Álvares Penteado)**

**Do you have any artistic abilities? Please List:**

**YES,DANCE.**

**Do you have any athletic abilities? Please list:**

**YES, RUNNING,CYCLING AND ALL FUNCIONAL TRAININGS.**

**What is you current occupation?**

**I'M A MODEL.**

**Please describe your personality:**

**I AM A QUIET PERSON, ORGANIZED, SMILING, GOOD WITH LIFE, I LIKE TO PLAY SPORTS AND ENJOY THE DAY.I'M CURIOUS AND FUNNY TOO.**

**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?**

**BECAUSE I WANT TO HELP OTHER WOMEN HAVE 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. I AM OK.**

**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,I AM.**

**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?**

**IN BRAZIL.**

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

**YES,I HAVE 2 OLDER BROTHERS.DIEGO AND BRUNO.THE TWO ARE HARDWORKING AND GOOD PERSON.**

**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:**

**I HAVE NOTHING.**

**Do you drink alcohol? If yes, how many drinks per week?**

**NO.**

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

**NEVER.**

**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?**

**YES, I TAKE A MEDICINE FOR ATTENTION DEFICIT (VENVANSE-DIMESILATO DE LISDEXANFETAMINA)**

**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	61	182	Hazel	Hazel		Photographer
Mother	F	60	174	Hazel	Hazel		Business Woman
Paternal Grandmother	F	82	172	Hazel	Hazel	yes	
Paternal Grandfather	M	85	188	Hazel	Hazel	yes	
Maternal Grandmother	F	84	171	Hazel	Hazel		Retired
Maternal Grandfather	M	83	184	Hazel	Hazel	yes	
Sibling	M	35	181	Hazel	Hazel		Marketing Company

Family  
Genetic  
History

Sibling	M	32	186	Hazel	Hazel		Restaurant Owner
Sibling							
Sibling							

Disease/Medical Condition	Check one	To Whom	Passed away?	Age of onset/ Medication	Age at the time of passing
<b>Cancer</b>	No		Yes No		
<b>Mental Retardation</b>	No		Yes No		
<b>Autism / Asperger's</b>	No		Yes No		
<b>Physical Malformation</b>	No		Yes No		
<b>Paralysis or crippling disorders</b>	No		Yes No		
<b>Alcohol or Drug Addiction</b>	No		Yes No		
<b>Cystic Fibrosis</b>	No		Yes No		
<b>Sickle Cell Anemia</b>	No		Yes No		
<b>Lupus</b>	No		Yes No		
<b>Miscarriages, still births, neonatal deaths</b>	No		Yes No		
<b>High blood pressure, heart attacks or strokes</b>	No		Yes No		
<b>Memory loss or dementia</b>	No		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>Osteoporosis</b>	No		Yes No		
<b>Arthritis</b>	No		Yes No		
<b>Allergies</b>	No		Yes No		
<b>Blood diseases</b>	No		Yes No		
<b>Diabetes (Specifically Type 1 or Type 2)</b>	No		Yes No		
<b>Thyroid issues</b>	No		Yes No		
<b>Learning disabilities</b>	No		Yes No		
<b>Seizure or epilepsy</b>	No		Yes No		
<b>Depression</b>	No		Yes No		
<b>Panic attacks</b>	No		Yes No		
<b>Schizophrenia</b>	No		Yes No		
<b>Bipolar Disorder</b>	No		Yes No		
<b>ADD or ADHD</b>	No		Yes No		
<b>Age-related issues</b>	No		Yes No		
<b>Kidney problems / diseases</b>	No		Yes No		
<b>Reproductive problems: i.e. endometriosis, hysterectomies, late-term miscarriages, etc.</b>	No		Yes No		
<b>Vision/Sight/Eye Problems</b>	No		Yes No		

