Please choose a pseudonym for your profile: Diane V.
Date of Birth: 28/05/1987
Height:1,68 **Weight (lbs):**116
Hair Color: light brown **Eye Color:**green
Ethnic Origin: Brasileira
Maternal Heritage: **Paternal Heritage:**
Blood Type: O+

Highest Level of education; graduate in college
What was your college GPA?

What college(s) or university(ies) have you attended? Pharmacy - PUC-PR, and now International Relation - Uninter

Do you have any artistic abilities? Please List: dancing

Do you have any athletic abilities? Please list: Running, Muay Thai, Workout, Swimming

What is you current occupation? Model

Please describe your personality: I am a quiet, studious and hardworking person. I love traveling. I'm very adaptable to new environments. very friendly and always helpful when needed. very active I am always exercising doing bodybuilding, running or training muay thai. I am very close to my family and I have the values that they passed me.

Do you wear or have you worn eyeglasses? If yes, at what age did you start wearing them? Yes, I wear reading glasses. I started using it in high school. Today I use 1.5 degrees.

Have you worn braces? No.

Why do you want to become a donor? Yes.

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?

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

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

Where did you grow up? In South of Brasil.

Do you have any siblings? If so, tell us about each of them: Yes, I have one little sister. She is 23.

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? Just social drinks, in dinners or special events.

Have you ever been pregnant? If yes, how many times and what was the outco- me? 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? I take supplements that my nutrologist prescribed me just to improve my health and keep all exams always at the correct levels.

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	Education Level	Deceased	Occupation
Father	M	57	1,88	Light green	Gray	postgraduate		labor judge
Mother	F	52	1,66	Dark green	Light brown	postgraduate		Teacher
Paternal Grandmother	F	95		Blue	White			
Paternal Grandfather	M						X	
Maternal Grandmother	F							
Maternal Grandfather	M						X	
Sibling	F	23	1,74	Brown	Blond	Graduated		Student
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		

Disease/Medical Condition	Check one	To Whom	Passed away?	Age of onset/ Medication	Age at the time of passing
Learning disabilities	No		Yes No		
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		