Please choose a pseudonym for your profile: LU

Date of Birth: 14/05/1989

Height:1,70   **Weight (lbs): 51KG**

Hair Color: DARK BLONDE   **Eye** GREEN EYES

Ethnic Origin: ITALIAN

Maternal Heritage: ITALIAN   **Paternal Heritage:**ITALIAN

Blood Type: O POSITIVE

Highest Level of education

College Major

What was your college GPA? SÃO JOSE COLLEGE

What college(s) or university(ies) have you attended? SÃO JOSE AND URI CAMPUS DE ERECHIM

Do you have any artistic abilities? Please List:
DRAWING AND DANCING

Do you have any athletic abilities? Please list:
GOOD FLEXIBILITY AND RUNNING

What is you current occupation?
PILATES INSTRUCTOR

Please describe your personality:
I AM CHEERFUL, HOMOROUS, BRAVE, HONEST, CALM, SINCERE, AMBITIOUS, FOCUSED, I LOVE ANIMALS, NATURE, SPORTS AND PARTIES.

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 MOTHERS WHO CAN NOT HAVE CHILDREN

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?
YES

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

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

Where did you grow up?
ERECHIM, RIO GRANDE DO SUL, BRASIL

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?
YES, 2-3 DRINKS

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	Education Level	Deceased	Occupation
Father	M	61	1,76	BROWN	BROWN	3 DEGREE	NO	BUSINESS
Mother	F	61	1,62	GREEN	DARK BLONDE	3 DEGREE	NO	RETIRED
Paternal Grandmother	F	84	1,60	GREEN	BROWN	ELEMENTARY SCHOOL	NO	RETIRED
Paternal Grandfather	M	91	1,78	BROWN	DARK BLONDE	ELEMENTARY SCHOOL	YES	RETIRED
Maternal Grandmother	F	90	1,60	GREEN	BROWN	ELEMENTARY SCHOOL	YES	RETIRED
Maternal Grandfather	M	88	1,80	BROWN	DARK BLONDE	ELEMENTARY SCHOOL	YES	RETIRED
Sibling								

Family Genetic History								
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		

Disease/Medical Condition	Check one	To Whom	Passed away?		Age of onset/ Medication	Age at the time of passing
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		
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		