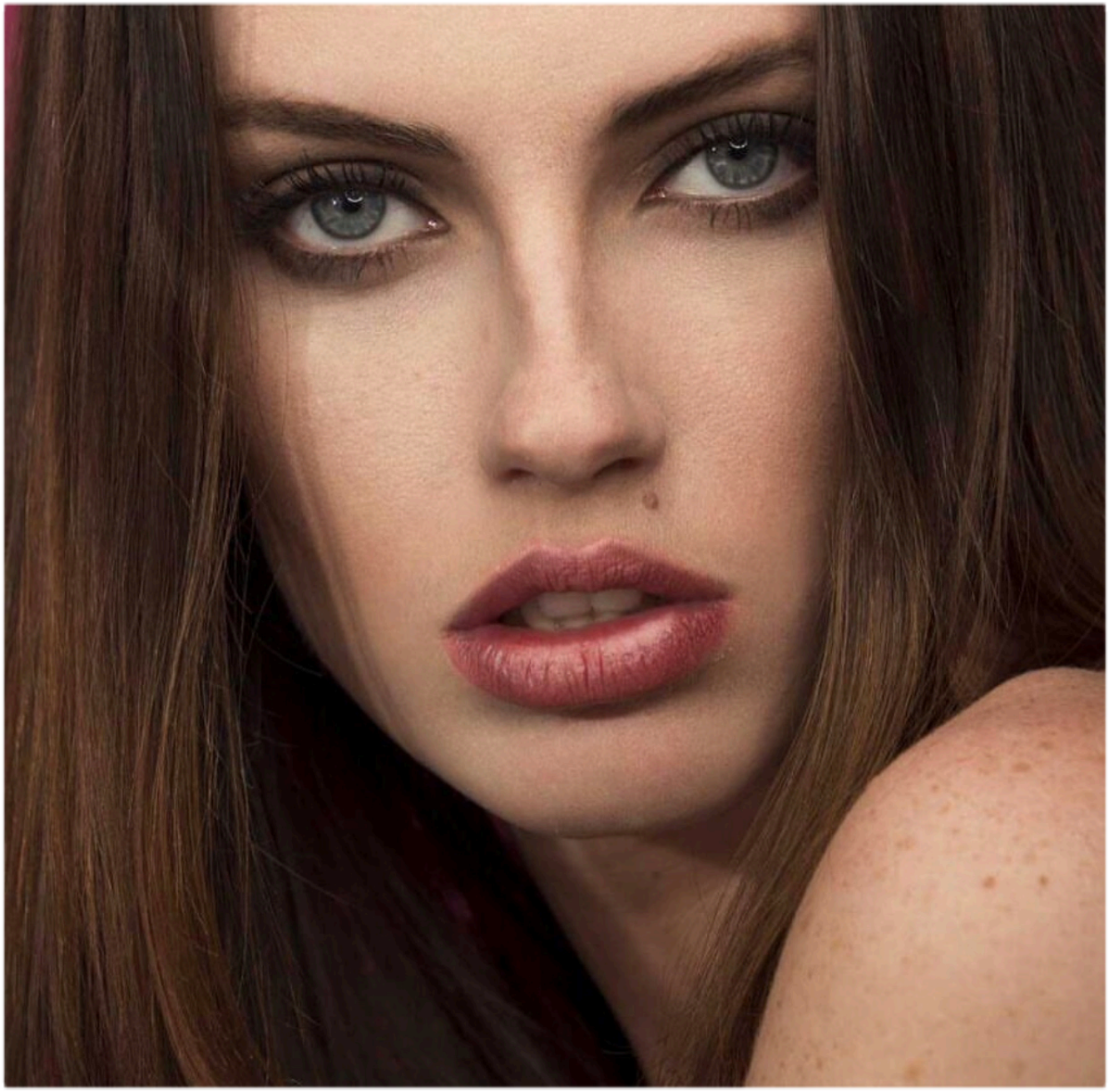

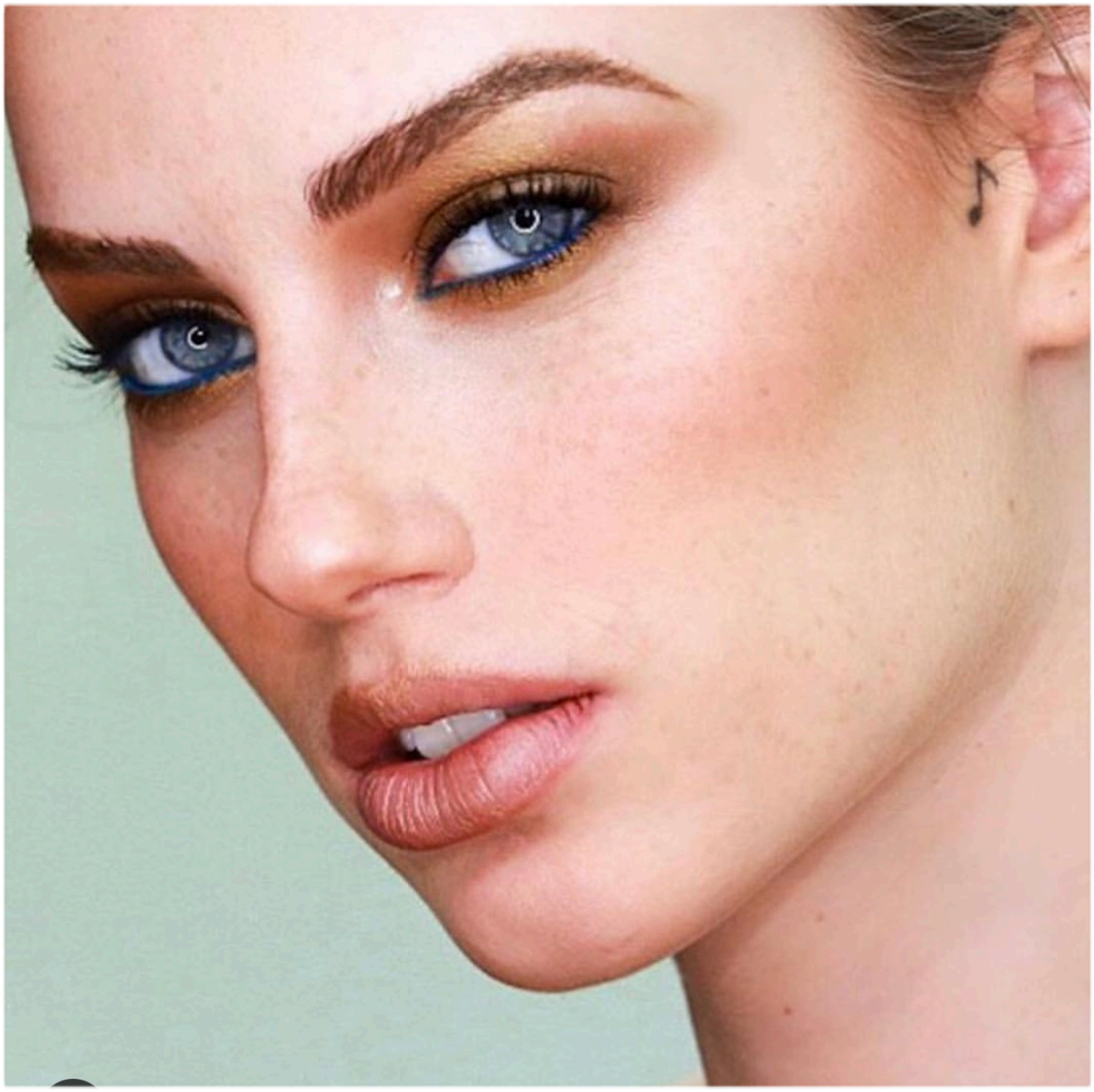

Please choose a pseudonym for your profile: Tiphanye Charitatos Vecchio
Date of Birth: 21/03/1994
Height: 175 **Weight (lbs): 110**
Hair Color: Light-hazel **Eye Color: Blue**
Ethnic Origin: Greek & Italian
Maternal Heritage: Italian & Portuguese **Paternal Heritage: Greek**
Blood Type: A+

Highest Level of education

College

College Major

Board Commissary

What was your college GPA?

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

Sao Paulo Commissary school Gol

Do you have any artistic abilities? Please List:

Play Piano and Dance

Do you have any athletic abilities? Please list:

Running and Gym

What is your current occupation?

Model

Please describe your personality:

I love talking to people, I enjoy making friends and I consider myself as a very calm person

Do you wear or have you worn eyeglasses? If yes, at what age did you start wearing them?

No, I am not using them

Have you worn braces?

No

Why do you want to become a donor?

I would like to become a donor in order to help people who would like to 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?

Brazil – Sao Paulo

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

?

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?

Very casually, like two times a month

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	58	181	Green	Hazel		Retired

Family Genetic History							
Mother	F	60	170	Light brown	Hazel		Retired
Paternal Grandmother	F	81	171	Hazel	Hazel		Retired
Paternal Grandfather	M	83	183	Dark brown	Hazel		Retired
Maternal Grandmother	F	77	164	Hazel	Hazel		Retired
Maternal Grandfather	M	80	178	Gree n	Light brown		Retired
Sibling	F	23	169	Hazel	Hazel		Studant
Sibling	F	20	171	Hazel	Hazel		Studant
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		

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

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