
adidas

choose a pseudonym for your profile: MARIA HELENA

Date of Birth: 30/03/1997
Height: 1,67 **Weight (lbs):** 105,82
Hair Color: BROWN **Eye Color:** brown
Ethnic Origin: **Maternal Heritage:** SPANISH
Paternal Heritage: ITALIAN
Blood Type: A-

Highest Level of education : 1 YEAR OFF COLLEGE

College Major : ART

What was your college GPA? A+

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

Do you have any artistic abilities? Please List: DANCE,ACTING, WRITING

Do you have any athletic abilities? Please list: DANCE, RUNING, VOLEY

What is your current occupation? MODEL AND ACTRESS

Please describe your personality: FRIENDLY ,HAPPY , POSITIVE, ENERGETIC,ARTISTIC

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 PARENTS THAT CAN'T HAVE KIDS

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?NO

Are you open to exchanging future contact information with your intended Parents(s)? NO

Where did you grow up? BELO HORIZONTE ,MINAS GERAIS ,BRAZIL

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?
SOMETIMES , 1 A WEEK

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	56	1,82	GREEN	BROWN	NO	ENTREPRENOUR
Mother	F	51	1,63	BROWN	BROWN	NO	
Paternal Grandmother	F	88	1,70	BROWN	BROWN	NO	HOUSE WIFE
Paternal Grandfather	M		1,80	BROWN	BROWN	YES	MAYOR OF A CITY
Maternal Grandmother	F		1,59	BROWN	BROWN	YES	COOK
Maternal Grandfather	M		1,78	GREEN	BROWN	YES	SOCCER PLAYER
Sibling							
Sibling							
Sibling							
Sibling							

Disease/Medical Condition	Check one	NO	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	NO	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**		