









Please choose a pseudonym for your profile: Brenda

Date of Birth: 17/01/1996

Height: 5 feet 7 inches

Weight (lbs): 110 lbs

HairColor: Light Brown

Eye Color: Brown

Ethnic Origin: European

Maternal Heritage: German

Paternal Heritage: Italian

Blood Type:

Highest Level of Education: College completed

Do you have any artistic abilities? Please List:

None

Do you have any athletic abilities? Please list:

None

What is your current occupation?

Student

Please describe your personality:

I am a loyal person, hardworking, persistent, a little bit stubborn and very generous

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?

I want to help people who can't have babies

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

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

Yes, Samuel 17 years old and Victor is 13 years old which I grow up with (mother and father)
Maria, Adrian and Agatha which I have no contact (father side)

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:

Yes, appendicitis

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?

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	42	1,74	Brown	Brown	High school	YES	
Mother	F	40	1,65	Green	Brown	High school	NO	Cleaning lady
Paternal Grandmother	F	64	1,61	Brown	Brown	High school	NO	Retired

Family Genetic History								
Paternal Grandfather	M	65	1,74	Brown	Brown	High school	NO	Retired
Maternal Grandmother	F	57	1,64	Brown	Brown	High school	NO	Retired
Maternal Grandfather	M	60	1,71	Green	Brown	High school	NO	Retired
Sibling	M	17	1,72	Brown	Brown	High school	NO	Retired
Sibling	M	13	1,55	Brown	Brown	School	NO	Retired
Sibling								
Sibling								

Disease/Medical Condition	Check one	To Whom	Passed away?	Age of onset/Medication	Age at the time of passing
Cancer	Yes No X		Yes No		
Mental Retardation	Yes No X		Yes No		

Disease/Medical Condition	Check one	To Whom	Passed away?	Age of onset/Medication	Age at the time of passing
Autism / Asperger's	Yes No X		Yes No		
Physical Malformation	Yes No X		Yes No		
Paralysis or crippling disorders	Yes No X		Yes No		
Alcohol or Drug Addiction	Yes No X		Yes No		
Cystic Fibrosis	Yes No X		Yes No		
Sickle Cell Anemia	Yes No X		Yes No		
Lupus	Yes No X		Yes No		
Miscarriages, still births, neonatal deaths	Yes No X		Yes No		
High blood pressure, heart attacks or strokes	Yes No X		Yes No		
Memory loss or dementia	Yes No X		Yes No		
Osteoporosis	Yes No X		Yes No		
Arthritis	Yes No X		Yes No		
Allergies	Yes No X		Yes No		
Blood diseases	Yes No X		Yes No		
Diabetes (Specifically Type 1 or Type 2)	Yes No X		Yes No		

Disease/Medical Condition	Check one	To Whom	Passed away?	Age of onset/Medication	Age at the time of passing
Thyroid issues	Yes No X		Yes No		
Learning disabilities	Yes No X		Yes No		
Seizure or epilepsy	Yes No X		Yes No		
Depression	Yes No X		Yes No		
Panic attacks	Yes No X		Yes No		
Schizophrenia	Yes No X		Yes No		
Bipolar Disorder	Yes No X		Yes No		
ADD or ADHD	Yes No X		Yes No		
Age-related issues	Yes No X		Yes No		
Kidney problems / diseases	Yes No X		Yes No		
Reproductive problems: i.e. endometriosis, hysterectomies, late-term miscarriages, etc.	Yes No X		Yes No		
Vision/Sight/Eye Problems	Yes No X		Yes No		