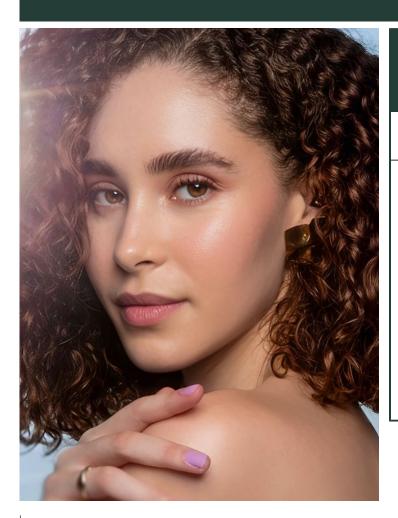


#### **EGG DONOR INFORMATION**



# **DONOR ID #4296**

#### **SHORT BIOGRAPHY:**

She loves reading, traveling, and engaging in meaningful conversations. She enjoys staying active, going to the gym, eating well, and exercising. She cherishes her friendships, laughs easily, and is surrounded by great people. Family means the world to her, she has two sisters and a brother. As a Cancer, she has a deep love for home and family.

#### **DONOR PERSONAL INFORMATION**

**Location:** Brazil **Height:** 5' 9"

Year of Birth: 2000 Weight: 130

**Ethnicity:** Caucasian **Eye Color:** Brown

Maternal Heritage: Brazilian Natural Hair Color: Brown

Parental Heritage: Italian

#### PERSONAL INFORMATION

#### WHAT IS THE HIGHEST EDUCATION LEVEL YOU HAVE ATTAINED?

High school graduate

#### DO YOU HAVE A MENSTRUAL CYCLE EVERY MONTH?

Yes

#### PLEASE INDICATE WHAT TYPE OF BIRTH CONTROL YOU ARE CURRENTLY USING:

None

#### PLEASE DESCRIBE YOUR GOALS/AMBITIONS THAT YOU HAVE

I'm an international model with a strong passion for growing my career, walking the world's top runways, and making my mark in the fashion industry. I love traveling, experiencing new cultures, and embracing opportunities that help me grow. Beyond my career, I'm dedicated to supporting my family, uplifting those around me, and creating a lasting impact.

#### **DESCRIBE WHAT YOU WERE LIKE AS A CHILD.**

I was blonde, tall, playful, I liked playing with dolls and reading

#### **DESCRIBE YOUR FAVORITE MEMORY.**

One day I was at my maternal grandmother's house and was playing in the yard with the hens.

#### **DESCRIBE YOUR PERSONALITY AND CHARACTER**

I am a calm, quiet person, my Cancer sign makes me very friendly, loyal, kind, and I have always had a very strong character and great loyalty to my friends and family.

#### WHAT ARE YOUR FAVORITE FOODS?

Pasta, orange, eggplant, mango, salad, grilled vegetables

#### WHAT DO YOU LIKE TO DO IN YOUR FREE TIME?

I like reading, doing yoga, working out, meditating, running in the park.

#### WHAT WOULD YOU CONSIDER YOUR GREATEST STRENGTHS AND WEAKNESSES?

I have a very good heart and sometimes people take advantage of that. It is my strong point and my weak point.

#### IF YOU COULD VISIT ANYWHERE IN THE WORLD, WHERE WOULD IT BE AND WHY?

Thailand, to see the festival of lights.

#### **DESCRIBE A TYPICAL DAY IN YOUR LIFE.**

I wake up, stretch, do yoga, drink water, make my coffee, go to the gym, come back and make my lunch, read and study languages and visit a friend, then I have dinner, take a shower and go to bed early.

#### WHY HAVE YOU DECIDED TO BECOME AN EGG DONOR?

Because I know women who can't have children, so I decided to help.

#### WHAT WERE/ARE YOUR FAVORITE CLASSES IN SCHOOL?

History, biology arts and English

#### PLEASE LEAVE A MESSAGE TO THE INTENDED PARENTS.

I truly believe these eggs carry your future child, who will one day be filled with joy and gratitude to have you as their loving parents.

#### ARE YOU COMMITTED TO BEING A DONOR?

Yes

#### **DO YOU SMOKE CIGARETTES?**

No

#### **FAMILY CHARACTERISTICS**

Family Member	Eye Color	Hair Color	Skin Complexion	Height	Weight	Body Type	<b>Education Level</b>	Occupation
Father	Green	Brown	Fair	5'9	176 Lbs	Thin	High School	Mason
Mother	Brown	Brown	Fair	5'4	121 Lbs	Thin	High School	Housewife
Brother 1	Blue	Blond	Fair	5'1	64 Lbs	Thin	4Th Grade	Young
Sister 1	Green	Blond	Fair	5'2	88 Lbs	Thin	High School	Student
Sister 2	Blue	Blonde	Fair	5'4	114.6 Lbs	Thin	Nutrition	Cashier
Children 1	Brown	Brown	Fair	5'0	92	Thin	Student	Young

#### REPRODUCTIVE HISTORY

#### **AGE AT FIRST PERIOD**

14

#### **ARE YOUR CYCLES**

Regular

#### **INTERVAL BETWEEN PERIODS**

28

HAVE YOU HAD A DIAGNOSIS OF ANY GYNECOLOGICAL PROBLEMS (IE; ENDOMETRIOSIS, PCOS, ABNORMAL PAP SMEARS, ETC.)?

No

HAVE YOU OR A PARTNER EVER BEEN DIAGNOSED WITH A SEXUALLY TRANSMITTED INFECTION (IE; CHLAMYDIA, GONORRHEA, SYPHILIS, HERPES, TRICHOMONAS, ETC.)?

No

DID YOUR MOTHER TAKE DES WHILE SHE WAS PREGNANT WITH YOU?

No

HAVE YOU EVER BEEN TOLD YOU ARE INFERTILE?

No

IS THERE A HISTORY OF INFERTILITY IN YOUR FAMILY?

No

HAVE YOU BEEN SEXUALLY ACTIVE DURING THE PAST SIX MONTHS?

Yes

**ARE YOU CURRENTLY SEXUALLY ACTIVE?** 

Yes

HOW MANY SEXUAL PARTNERS HAVE YOU HAD IN THE PAST SIX MONTHS?

2

ARE YOU CURRENTLY IN A MONOGAMOUS RELATIONSHIP?

No

ARE YOU CURRENTLY OR HAVE YOU TAKEN BIRTH CO	
Yes	
IF YES, WHAT BRAND	WHEN
Diane	2018
DO YOU USE OTHER FORMS OF BIRTH CONTROL	
No	
HAVE YOU HAD MORE THAN 10 SEXUAL PARTNERS?	
No	
HAVE YOU EVER HAD A SEXUAL PARTNER WHO WAS	GAY OR BISEXUAL?
No	
HAVE YOU EVER HAD SEXUAL RELATIONS WITH ANY	ONE SUSPECTED OR KNOWN TO BE HIV POSITIVE?
No	
HAVE YOU EVER HAD RELATIONS WITH A MAN WHO ANOTHER MAN?	HAS ENGAGED IN ANAL INTERCOURSE OR ORAL SEX WITH
No	
HAVE YOU BEEN EXPOSED TO RADIATION OR TOXIC MERCURY, GOLD)?	CHEMICALS IN YOUR WORK OR PERSONAL LIFE (I.E., LEAD,
No	
MEDICAL HISTORY	
MEDICAL HISTORY	MA, DIABETES, SEIZURE DISORDERS, TUBERCULOSIS, ETC)?
MEDICAL HISTORY	MA, DIABETES, SEIZURE DISORDERS, TUBERCULOSIS, ETC)?
MEDICAL HISTORY  DO YOU HAVE ANY MEDICAL ILLNESSES (I.E., ASTHM  No	MA, DIABETES, SEIZURE DISORDERS, TUBERCULOSIS, ETC)?
MEDICAL HISTORY  DO YOU HAVE ANY MEDICAL ILLNESSES (I.E., ASTHM  No	MA, DIABETES, SEIZURE DISORDERS, TUBERCULOSIS, ETC)?
MEDICAL HISTORY  DO YOU HAVE ANY MEDICAL ILLNESSES (I.E., ASTHM  NO  HAVE YOU EVER HAD SURGERY? PLEASE DESCRIBE:  NO	
MEDICAL HISTORY  DO YOU HAVE ANY MEDICAL ILLNESSES (I.E., ASTHM  NO  HAVE YOU EVER HAD SURGERY? PLEASE DESCRIBE:  NO	
MEDICAL HISTORY  DO YOU HAVE ANY MEDICAL ILLNESSES (I.E., ASTHM NO  HAVE YOU EVER HAD SURGERY? PLEASE DESCRIBE: NO  LIST CURRENT ALLERGIES (FOOD, POLLEN, BEE STIN None	IGS, MEDICATIONS, ETC.)
MEDICAL HISTORY  DO YOU HAVE ANY MEDICAL ILLNESSES (I.E., ASTHM NO  HAVE YOU EVER HAD SURGERY? PLEASE DESCRIBE: NO  LIST CURRENT ALLERGIES (FOOD, POLLEN, BEE STIN None	IGS, MEDICATIONS, ETC.)
MEDICAL HISTORY  DO YOU HAVE ANY MEDICAL ILLNESSES (I.E., ASTHM NO  HAVE YOU EVER HAD SURGERY? PLEASE DESCRIBE: NO  LIST CURRENT ALLERGIES (FOOD, POLLEN, BEE STIM None  DESCRIBE ANY CHILDHOOD ALLERGIES YOU'VE OUT None  LIST ALL DRUGS, INCLUDING PHYSICIAN PRESCRIBE	IGS, MEDICATIONS, ETC.)
MEDICAL HISTORY  DO YOU HAVE ANY MEDICAL ILLNESSES (I.E., ASTHM NO  HAVE YOU EVER HAD SURGERY? PLEASE DESCRIBE: NO  LIST CURRENT ALLERGIES (FOOD, POLLEN, BEE STIM None  DESCRIBE ANY CHILDHOOD ALLERGIES YOU'VE OUT None  LIST ALL DRUGS, INCLUDING PHYSICIAN PRESCRIBE	IGS, MEDICATIONS, ETC.) GROWN:
MEDICAL HISTORY  DO YOU HAVE ANY MEDICAL ILLNESSES (I.E., ASTHM NO  HAVE YOU EVER HAD SURGERY? PLEASE DESCRIBE: NO  LIST CURRENT ALLERGIES (FOOD, POLLEN, BEE STIN None  DESCRIBE ANY CHILDHOOD ALLERGIES YOU'VE OUT None  LIST ALL DRUGS, INCLUDING PHYSICIAN PRESCRIBE HERBS) THAT YOU ARE CURRENTLY TAKING: None	IGS, MEDICATIONS, ETC.)  GROWN:  D AND NON-PRESCRIPTION (PLEASE INCLUDE VITAMINS AND
MEDICAL HISTORY  DO YOU HAVE ANY MEDICAL ILLNESSES (I.E., ASTHM NO  HAVE YOU EVER HAD SURGERY? PLEASE DESCRIBE: NO  LIST CURRENT ALLERGIES (FOOD, POLLEN, BEE STIN None  DESCRIBE ANY CHILDHOOD ALLERGIES YOU'VE OUT None  LIST ALL DRUGS, INCLUDING PHYSICIAN PRESCRIBE HERBS) THAT YOU ARE CURRENTLY TAKING: None	IGS, MEDICATIONS, ETC.)  GROWN:  D AND NON-PRESCRIPTION (PLEASE INCLUDE VITAMINS AND
MEDICAL HISTORY  DO YOU HAVE ANY MEDICAL ILLNESSES (I.E., ASTHM NO  HAVE YOU EVER HAD SURGERY? PLEASE DESCRIBE:  NO  LIST CURRENT ALLERGIES (FOOD, POLLEN, BEE STIN None  DESCRIBE ANY CHILDHOOD ALLERGIES YOU'VE OUT NONE  LIST ALL DRUGS, INCLUDING PHYSICIAN PRESCRIBE HERBS) THAT YOU ARE CURRENTLY TAKING:  None  LIST ANY OTHER MEDICATIONS YOU'VE TAKEN IN THE NONE	IGS, MEDICATIONS, ETC.)  GROWN:  D AND NON-PRESCRIPTION (PLEASE INCLUDE VITAMINS AND
MEDICAL HISTORY  DO YOU HAVE ANY MEDICAL ILLNESSES (I.E., ASTHM NO  HAVE YOU EVER HAD SURGERY? PLEASE DESCRIBE:  NO  LIST CURRENT ALLERGIES (FOOD, POLLEN, BEE STIN None  DESCRIBE ANY CHILDHOOD ALLERGIES YOU'VE OUT NONE  LIST ALL DRUGS, INCLUDING PHYSICIAN PRESCRIBE HERBS) THAT YOU ARE CURRENTLY TAKING:  None  LIST ANY OTHER MEDICATIONS YOU'VE TAKEN IN THE NONE	IGS, MEDICATIONS, ETC.)  GROWN:  D AND NON-PRESCRIPTION (PLEASE INCLUDE VITAMINS AND
MEDICAL HISTORY  DO YOU HAVE ANY MEDICAL ILLNESSES (I.E., ASTHM NO  HAVE YOU EVER HAD SURGERY? PLEASE DESCRIBE:  NO  LIST CURRENT ALLERGIES (FOOD, POLLEN, BEE STIN None  DESCRIBE ANY CHILDHOOD ALLERGIES YOU'VE OUT NONE  LIST ALL DRUGS, INCLUDING PHYSICIAN PRESCRIBE HERBS) THAT YOU ARE CURRENTLY TAKING:  None  LIST ANY OTHER MEDICATIONS YOU'VE TAKEN IN THE NONE  HAVE YOU EVER HAD A BLOOD TRANSFUSION?	IGS, MEDICATIONS, ETC.)  GROWN:  D AND NON-PRESCRIPTION (PLEASE INCLUDE VITAMINS AND  HE LAST FIVE YEARS:

HAVE YOU BEEN EXPOSED TO RADIATION OR TOXIC CHEMICALS IN YOUR WORK OR PERSONAL LIFE (IE; LEAD, MERCURY, GOLD)?

No			
HAVE YOU EVER HAD UNEX	PLAINED	WEIGHT LOSS?	
No			
HAVE YOU EVER HAD KAPO	SI SARCO	DMA?	
No			
HAVE YOU EVER HAD FEVE	R OF UNK	(NOWN ORIGIN?	
No			
HAVE YOU EVER HAD PNEU	MOCYST	C PNEUMONIA?	
No			
HAVE YOU EVER HAD SEXU	AL RELAT	TIONS WITH ANYONE V	VITH THE ABOVE SYMPTOMS/DISEASES?
No			
DO YOU SMOKE CIGARETTE	S?		
No			
DO YOU DRINK ALCOHOL?			
No			
HAVE YOU EVER USED REC	REATION	AL DRUGS? (LSD, MAR	IJUANA, HEROIN OR COCAINE, ETC.)
No			
HAVE YOU EVER BEEN TREA	ATED FOR	R DEPRESSION?	
No			
HAVE YOU EVER ATTEMPTE	D SUICID	E?	
No			
FAMILY MEDICAL HISTORY			
Family Member	Age	Age At Death	Medical Problems Or Cause Of Death
BONES, MUSCLES, JOINTS,	LIMBS		
No			
GASTROINTESTINAL SYSTE	М		
No			
NERVOUS SYSTEM, BRAIN,	SPINAL C	CORD	
No			
BLOOD OR CIRCULATORY S	YSTEM		
No			
RESPIRATORY SYSTEM			
No			
GENITAL/URINARY TRACT			
No			
METABOLIC (HORMONES, E	NZYMES,	ETC)	

NΙ	
IN	

No

DONOR RISK ASSESSMENT QUESTIONNAIRE
1. HAVE YOU INJECTED DRUGS FOR A NON-MEDICAL REASON IN THE LAST FIVE YEARS, INCLUDING INTRAVENOUS, INTRAMUSCULAR AND SUBCUTANEOUS INJECTION?
No
2. HAVE YOU RECEIVED HUMAN-DERIVED CLOTTING FACTOR CONCENTRATES, INCLUDING FACTOR VIII AND/OR FACTOR IX CONCENTRATE FOR HEMOPHILIA OR A RELATED CLOTTING DISORDER?
No
3. IN THE PAST FIVE YEARS, HAVE YOU BEEN GIVEN MONEY OR DRUGS IN EXCHANGE FOR HAVING SEX?
No
4. IN THE PAST 12 MONTHS, HAVE YOU BEEN IN JAIL FOR MORE THAN 72 CONSECUTIVE HOURS?
No
5. IN THE PAST 12 MONTHS, HAVE YOU HAD SEX WITH ANYONE WHO WOULD ANSWER YES TO THE PREVIOUS QUESTIONS?
No
6. IN THE PREVIOUS 12 MONTHS, HAVE YOU HAD SEX WITH A PERSON WITH KNOWN OR SUSPECTED HIV, HEPATITIS B OR HEPATITIS C?
No
7. IN THE PAST 12 MONTHS, HAVE YOU BEEN EXPOSED TO KNOWN OR SUSPECTED HIV, HEPATITIS B AND/OR HEPATITIS C INFECTED BLOOD THROUGH PERCUTANEOUS INOCULATION (E.G., NEEDLE STICK) OR THROUGH CONTA WITH AN OPEN WOUND, NON-INTACT SKIN OR MUCUS MEMBRANE?
No
8. IN THE PAST 12 MONTHS HAVE YOU HAD AN ACCIDENTAL NEEDLE STICK, SHARP INSTRUMENT INJURY, CONTACT WITH HUMAN BLOOD, SERUM OR PLASMA IN THE EYE, MUCOUS MEMBRANES (LIPS OR INTERIOR OF NOSE) OR SORES?
No
9. IN THE PAST 12 MONTHS , HAVE YOU LIVED WITH (RESIDED IN THE SAME DWELLING) ANOTHER PERSON WHO HA HEPATITIS B OR CLINICALLY ACTIVE (SYMPTOMATIC) HEPATITIS C INFECTION?
No
10. IN THE PAST 12 MONTHS, HAVE YOU HAD EAR, SKIN OR BODY PIERCING, SCARIFICATION OR TATTOOING?
No
11. HAVE YOU HAD A CLINICAL DIAGNOSIS OF HEPATITIS?
No
12. HAVE YOU, YOUR SEXUAL PARTNER(S) AND/OR ANY MEMBER OF YOUR HOUSEHOLD EVER HAD A TRANSPLANT OF MEDICAL PROCEDURE THAT INVOLVED BEING EXPOSED TO LIVE CELLS, TISSUE OR ORGANS FROM AN ANIMAL?
No
13. HAVE YOU BEEN SUSPECTED TO HAVE OR DIAGNOSED WITH WEST NILE VIRUS (INCLUDING DIAGNOSIS BASED O SYMPTOMS AND/OR LABORATORY RESULTS, OR CONFIRMED WNV VIREMIA) IN THE PAST 120 DAYS?
No

14. WITHIN THE PAST 8 WEEKS, HAVE YOU HAD A SMALLPOX VACCINATION?

15. WITHIN THE PAST 8 WEEKS, HAVE YOU HAD CLOSE CONTACT WITH A SMALLPOX VACCINATION SITE OF SOMEONE ELSE WHO RECEIVED THE VACCINATION (EXAMPLES INCLUDE TOUCHING THE SITE, THE BANDAGES COVERING THE SITE OR HANDLING BEDDING OR CLOTHING THAT HAS BEEN IN CONTACT WITH AN UNBANDAGED VACCINATION SITE)?
No
17. HAVE YOU OR ANY OF YOUR BLOOD RELATIVES BEEN DIAGNOSED WITH CREUTZFELDT-JAKOB DISEASE (CJD)?
No
18. HAVE YOU BEEN DIAGNOSED WITH DEMENTIA OR ANY DEGENERATIVE OR DEMYELINATING DISEASE OF THE CENTRAL NERVOUS SYSTEM OR OTHER NEUROLOGICAL DISEASE OF UNKNOWN ETIOLOGY?
No
20. HAVE YOU EVER RECEIVED A NON-SYNTHETIC DURA MATER (BRAIN COVERING) GRAFT
No
21. HAVE YOU RECEIVED A BITE FROM AN ANIMAL SUSPECTED FOR RABIES WITHIN THE LAST 6 MONTHS?
No
22. HAVE YOU BEEN DIAGNOSED OR SUSPECTED TO HAVE T. CRUZI INFECTION OR CHAGAS DISEASE?
No
23. FROM 1980 THROUGH 1996 WERE YOU A MEMBER IF THE U.S. MILITARY, A CIVILIAN MILITARY EMPLOYEE OR A DEPENDENT OF A MILITARY MEMBER OR CIVILIAN MILITARY EMPLOYEE?
No
24. SINCE 1980, HAVE YOU EVER LIVED IN OR TRAVELED TO EUROPE (INCLUDES: ALBANIA, AUSTRIA, BELGIUM, BOSNIA-HERZEGOVINA, BULGARIA, CROATIA, CZECH REPUBLIC, DENMARK, FINLAND, FRANCE, GERMANY, GREECE, HUNGARY, IRELAND, ITALY, LIECHTENSTEIN, LUXEMBOURG, MACEDONIA, NETHERLANDS, NORWAY, POLAND, PORTUGAL, ROMANIA, SLOVAK REPUBLIC, SLOVENIA, SPAIN, SWEDEN, SWITZERLAND, AND YUGOSLAVIA)?
Yes
24A. FROM THE BEGINNING OF 1980 THROUGH THE END OF 1996 DID YOU SPEND TIME THAT ADDS UP TO 3 MONTHS OR MORE IN THE U.K. (INCLUDES ENGLAND, IRELAND, SCOTLAND, WALES, THE ISLE OF MAN, THE CHANNEL ISLANDS, GIBRALTAR, AND THE FALKLAND ISLANDS)?
No
24B. SINCE 1980, HAVE YOU RECEIVED A BLOOD TRANSFUSION OF BLOOD OR BLOOD COMPONENTS IN THE U.K. OR FRANCE?
No
24C. SINCE 1980 HAVE YOU SPENT TIME THAT ADDS UP TO 5 YEARS OR MORE IN EUROPE (INCLUDING TIME SPENT IN THE U.K. BETWEEN 1980 AND 1996)?
No
FDA REQUIRED SCREENING
HAVE YOU EVER HAD A SEXUALLY TRANSMITTED DISEASE OR INFECTION (STD/STI)?
No
IN THE PAST 5 YEARS HAVE YOU HAD SEXUAL RELATIONS WITH A MALE HOMOSEXUAL, BISEXUAL, OR IV DRUG USER?
No
HAVE YOU HAD A PARTNER WHO HAD SEXUAL RELATIONS WITH A MALE HOMOSEXUAL, BISEXUAL, OR IV DRUG USER?
No
HAS YOUR CURRENT PARTNER EVER BEEN IN PRISON?

No	
IN THE PAST 12	MONTHS HAVE YOU BEEN IN JAIL FOR MORE THAN 3 DAYS IN A ROW?
No	
IN THE PAST 12 3 DAYS IN A RO	MONTHS HAVE YOU HAD SEXUAL RELATIONS WITH ANYONE WHO HAS BEEN IN JAIL FOR MORE THAW?
No	
IN THE PAST 12 HEPATITIS C?	MONTHS HAVE YOU HAD SEX WITH A PERSON KNOWN OR SUSPECTED TO HAVE HIV, HEPATITIS B
No	
IN THE PAST 12 VIRAL HEPATITI	MONTHS HAVE YOU BEEN IN CONTACT WITH A PERSON KNOWN OR SUSPECTED TO HAVE ACTIVE S?
No	
IN THE PAST 12 THE ABOVE QUE	MONTHS HAVE YOU HAD SEXUAL RELATIONS WITH ANYONE WHO WOULD ANSWER YES TO ANY OF
No	
HAVE YOU EVER	R GIVEN OR RECEIVED MONEY OR DRUGS IN EXCHANGE FOR ANY SEXUAL ACT?
No	
WERE YOU BOR	N IN OR DID YOU LIVE IN OR TRAVEL TO AFRICA BETWEEN 1977 AND TODAY?
No	
HAVE YOU HAD	SEXUAL CONTACT WITH ANYONE BORN IN OR LIVED IN AFRICA BETWEEN 1977 AND TODAY?
No	SEASE CONTACT WITH ANTIONE BONN IN ON EIVED IN AT NICA DETWEEN 1377 AND TODAT.
AFTER AGE 11.	HAVE YOU HAD VIRAL HEPATITIS, HEPATITIS B, OR HEPATITIS C?
No	,
HAVE YOU EVER	R BEEN TOLD THAT YOU COULD NOT DONATE BLOOD?
No	
HAVE YOU EVER	R RECEIVED A BLOOD TRANSFUSION?
No	
HAS YOUR PART	INER EVER RECEIVED A BLOOD TRANSFUSION?
No	
DO YOU HAVE A	BLOOD CLOTTING DISORDER AND RECEIVE HUMAN DERIVED CLOTTING FACTOR CONCENTRATION?
No	
HAVE YOU EVER	R RECEIVED GROWTH HORMONES MADE FROM HUMAN PITUITARY GLANDS (HGH)?
No	
INIECTED ANY T	YPE OF DRUG FOR NON-MEDICAL REASONS
No	THE OF BROOT OR HOR PERSONS READONS
	IA (INCLUDING MEDICAL MADIIIIANA)
No MARIJUAN	IA (INCLUDING MEDICAL MARIJUANA)

No	
USED LSD (ANGEL DUST)	
No	
USED METHAMPHETAMINE	
No	
USED ANY ILLICIT DRUG NOT LISTED	
No	
HAVE YOU EVER USED PRESCRIPTION MEDICATIONS FOR REASONS OTHER THAN THEIR INTENDED USE?	
No	
ARE YOU CURRENTLY USING ANY ILLICIT DRUGS OR PRESCRIPTION DRUGS FOR NON-MEDICAL REASONS?	
No	
DURING WORK ARE YOU EXPOSED TO TOXIC OR RADIOACTIVE SUBSTANCES?	
No	
HAVE YOU EVER HAD A NEEDLE STICK INJURY?	
No	
HAVE YOU EVER BEEN TESTED FOR HIV/AIDS?	
No	
HAVE YOU RECENTLY RECEIVED ANY VACCINATIONS?	
No	
IN THE PAST 7 DAYS HAVE YOU HAD ANY OF THE FOLLOWING SYMPTOMS?	
No	
HAVE YOU OR YOUR PARTNER EVER BEEN DIAGNOSED WITH WEST NILE VIRUS (WNV)?	
No	
HAVE YOU EVER RECEIVED A DURA-MATER (BRAIN COVERING TISSUE) GRAFT?	
No	
HAVE YOU OR YOUR PARTNER EVER BEEN DIAGNOSED WITH CJD?	
No	
BETWEEN 1980 AND 1996 WERE YOU A MEMBER OF THE US MILITARY OR CIVILIAN EMPLOYEE?	
No	
BETWEEN 1980 AND 1996 WERE YOU A DEPENDENT OF A MEMBER OF THE US MILITARY?	
No	
HAVE YOU TRAVELED TO A COUNTRY AFFECTED BY OR TREATED FOR SARS IN THE PAST 14 DAYS?	
No	
No	
IN THE PAST 12 MONTHS HAVE YOU RECEIVED ANY OF THE FOLLOWING	

• None

# **TRAVEL** BETWEEN 1980 AND TODAY, HAVE YOU TRAVELED TO ANY OF THE FOLLOWING EUROPEAN COUNTRIES? CHECK ALL THAT APPLY. NONE HAVE YOU SPENT A TOTAL OF 6 MONTHS OR MORE ASSOCIATED WITH A MILITARY BASE IN ANY OF THE FOLLOWING **COUNTRIES? CHECK ALL THAT APPLY.** NONE **MEXICAN RIVIERA** NONE THE CARIBBEAN NONE **CENTRAL AMERICA** NONE **PACIFIC ISLANDS** NONE **SOUTH AMERICA** NONE **ASIA** NONE **AFRICA** NONE **MEDICAL HISTORY OTHER HEART DISEASE OTHER BREATHING PROBLEM** None None **OTHER KINDNEY PROBLEM** None

### OTHER BLADDER PROBLEM

None

#### **OTHER GI DISEASE**

None

#### **OTHER MUSCULOSKELETAL DISEASE**

None

#### **OTHER HORMONAL DISEASE**

	None	
		_
OTHER REPRODUCTIVE DISEASE		
	None	
OTHER BLOOD DISEASE		
	None	
OTHER EYES, EARS, AND SKIN DISEASE		
	None	
OTHER NEUROLOGICAL DISEASE		
	None	
OTHER PSYCHOLOGICAL DISORDER		
	None	
ANY OTHER DISEASE OR DISORDER		
	None	

# **DONOR ADDITIONAL PHOTOS**









# **CHILDHOOD ADDITIONAL PHOTOS**







# **FAMILY ADDITIONAL PHOTOS**





