MEDICAL HISTORY

Donor Code - 153599

General Data:

Did you take part in an egg donation program before? Yes

Have you ever had a miscarriage? No

If yes, when did it occur? -

Have you ever had an abortion? No

If yes, when did it occur? -

Have you ever had a missed miscarriage? No

If yes, when did it occur? -

Have you ever had a stillbirth? No

If yes, when did it occur? -

Have you ever had a Caesarean operation? Yes

If yes, when did it occur? 2013

Were all your childbirths in time? Yes

Are you currently breastfeeding? No

Please complete information about your children in the table below:

Child's Sex	Child's Year of Birth	Height and Weight at Birth
female	2007	3400 g and 52 cm
female	2013	2990 g and 50 cm

Personal Health Data:

Do you currently have any allergies? No

If yes, please specify them -

Describe your vision (without glasses): satisfactory

Are you currently wearing glasses or contact lenses No

If yes, at what age did you start wearing glasses or contact lenses? -

Have you ever had corrective laser surgery? No

What is the condition of your teeth? Good

Are you a vegetarian? No

Do you have tattoos? Yes

If yes, how many? 1

Have you ever had any surgical interventions? No

Have you ever had any broken bones? No

Have you ever smoked cigarettes? Yes

Are you currently smoking? No

How often do you drink alcoholic beverages? Not often

Have you ever used drugs? No

Have you ever been in relationship with a partner who used or might have used drugs? No

Reproductive and Sexual Life Data:

At what age did you have your first period? 15

Is your period regular? Yes

An average interval between your periods 25

Do you feel any pain or cramps during your period? Yes

Do you have any bleeding between your periods? No

Do you have any nipple discharge? No

Is there any case of twins or other multiple births in your family? No

If yes, please specify it -

What is your sexual orientation? Traditional

What method of contraception do you currently use? Condoms

Are you currently sexuallly active? Yes

Is your relationship monogamous? Yes

How many partners did you have in the past year? 1

Family Background:

Describe the health condition or cause of death of all family members:

Biological mother: Died because of Covid-19

Biological father: Died, health was satisfactory

Biological maternal grandmother: healthy

Biological maternal grandfather: Died, age-related disease

Biological paternal grandmother: Died, age-related disease

Biological paternal grandfather: Died, age-related disease

Sister: healthy

Medical History:

Specify if you, your grandparents, parents, siblings or children have had or have now any of the medical conditions mentioned below.

Diseases	Donor		Family members		
	Yes/No	When	Yes/No	Who	When
Heart Diseases					
Stroke	No	-	No	-	
Heart attack	No	-	No	-	
Heart murmur	No	-	No	-	
Hardening of the arteries	No	-	No	-	
High blood pressure	No	-	No	-	
Blood Diseases					
Anaemia	No	-	No	-	
Sickle cell anaemia	No	-	No	-	
Haemophilia or other bleeding problem	No	-	No	-	
Leukaemia	No	-	No	-	
Immune deficiency	No	-	No	-	

Von Willebrand disease	No	-	No	-	
Gaucher’s disease	No	-	No	-	
Blood clot	No	-	No	-	
Thalassemia	No	-	No	-	
Respiratory Diseases					
Asthma	No	-	No	-	
Emphysema	No	-	No	-	
Tuberculosis	No	-	No	-	
Lung cancer	No	-	No	-	
Pneumonia	No	-	No	-	
Cystic fibrosis	No	-	No	-	
Gastrointestinal Diseases					
Ulcer of stomach or duodenum	No	-	No	-	
Gallstones	No	-	No	-	
Hepatitis A	No	-	No	-	
Hepatitis B	No	-	No	-	

Hepatitis C	No	-	No	-	
Ulcerative colitis	No	-	No	-	
Crohn’s disease	No	-	No	-	
Intestinal cancer	No	-	No	-	
Cirrhosis	No	-	No	-	
Pyloric stenosis	No	-	No	-	
Endocrine Diseases					
Diabetes mellitus	No	-	No	-	
Hypoglycaemia	No	-	No	-	
Thyroid disease	No	-	No	-	
Thyroid cancer	No	-	No	-	
Goitre	No	-	No	-	
Adrenal dysfunction	No	-	No	-	
Phenylketonuria	No	-	No	-	
Urinary Diseases					
Kidney disease	No	-	No	-	
Kidney stones	No	-	No	-	

Reproductive Diseases					
Infertility	No	-	No	-	
Undescended testicle	No	-	No	-	
Hypospadias	No	-	No	-	
Prostate cancer	No	-	No	-	
Uterine fibroids	No	-	No	-	
Endometriosis	No	-	No	-	
Cervical cancer	No	-	No	-	
Ovarian cancer	No	-	No	-	
Ovarian cysts	No	-	No	-	
Uterine cancer	No	-	No	-	
Breast cancer	No	-	No	-	
Spontaneous abortion	No	-	No	-	
Miscarriage	No	-	No	-	
Stillbirth	No	-	No	-	
Rectal disorder	No	-	No	-	
Premature menopause	No	-	No	-	

Hermaphroditism	No	-	No	-	
Neurological Diseases					
Migraines	No	-	No	-	
Mental retardation	No	-	No	-	
Down’s syndrome	No	-	No	-	
Turner’s syndrome	No	-	No	-	
Fragile X	No	-	No	-	
Multiple sclerosis	No	-	No	-	
Cerebral palsy	No	-	No	-	
Epilepsy, seizures	No	-	No	-	
Hydrocephalus	No	-	No	-	
Spinal cord disorder	No	-	No	-	
Huntington’s chorea	No	-	No	-	
Canavan’s disease	No	-	No	-	
Tay-Sachs disease	No	-	No	-	
Wilson’s disease	No	-	No	-	
Parkinson’s disease	No	-	No	-	

Alzheimer’s disease	No	-	No	-	
Mental Diseases					
Schizophrenia	No	-	No	-	
Depression	No	-	No	-	
Suicide	No	-	No	-	
Mentally handicap	No	-	No	-	
Tourette's syndrome	No	-	No	-	
Bipolar disorder	No	-	No	-	
Musculoskeletal Diseases					
Muscular dystrophy	No	-	No	-	
Lupus	No	-	No	-	
Deformity of spine / Spina bifida	No	-	No	-	
Osteoporosis	No	-	No	-	
Dwarfism	No	-	No	-	
Rheumatoid arthritis	No	-	No	-	
Osteoarthritis	No	-	No	-	

Gout	No	-	No	-	
Cleft palate / Cleft lip	No	-	No	-	
Marfan syndrome	No	-	No	-	
Sense Organs Diseases					
Deafness before 60	No	-	No	-	
Cataracts before 60	No	-	No	-	
Blindness	No	-	No	-	
Colour blindness	No	-	No	-	
Deviated septum	No	-	No	-	
Glaucoma	No	-	No	-	
Retinitis pigmentosa	No	-	No	-	
Nearsightedness	No	-	No	-	
Farsightedness	No	-	No	-	
Astigmatism	No	-	No	-	
Skin Diseases					
Acne	No	-	No	-	
Eczema	No	-	No	-	

Skin cancer	No	-	No	-	
Pigmentation disorder	No	-	No	-	
Neurofibromatosis	No	-	No	-	
Other Diseases					
Alcoholism	No	-	No	-	
Drug abuse or addiction	No	-	No	-	
Nicotine addiction	No	-	No	-	

FAMILY MEDICAL SUMMARY	
Medical issue	**A person who had a medical issue detected**
No	-