**MEDICAL HISTORY**
**Donor Code - 115439**

## 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 Cesarean section? No
If yes, when did it occur? -
Were all your childbirths in time? Yes
Are you currently breastfeeding? No
Please complete the information about your children in the table below:

| Child's Sex | Child's Year of Birth | Height and Weight at Birth |
|---|---|---|
| Male | 04.11.2020 | 3000 g and 48 cm |
| Male | 04.11.2020 | 3100 g and 50 cm |

## Personal Health Data:

Do you currently have any allergies? Ye
Describe your vision (without glasses) Good
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 a 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? 14 years old
Is your period regular? Yes
An average interval between your periods 28-30 days
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? Yes
If yes, please specify it - I have

What is your sexual orientation? Traditional
What method of contraception do you currently use? No contraception
Are you currently sexually active? No
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:** healthy
**Biological father:** healthy
**Biological maternal grandmother:** healthy
**Biological maternal grandfather:** healthy
**Biological paternal grandmother:** healthy
**Biological paternal grandfather:** healthy
**Sibling:** brother is healthy

## Medical History:

Specify if you, your grandparents, parents, siblings or children have had or have 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 | - | |

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|---|---|---|---|---|---|
| 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 | - | |

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|---|---|---|---|---|---|
| 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 | - | |

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|---|---|---|---|---|---|
| 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 | - | |

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|---|---|---|---|---|---|
| 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 | - | |

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|---|---|---|---|---|---|
| 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** | | | | | |

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|---|---|---|---|---|---|
| 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 | - |