



# ACRC Gametes Donation

ACRC Global Fertility Holding Group

**Donor Code : CDV007**



| Eye Color      | Hair Color                      | Height          |
|----------------|---------------------------------|-----------------|
| Brown          | Brown                           | 165 CM/ 55 KG   |
| Ethnicity      | Blood Type                      | Education       |
| Caucasian      | A                               | College Student |
| Donor Location | Willing to Travel Out of State? | Date of Birth   |
| Spain          |                                 | 1999            |



### **Basic Information**

|                   |   |
|-------------------|---|
| Date of Birth     | 22/02/1999  |
| Height            | <b>165 cm</b>   |
| Weight            | <b>55 kg</b>  |
| Hair Color        | <b>brown</b>  |
| Eye Color         | <b>brown</b>  |
| Ethnic Origin     | <b>caucasian</b>  |
| Maternal Heritage | <b>spanish</b>  |
| Paternal Heritage | <b>spanish</b>  |
| Blood Type        | <b>A+</b>   |
| Visa              | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |

### **Education and Background**

|  |  |
|--|--|
| Highest Level of education   | studying marketing at university                   |
| College Major  | digital marketing                                  |
| What was your college GPA?   | 8,5  |
| What college(s) or university(ies) have you attended?                                    | universidad complutense de madrid                  |
| Do you have any artistic abilities? Please List:   | sing, dance, painting                              |
| Do you have any athletic abilities?  | i go to the gym, boxing, skating                   |
| What is your current occupation?   | student  |
| Please describe your personality:  | ambitious, curious, intelligent and perfeccionist. |
| Do you wear or have you worn eyeglasses? If yes, at what age did you start wearing them? | no   |
| Have you worn braces?  | no   |

## **Questions:**

- Why do you want to become a donor?

It is important to me to help other people to achieve their dream of having a family.

- For Egg Donor: 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?

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? Madrid

- Do you have any siblings? If so, tell us about each of them: I have an older sister, she is my other half

- 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? 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

### **Egg Donor Please answer:**

- Have you ever been pregnant? If yes, how many times and what was the outcome?  
No

- Are your menstrual cycles regular? If no, please explain:  
Yes



| <b>Disease/Medical Condition</b>                     | <b>Check one</b> | <b>To Whom</b> | <b>Passed away?</b> | <b>Age of onset/Medication</b> | <b>Age at the time of passing</b> |
|--|------------------|----------------|---------------------|--------------------------------|-----------------------------------|
| <b>Cancer</b>  | no               |                | Yes No              |                                |                                   |
| <b>Mental Retardation</b>                            | no               |                | Yes No              |                                |                                   |
| <b>Autism / Asperger's</b>                           | no               |                | Yes No              |                                |                                   |
| <b>Physical Malformation</b>                         | no               |                | Yes No              |                                |                                   |
| <b>Paralysis or crippling disorders</b>              | no               |                | Yes No              |                                |                                   |
| <b>Alcohol or Drug Addiction</b>                     | no               |                | Yes No              |                                |                                   |
| <b>Cystic Fibrosis</b>                               | no               |                | Yes No              |                                |                                   |
| <b>Sickle Cell Anemia</b>                            | no               |                | Yes No              |                                |                                   |
| <b>Lupus</b>   | no               |                | Yes No              |                                |                                   |
| <b>Miscarriages, still births, neonatal deaths</b>   | no               |                | Yes No              |                                |                                   |
| <b>High blood pressure, heart attacks or strokes</b> | no               |                | Yes No              |                                |                                   |
| <b>Memory loss or dementia</b>                       | no               |                | Yes No              |                                |                                   |
| <b>Osteoporosis</b>                                  | no               |                | Yes No              |                                |                                   |
| <b>Arthritis</b>                                     | no               |                | Yes No              |                                |                                   |
| <b>Allergies</b>                                     | no               |                | Yes No              |                                |                                   |
| <b>Blood diseases</b>                                | no               |                | Yes No              |                                |                                   |
| <b>Diabetes (Specifically Type 1 or Type 2)</b>      | no               |                | Yes No              |                                |                                   |
| <b>Thyroid issues</b>                                | no               |                | Yes No              |                                |                                   |
| <b>Learning disabilities</b>                         | no               |                | Yes No              |                                |                                   |
| <b>Seizure or epilepsy</b>                           | no               |                | Yes No              |                                |                                   |
| <b>Depression</b>                                    | no               |                | Yes No              |                                |                                   |
| <b>Panic attacks</b>                                 | no               |                | Yes No              |                                |                                   |

| <b>Disease/Medical Condition</b>   | <b>Check one</b> | <b>To Whom</b> | <b>Passed away?</b> | <b>Age of onset/Medication</b> | <b>Age at the time of passing</b> |
|--|------------------|----------------|---------------------|--------------------------------|-----------------------------------|
| <b>Schizophrenia</b>   | no               |                | Yes No              |                                |                                   |
| <b>Bipolar Disorder</b>  | no               |                | Yes No              |                                |                                   |
| <b>ADD or ADHD</b>   | no               |                | Yes No              |                                |                                   |
| <b>Age-related issues</b>  | no               |                | Yes No              |                                |                                   |
| <b>Kidney problems / diseases</b>  | no               |                | Yes No              |                                |                                   |
| <b>Reproductive problems: i.e. endometriosis, hysterectomies, late-term miscarriages, etc.</b> | no               |                | Yes No              |                                |                                   |
| <b>Vision/Sight/Eye Problems</b>   | no               |                | Yes No              |                                |                                   |













