



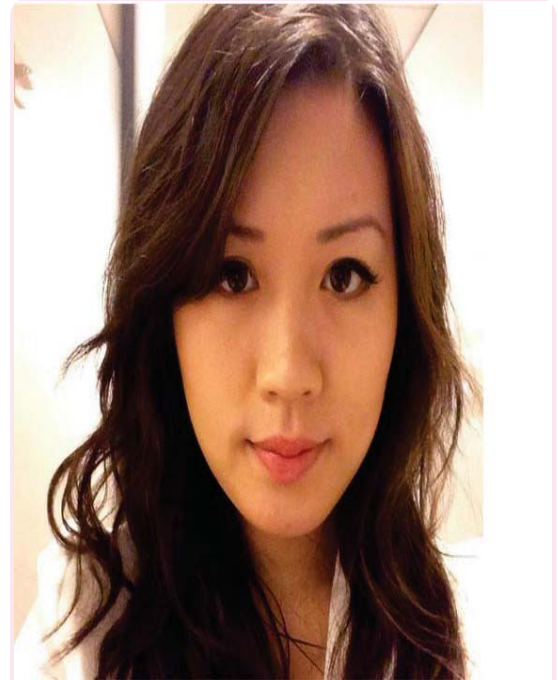
Messege to the Potential Couple

YD-705-DS-751

所在国家	美国
籍贯	美国
出生或年龄	28岁
身高	5'02(英文单位i)
体重	100LBS
血型	AB
当前受教育程度	本科
视力	正常
是否吸烟	否
健康状况	很好
是否捐过卵	否

联系方式: 400-887-1005

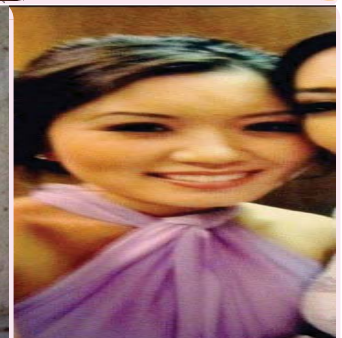
档案制作时间: 2014年3月份



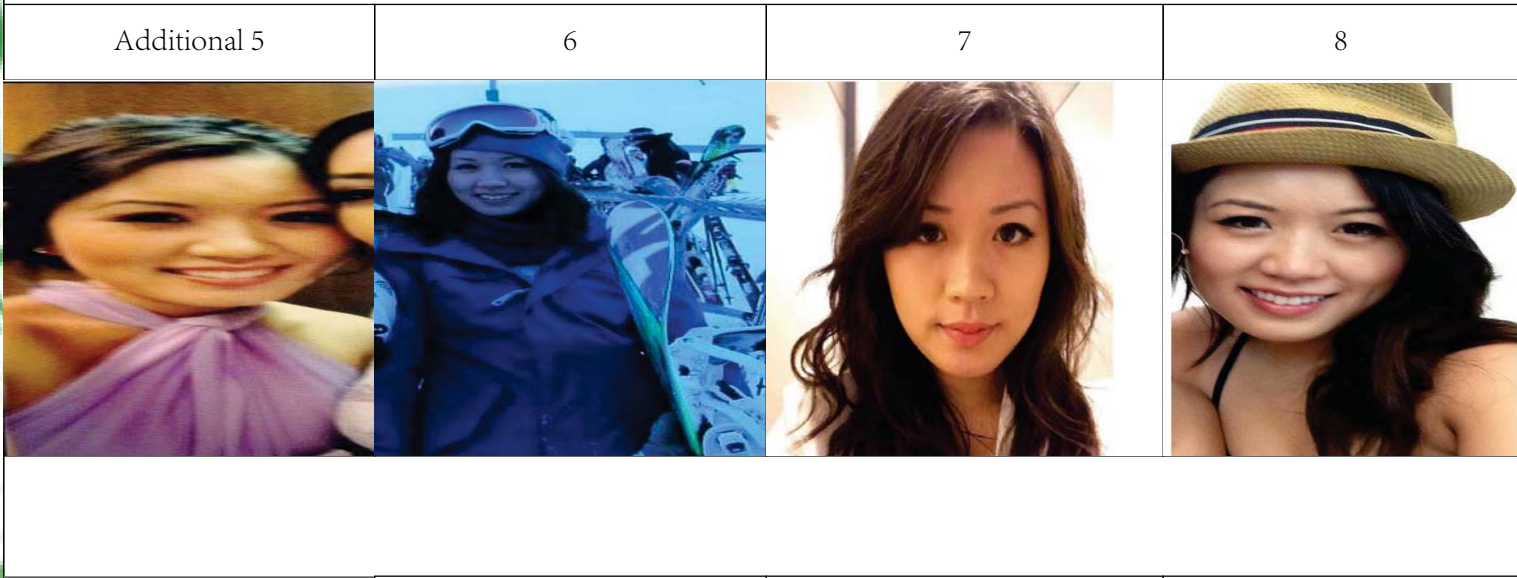
Donor Candidate



With Family Members



With Family Members



Profiles Presentation Lu Jie

Interview by DS

DONOR Applicant Nick Name 751

TODAY 14-3-31

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2014.03.31  
L\_Jie

622 FORM  
DNAP Profile

DAP YUlane.org  
Donor Assessment Program



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Profiles Presentation Lu Jie Page 3

Interview by DS

DONOR Applicant Nick Name 751



Donor Data sourced by the Donor Agency

Nick Name: 751

**Donor Number**

"751"

**What is your city?**

"Houston"

**What is your state?**

"Texas"

**What race would you most likely be affiliated?**

"Asian"

**What is your blood type?**

"AB-"

**Age**

"28"

**What is your height?**

"5'02"

**What is your weight in pounds?**

"100"

**What is your body type?**

"Athletic"

**What is your skin complexion?**

"Light"

**What is your natural hair color?**

"Dark Brown"

**What is your hair texture?**

"Straight"

**What is your eye color?**

"Brown"

**Describe any distinguishing physical characteristics.**

"na"

**Have you had any plastic surgery?**

"No"

**Have you had any orthodontia?**

"No"

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Donor Data sourced by the Donor Agency  
Nick Name: 751

Have you had vision correction surgery?

"Yes"

Do you have glasses?

"No"

Do you have contacts?

"No"

Do you have hearing problems?

"No"

Select the general shape of your face.

"Oval"

How significant was your adolescent acne?

"Slight"

How significant is your adult acne?

"None"

What was your natural hair color as a child?

"Dark Brown"

What is your natural hair color as an adult?

"Dark Brown"

What is your hair type?

"Medium"

What is your hair fullness?

"Thick"

Select the general shape of your eyes.

"Almond"

Select the general size of your eyes.

"Average"

Select the general shade of your eyes.

"Medium"

Select the general description of your eyebrows.

"Medium"

Select the general description of your eyelashes.

"Normal"

Select the general description of the size of your mouth.

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Donor Data sourced by the Donor Agency

Nick Name: 751

Select the general description of the size of your lips.

"Full"

Select the general description of the shape of your chin.

"Oval"

Select the general description of the cleft in your chin.

"Medium"

Do you have dimples?

"Left and Right"

Select the general description of the size of your teeth.

"Average"

What is your frame size?

"Petite"

What are your natural chest measurements in inches?

"32"

What is your waist size in inches?

"24"

What is your hip size in inches?

"32"

What is your dress size?

"00"

Describe any significant moles you may have on your body.

"00"

Select the general description of your skin tone.

"Olive"

Select the general shade of your skin.

"Fair"

Select the general description of your type of skin.

"Combination"

Select the general description of freckles on your body.

"None"

Select the general description of your ability to tan.

"Slightly Tan"

What is your dominant hand?

"Right"

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Donor Data sourced by the Donor Agency

Nick Name: 751

How many times have you donated eggs?

"0"

What is your occupation?

"Operations Analyst"

What is your college GPA? (or enter N/A if haven't attended college)

"3.5"

What languages do you know?

"Chinese""English"

Please complete the table regarding your education.

Type of Education	GPA	Degree	Area of Study
High School:	4.0	Diploma	General Studies
Community College:			
Bachelors Degree:	3.5	B.S	Biology
Graduate School:			
Professional School:	3.2	M.B.S	Pharmacy

Please complete the following table regarding test scores.

Tests	Score	Year
SAT Score:	1300	2002
ACT Score:	N/A	N/A

What were/are your best subjects in school?

"Writing, English, Science"

What areas of academic weakness to you have?

"History"

Please describe any awards you have received. (Do not provide information that may identify you).

"NA"

What are your career goals?

"Mid-Marketer"

Are you adopted?

"No"

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Donor Data sourced by the Donor Agency

Nick Name: 751

Please select the dominant ethnicity of each of the following relatives:

Family Ethnicity	MGM	MGF	PGM	PGF
Ethnicity:	Chinese	Chinese	Chinese	Chinese

What is your mother's ethnicity?

"Chinese"

What is your father's ethnicity?

"Chinese"

Please select the height of each of the following family members:

Family Height	Mother	Father	MGM	MGF	PGM	PGF
Height:	5'00"	5'09"	5'01"	5'09"	5'04"	5'10"

Please select the weight (in pounds) of each of the following family members: (please just enter the number or unknown)

Family Weight	Mother	Father	MGM	MGF	PGM	PGF
Weight:	100	155	NA	NA	NA	NA

Please select the body type of each of the following family members:

Family Body Type	Mother	Father	MGM	MGF	PGM	PGF
Body Type:	Straight	Athletic	Straight	Straight	Straight	Athletic

Please select the eye color of each of the following family members:

Family Eye Color	Mother	Father	MGM	MGF	PGM	PGF
Eye Color:	Brown	Brown	Brown	Brown	Brown	Brown

Please select the natural hair color of the following family members as they were when they were a young adult:

Family Hair Color	Mother	Father	MGM	MGF	PGM	PGF
Hair Color:	Brown	Brown	Brown	Dark Brown	Dark Brown	Dark Brown

Please select the skin tone of each of the following family members:

Family Skin Tone	Mother	Father	MGM	MGF	PGM	PGF
Skin Tone:	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow

Are you of Mediterranean ancestry?

"No"





Donor Data sourced by the Donor Agency

Nick Name: 751

Are you of Jewish ancestry?

"No"

Are you of African ancestry?

"No"

Are there any known genetic conditions in your family?

"No"

Do you have children?

"No"

Please provide the following information about your full siblings (enter n/a in a cell if you have siblings):

Siblings	Gender	Height	Weight	Body Type	Eye Color	Hair Color	Skin Tone
Sibling 1:	Male	5'10"	160	athletic	brown	brown	light
Sibling 2:							
Sibling 3:							
Sibling 4:							
Sibling 5:							

Please provide the following information about your family members:

Family Member	Age (if living)	Age at Death	Cause of Death	Occupation	Education Level
Mother:	58			Engineer	Masters
Father:	55			Aircraft Engineer	Bachelors
Maternal Grandmother:		68	?????		
Maternal Grandfather:		97	Old Age		
Paternal Grandmother:	80			Owned a Business	College
Paternal Grandfather:		N/A	N/A	N/A	N/A
Sibling 1:					
Sibling 2:					

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Donor Data sourced by the Donor Agency  
Nick Name: 751

Sibling 3:

Sibling 4:

Sibling 5:

How many full siblings are in your family? (include yourself)

"1"

Please add any other comments about your health or your immediate family's health history.

"NA"

Why do you want to become an egg donor?

"the help families in need"

Is your husband / partner supportive of your desire to be a donor?

"N/A"

What is your personality like? Are you outgoing, shy, reserved, easy going?

"easy going"

What are your plans for the future? Where do you see yourself in 5 and 10 years?

"travel, get married, start a family."

What has been your most proud moment to date? What achievement are you most proud of?

"graduating pharmacy school"

What is your personal philosophy of life?

"you are in control of your own happiness"

What do you like to do with your leisure time?

"read, play golf, watch movies, cook"

How active are you physically?

"relatively active"

What sports or activities do you participate in?

"tennis, swimming, yoga"

Have you played on sports teams or excelled in athletics? Which ones?

"swim team"

What your other skills or talents such as writing, acting, dancing, etc.

"writing"

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Donor Data sourced by the Donor Agency  
Nick Name: 751

Name some of your interests. Reading, traveling, camping, sewing, etc.

"cooking, creative projects, reading, planning"

List any clubs, sport teams, organizations that you belong to:

"none at the moment"

List any honors or awards you have received.

"deans list"

What sort of volunteer work have you done?

"texas childrens hospital, museum of natural science"

What is your favorite food?

"asian"

What is your favorite song?

"U2"

Who is your favorite star / celebrity?

"Natalie Portman"

What is your favorite book?

"Water for Elephants"

What is your favorite color?

"gray"

What is your favorite sport?

"basketball"

What was your favorite childhood activity?

"playing imaginative games"

Who do you admire most and why?

"Natalie Portman - beautiful and intelligent"

Do you have or did you have a pet? What type?

"dog"

Are you religious or spiritual?

"spiritual"

Do you practice your religion?

"somewhat"

What religion or spiritual ritual do you practice now?

"buddhis"

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Donor Data sourced by the Donor Agency

Nick Name: 751

What is one thing that is totally unique about you?

"I'm multifaceted in many areas of life."

What would you like to say to any potential recipient?

"Congatulations on the start of your new family!"

Describe yourself as a young child.

"sociable, smart"

What was your favorite thing to do as a child?

"color"

What was your favorite subject in school?

"English"

What do you remember most about your mother when you were a child?

"she worked a lot"

What do you remember most about your father when you were a child?

"he made me breakfast and taught me the time table"

What was your favorite vacation as a child?

"Disney World"

Carefully review the following list of medical problems (CONGENITAL ABNORMALITIES/BIRTH DEFECTS) and identify which ones you or one of your genetic relatives have or had. Please consider each condition carefully for each family member. If you and none of your family members have a history of the specific medical condition, please check "None".

Birth Defects	None	Self	Children	Mother	Father	Sibling	Grandparents	Aunt/Uncle	Cousin
Cleft Lip / Palate:	<input checked="" type="checkbox"/>								
Congenital Hip Problems:	<input checked="" type="checkbox"/>								
Club Feet:	<input checked="" type="checkbox"/>								
Heart Defect:	<input checked="" type="checkbox"/>								
Hearing Problems:	<input checked="" type="checkbox"/>								
Spina Bifida - Neural Tube (open spine):	<input checked="" type="checkbox"/>								
Microcephaly:	<input checked="" type="checkbox"/>								

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Donor Data sourced by the Donor Agency  
Nick Name: 751

**Holoprosencephaly**  
- a single-lobed  
brain structure and  
severe skull and  
facial defects:   
Other:

Carefully review the following list of medical problems (CHROMOSOMAL ABNORMALITIES) and identify which ones you or one of your genetic relatives have or had. Please consider each condition carefully for each family member. If you and none of your family members have a history of the specific medical condition, please check "None".

Chromosomal None Self Children Mother Father Sibling Grandparents Aunt/Unde Cousin

**Down Syndrome:**

**Other (i.e. Turner, Fragile X, Klinefelter's etc.):**

Carefully review the following list of medical problems (CANCER) and identify which ones you or one of your genetic relatives have or had. Please consider each condition carefully for each family member. If you and none of your family members have a history of the specific medical condition, please check "None".

Cancer	None	Self	Children	Mother	Father	Sibling	Grandparents	Aunt/Unde	Cousin
<b>Breast:</b>	<input checked="" type="checkbox"/>								
<b>Colon or Intestinal:</b>	<input checked="" type="checkbox"/>								
<b>Lung:</b>	<input checked="" type="checkbox"/>								
<b>Ovarian or Uterine:</b>	<input checked="" type="checkbox"/>								
<b>Prostate or Testicular:</b>	<input checked="" type="checkbox"/>								
<b>Skin:</b>	<input checked="" type="checkbox"/>								
<b>Stomach:</b>	<input checked="" type="checkbox"/>								
<b>Thyroid:</b>	<input checked="" type="checkbox"/>								
<b>Blood (e.g. leukemia):</b>	<input checked="" type="checkbox"/>								
<b>Other:</b>									

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Donor Data sourced by the Donor Agency  
Nick Name: 751

carefully review the following list of medical problems (HEART) and identify which ones you or one of your genetic relatives have or had. Please consider each condition carefully for each family member. If you or none of your family members have a history of the specific medical condition, please check "None".

Heart	None	Self	Children	Mother	Father	Sibling	Grandparents	Aunt/Uncle	Cousin
Stroke:	<input checked="" type="checkbox"/>								
Heart Attack:	<input checked="" type="checkbox"/>								
Congenital Heart Disease:	<input checked="" type="checkbox"/>								
Heart Disease or Defect:	<input checked="" type="checkbox"/>								
Hardening of the Arteries:	<input checked="" type="checkbox"/>								
High Blood Pressure:	<input checked="" type="checkbox"/>								
High Cholesterol Level:	<input checked="" type="checkbox"/>								

carefully review the following list of medical problems (REPRODUCTIVE OUTCOMES) and identify which ones you or one of your genetic relatives have or had. Please consider each condition carefully for each family member. If you and none of your family members have a history of the specific medical condition, please check "None".

Reproductive Outcomes	None	Self	Children	Mother	Father	Sibling	Grandparents	Aunt/Uncle	Cousin
2 or more Miscarriages:	<input checked="" type="checkbox"/>								
Stillborn:	<input checked="" type="checkbox"/>								
Premature Menopause:	<input checked="" type="checkbox"/>								
Death of a newborn infant:	<input checked="" type="checkbox"/>								



Donor Data sourced by the Donor Agency  
Nick Name: 751

- Childhood death:
- Birth Defects:
- Infertility:
- Premature Birth:

Carefully review the following list of medical problems (GENITAL/REPRODUCTIVE) and identify which ones you or one of your genetic relatives have or had. Please consider each condition carefully for each family member. If you and none of your family members have a history of the specific medical condition, please check "None".

Genitals / Reproductive    None    Self    Children    Mother    Father    Sibling    Grandparents    Aunt/Uncle    Cousin

- Hermaphroditism / Ambiguous Genitals:
- Hypospadias or Undescended Testicle(s):
- Uterine Fibroids:
- Ovarian Cysts or Ruptured:
- Lumps or Cysts in Breast or Discharge:
- Polycystic Ovarian Syndrome (PCOS):
- Pelvic Inflammatory Disease (PID):
- Endometriosis:

Carefully review the following list of medical problems (BLOOD) and identify which ones you or one of your genetic relatives have or had. Please consider each condition carefully for each family member. If you and none of your family members have a history of the specific medical condition, please check "None".

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Donor Data sourced by the Donor Agency

Nick Name: 751

	Blood	None	Self	Children	Mother	Father	Sibling	Grandparents	Aunt/Uncle	Cousin
<b>Anemia:</b>	<input checked="" type="checkbox"/>									
<b>Sickle-Cell Anemia:</b>	<input checked="" type="checkbox"/>									
<b>Factor V Leiden Thrombophilia (blood clots or strokes):</b>	<input checked="" type="checkbox"/>									
<b>Hemophilia or other Bleeding/Clotting Disorder such as Von Willebrand's Disease:</b>	<input checked="" type="checkbox"/>									
<b>Immune Deficiency:</b>	<input checked="" type="checkbox"/>									
<b>Leukemia:</b>	<input checked="" type="checkbox"/>									
<b>Lymphoma or Swollen Lymph Nodes:</b>	<input checked="" type="checkbox"/>									
<b>HIV:</b>	<input checked="" type="checkbox"/>									
<b>Thalassemia:</b>	<input checked="" type="checkbox"/>									
<b>Polyarteritis Nodosa:</b>	<input checked="" type="checkbox"/>									
<b>Other Blood Disorder:</b>	<input checked="" type="checkbox"/>									

Carefully review the following list of medical problems (RESPIRATORY) and identify which ones you or one of your genetic relatives have or had. Please consider each condition carefully for each family member. If you and none of your family members have a history of the specific medical condition, please check "None".

	Respiratory	None	Self	Children	Mother	Father	Sibling	Grandparents	Aunt/Uncle	Cousin
<b>Asthma:</b>	<input checked="" type="checkbox"/>									
<b>Hay Fever:</b>	<input checked="" type="checkbox"/>									
<b>Emphysema:</b>	<input checked="" type="checkbox"/>									
<b>Tuberculosis:</b>	<input checked="" type="checkbox"/>									

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Donor Data sourced by the Donor Agency  
Nick Name: 751

Pneumonia:

Alpha-1  
anyitrypsin  
Disorder:

Blood in  
Sputum:

Other Lung  
Disease:

Carefully review the following list of medical problems (GASTRO-INTESTINAL) and identify which ones you or one of your genetic relatives have or had. Please consider each condition carefully for each family member. If you and none of your family members have a history of the specific medical condition, please check "None".

Gastro-Intestinal None Self Children Mother Father Sibling Grandparents Aunt/Unde Cousin

Appendicitis:

Ulcer of  
Stomach or  
Duodenum:

Gallstones:

Hepatitis A, B,  
or C:

Cirrhosis of the  
Liver:

Other Liver  
Disease:

Ulcerative  
Colitis:

Crohns  
Disease:

Pyloric  
Stenosis:

Multiple Polyps  
of the Colon:

Rectal  
Disorder:

Inflammatory

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Donor Data sourced by the Donor Agency  
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**Bowel Disease:**

Any other  
problem of the  
digestive  
system:

Carefully review the following list of medical problems (METABOLIC/ENDOCRINE) and identify which ones you or one of your genetic relatives have or had. Please consider each condition carefully for each family member. If you and none of your family members have a history of the specific medical condition, please check "None".

Metabolic/Endocrine None Self Children Mother Father Sibling Grandparents Aunt/Unde Cousin

Diabetes requiring  
insulin therapy:

Diabetes not  
requiring insulin  
therapy:

Childhood  
Diabetes:

Thyroid Disorder:

Goiter:

Hypoglycemia:

Adrenal  
Dysfunction or  
Disorder:

Phenyl Ketonuria  
(PKU) or inherited  
Metabolism  
Disorder:

Obesity:

Dwarfism:

Carefully review the following list of medical problems (URINARY) and identify which ones you or one of your genetic relatives have or had. Please consider each condition carefully for each family member. If you and none of your family members have a history of the specific medical condition, please check "None".

Urinary None Self Children Mother Father Sibling Grandparents Aunt/Unde Cousin

Kidney Problems:

Polycystic Kidney

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Donor Data sourced by the Donor Agency

Nick Name: 751

Disease:

Other disease/defect of urinary tract (urethra, bladder, ureter):

Carefully review the following list of medical problems (NEUROLOGICAL) and identify which ones you or one of your genetic relatives have or had. Please consider each condition carefully for each family member. If you and none of your family members have a history of the specific medical condition, please check "None".

Neurological	None	Self	Children	Mother	Father	Sibling	Grandparents	Aunt/Unde	Cousin
Migraines:		<input checked="" type="checkbox"/>							
Mental Retardation:		<input checked="" type="checkbox"/>							
Senility or Mental Deterioration before age 50:		<input checked="" type="checkbox"/>							
Multiple Sclerosis:		<input checked="" type="checkbox"/>							
Cerebral Palsy:		<input checked="" type="checkbox"/>							
Neurofibromatosis:		<input checked="" type="checkbox"/>							
Epilepsy / Seizures:		<input checked="" type="checkbox"/>							
Attention Deficit Disorder / Hyperactivity:		<input checked="" type="checkbox"/>							
Autism / Asperger's:		<input checked="" type="checkbox"/>							
Alzheimer's Disease / Dementia:		<input checked="" type="checkbox"/>							
Hydrocephalus:		<input checked="" type="checkbox"/>							
Tuberous Sclerosis:		<input checked="" type="checkbox"/>							
Parkinson's Disease:		<input checked="" type="checkbox"/>							

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Donor Data sourced by the Donor Agency  
Nick Name: 751

- Creutzfeldt-Jakob Disease:
- Scoliosis:
- Myasthenia Gravis:
- Huntington's or Wilson's Disease:
- Tourettes's Syndrome:
- Other diseases of the nervous system:

Carefully review the following list of medical problems (MENTAL HEALTH) and identify which ones you or one of your genetic relatives have or had. Please consider each condition carefully for each family member. If you and none of your family members have a history of the specific medical condition, please check "None".

Mental Health	None	Self	Children	Mother	Father	Sibling	Grandparents	Aunt/Unde	Cousin
Anxiety / Panic Attacks:	<input checked="" type="checkbox"/>								
Anorexia / Bulimia / Other eating disorders:	<input checked="" type="checkbox"/>								
Depression:	<input checked="" type="checkbox"/>								
Schizophrenia:	<input checked="" type="checkbox"/>								
Manic Depressive or Bipolar Disorder:	<input checked="" type="checkbox"/>								
Other mental health disorder requiring hospitalization:	<input checked="" type="checkbox"/>								
Suicide Attempts:	<input checked="" type="checkbox"/>								
Other mental health problems that warranted counseling:	<input checked="" type="checkbox"/>								

Carefully review the following list of medical problems (MUSCLE/BONEJOINTS) and identify which ones you or one of

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Donor Data sourced by the Donor Agency

Nick Name: 751

your genetic relatives have or had. Please consider each condition carefully for each family member. If you and none of your family members have a history of the specific medical condition, please check "None".

Muscle/Bone/Joints None Self Children Mother Father Sibling Grandparents Aunt/Uncle Cousin

**Muscular Dystrophy:**

**Achondroplasia-form of dwarfism with abnormal bone growth:**

**Other Chronic Muscle Disease:**

**Osteogenesis imperfecta (brittle bone disease):**

**Loss of Muscle Coordination:**

**Osteoporosis:**

**Marfan Syndrome:**

**Arthritis:**

**Rheumatoid or Juvenile Arthritis:**

**Spinal Muscular Atrophy:**

**Hereditary Low Back Disorder or Deformity of Spine:**

**Reiter's Disease:**

**Myasthenia Gravis:**

**Gout:**

**Metabolic Bone Disease:**

**Lupus (systemic lupus erythematosis - SLE):**

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Donor Data sourced by the Donor Agency  
Nick Name: 751

Carefully review the following list of medical problems (SIGHT/SOUND/SMELL) and identify which ones you or one of your genetic relatives have or had. Please consider each condition carefully for each family member. If you and none of your family members have a history of the specific medical condition, please check "None".

Sight/Sound/Smell	None	Self	Children	Mother	Father	Sibling	Grandparents	Aunt/Unde	Cousin
Amusia (medical tone deafness):	<input checked="" type="checkbox"/>								
Deafness before age 60:	<input checked="" type="checkbox"/>								
Deformity of the ear:	<input checked="" type="checkbox"/>								
Cataracts before age 50:	<input checked="" type="checkbox"/>								
Blindness:	<input checked="" type="checkbox"/>								
Color Blindness:	<input checked="" type="checkbox"/>								
Sever Myopia:	<input checked="" type="checkbox"/>								
Glaucoma:	<input checked="" type="checkbox"/>								
Retinoblastoma:	<input checked="" type="checkbox"/>								
Retinitis Pigmentosa:	<input checked="" type="checkbox"/>								
Deviated Septum:	<input checked="" type="checkbox"/>								
Another other Sensory Disorder:	<input checked="" type="checkbox"/>								

Carefully review the following list of medical problems (SKIN) and identify which ones you or one of your genetic relatives have or had. Please consider each condition carefully for each family member. If you and none of your family members have a history of the specific medical condition, please check "None".

Skin	None	Self	Children	Mother	Father	Sibling	Grandparents	Aunt/Unde	Cousin
Acne:	<input checked="" type="checkbox"/>								
Albinism:	<input checked="" type="checkbox"/>								
Eczema:	<input checked="" type="checkbox"/>								
Excessive Facial Hair (Hirsutism):	<input checked="" type="checkbox"/>								
Pigmentation Disorders:	<input checked="" type="checkbox"/>								

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Donor Data sourced by the Donor Agency  
Nick Name: 751

- Psoriasis:
- Neurofibromatosis:
- Other disorders of the skin:
- Infectious Skin Disease:
- More than 5 purple or coffee colored spots on skin (size of quarter or larger):

Carefully review the following list of medical problems (OTHER) and identify which ones you or one of your genetic relatives have or had. Please consider each condition carefully for each family member. If you and none of your family members have a history of the specific medical condition, please check "None".

	Other	None	Self	Children	Mother	Father	Sibling	Grandparents	Aunt/Uncle	Cousin
Alcoholism:	<input checked="" type="checkbox"/>									
Drug Abuse, Misuse or Addiction:	<input checked="" type="checkbox"/>									
Premature degeneration of any organ system:	<input checked="" type="checkbox"/>									
Anorexia:	<input checked="" type="checkbox"/>									
Bulimia:	<input checked="" type="checkbox"/>									
Other Eating Disorder:	<input checked="" type="checkbox"/>									
Any other condition not mentioned in any other question:	<input checked="" type="checkbox"/>									

Have you ever had a blood transfusion?

"No"

Have you ever had gonorrhea?

"No"

Have you ever had Human Papilloma Virus

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Donor Data sourced by the Donor Agency

Nick Name: 751

(HPV)?

"No"

Have you had chlamydia within the past 12 months?

"No"

Do you have herpes?

"No"

Have you ever had Trichomoniasis?

"No"

Have you ever had Syphilis?

"No"

Have you ever been exposed to radiation or toxic chemicals, besides routine dental procedures or broken bones?

"No"

Have you ever been diagnosed with Severe Adult Acne?

"No"

Have you ever been diagnosed with Sever Dysmenorrhea (painful cramps)?

"No"

Have you ever been diagnosed with Ovarian Cysts?

"No"

Have you ever been diagnosed with Polycystic Ovarian Disease?

"No"

Have you ever been diagnosed with Thyroid Disease?

"No"

Do you have allergies?

"No"

Do you take daily medications?

"No"

Do you take any herbal supplements?

"No"

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Nick Name: 751

Have you ever had any major medical problems?

"No"

How would you describe your overall health, both mentally and physically?

"very healthy"

How old were you when you had your first period?

"12"

Are your cycles regular when not on the pill?

"Yes"

How many days are there from the beginning of one period to the beginning of the next period?

"21"

How many pregnancies have you had?

"0"

How many miscarriages have you had?

"0"

Has anyone in your immediate family (grandparents, parents, self, siblings) had multiple births?

"No"

What method of birth control do you use?

"Birth Control Pills"

Do you drink?

"Yes"

How many drinks do you usually consume in a week?

"1-5"

Do you smoke or use tobacco products?

"No"

When is the last time you had marijuana?

"Never"

When is the last time you have used

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recreational or illicit drugs (cocaine, LSD, heroin, barbiturates, narcotics, opiates, amphetamines, hallucinogens, tranquilizers, PCP, steroids for non-medical reasons, or etc.)?

"Never"

Do you have any tattoos?

"Yes"

If "Yes", when and where on your body.

"side"

Do you have any body piercings?

"No"

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