ViaCord
From Revvity

Biological Mother or Surrogate
Health History Questionnaire (Adoption/Surrogate)

VID#: _____

Why Completing this Form is so Important:

- Without this information, ViaCord will be unable to release the child's newborn stem cells for therapeutic use in the future.
- This information is required for the potential therapeutic use of the newborn stem cells for the child or a first or second degree relative (parent, sibling, child, grandparent, aunt, uncle, niece, or nephew).
- ViaCord is required by state and federal regulations to ask questions to assess the potential risk for exposure to certain infectious diseases.

Who Should Complete this Form?

- The woman carrying the pregnancy should complete this document.

What You Need to Know Before Answering:

- The Health History Questionnaire contains questions that are similar to those asked when donating blood.
- It also contains questions about behaviors and travel history that you may find to be sensitive and of a personal nature.
- Each question must be completed and will need to be answered to the best of your ability.

Need Help with Questions:

- If you need help or have questions, call 800-998-4226.

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Biological Mother or Surrogate Information

First Name | Middle Initial | Last Name

Maiden Name | Date of Birth

Home Phone Number | Cell Phone Number

Email Address

Home Address

Street Address 1 | Street Address 2

City | State | Zip Code

Obstetric Care

**If not carrying the child, please put "N/A" for each field in the section below.*

OB/CNM First Name | OB/CNM Last Name

OB/CNM Practice Name | OB/CNM Phone Number

OB/CNM Address | City | State | Zip Code

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Delivery Information

**If not carrying the child, please put "N/A" for each field in the section below.*

Hospital Name

Hospital Phone Number

Hospital Address

City

State

Zip Code

Expected Due Date

Birth Type (Single, Twins, Triplets, etc.)

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Current Health

1. Currently taking an antibiotic?

   ○ Yes ○ No

2. Currently taking any other medication for an infection?

   ○ Yes ○ No

Please Read the Medication List

3. Are you now taking, or have you ever taken any medications on the Medication List? (See Appendix A)

   ○ Yes ○ No

4. Have you read the educational materials? (See Appendix D)

   ○ Yes ○ No

In the Past **8 Weeks** Have You:

5. Had any vaccinations or other shots, including smallpox?

   ○ Yes ○ No

   If yes, explain:

In the Past **12 Weeks** Have You:

6. Had contact with someone who had a smallpox vaccination (i.e., touching the vaccination area or the scab, including the covering bandages, or touching clothing, towels, or bedding that might have come in contact with an unbandaged vaccination area or scab)?

   ○ Yes ○ No

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In the Past **12 Months** Have You:

7. Had a medical diagnosis, positive/reactive test, or suspicion of the West Nile Virus infection?

   ○ Yes ○ No

8. Had a blood transfusion or blood component?

   ○ Yes ○ No

9. Come in contact with someone else's blood?

   ○ Yes ○ No

10. Had an exposure to known or suspected HIV, HBV, and/or HCV-infected blood through percutaneous inoculation (for example needle-stick) or through contact with an open wound, non-intact skin, or mucous membrane?

    ○ Yes ○ No

11. Had a transplant or graft from someone other than yourself, such as organ, bone marrow, stem cell, cornea, sclera, bone, skin, or other tissue?

    ○ Yes ○ No

12. Had sexual contact with anyone who has HIV/AIDS infection, including a positive or reactive test for the HIV/AIDS virus?

    ○ Yes ○ No

13. Had sexual contact with a prostitute or anyone else who takes money or drugs or other payment for sex?

    ○ Yes ○ No

14. Had sexual contact with anyone who has ever injected (including intravenous, intramuscular, or subcutaneous injections) drugs or steroids, or anything not prescribed by their doctor?

    ○ Yes ○ No

15. Had sexual contact with a male who has ever had sexual contact with another male?

    ○ Yes ○ No

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16. Had sexual contact with a person with hemophilia or other related clotting disorders, who received human derived clotting factor concentrates, or received factor VIII or factor IX concentrates, which was not heat-treated or otherwise virally inactivated?

Yes No

17. Had sexual contact with a person who has hepatitis B infection or clinically active (symptomatic) hepatis C infection?

Yes No

18. Lived with (resided in the same dwelling) another person who has hepatitis B or clinically active (symptomatic) hepatitis C infection?

Yes No

19. Had undergone tattooing, ear piercing or body piercing, in which sterile procedures were not used (e.g., contaminated instruments and/or ink were used, or shared instruments that had not been sterilized between uses were used)?

Yes No

20. Had a confirmed positive test or been treated for syphilis or other sexually transmitted infections?

Yes No

21. Been in juvenile detention, lockup, jail, or prison for more than 72 consecutive hours or had sex with an individual that has?

Yes No

22. Been bitten or scratched by any pet, stray, farm, or wild animal that was suspected of having rabies?

Yes No

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In the Past **3 Years** Have You:

23. Been outside the United States or Canada?

Yes No

If yes, please provide location, dates and duration :

In the Past **5 Years** Have You:

24. Received money, drugs, or other payment for sex?

Yes No

25. Injected (including intravenous, intramuscular, or subcutaneous injections) drugs, steroids, or anything not prescribed by their doctor?

Yes No

From **1980 through 1996**:

26. Did you spend 3 months or more cumulatively in the United Kingdom (UK) from the beginning of 1980 through the end of 1996? (Review list of countries in the UK. See Appendix B).

Yes No

27. Are you a current or former U.S. military member, civilian military employee, or a dependent of a military member or civilian employee who resided at U.S. military bases in Northern Europe (Germany, Belgium, Netherlands) for 6 months or more cumulatively from 1980 through 1990, or elsewhere in Europe (Greece, Turkey, Spain, Portugal, and Italy) for 6 months or more cumulatively from 1980 through1996?

Yes No

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From **1980 to the Present**, Did You:

28. Spend 5 years or more cumulatively in Europe? (Review list of countries in Europe. See Appendix B.)

Yes No

29. Receive any transfusion of blood or blood components in the United Kingdom or France? (Review list of countries in the UK. See Appendix B.)

Yes No

Have you **EVER**:

30. Had any positive test for the HIV/AIDS virus?

Yes No

31. Had hepatitis, any positive test for hepatitis, or hepatitis of unknown etiology?

Yes No

32. Had malaria or traveled (greater than 24 hours to less than 5 years) to or resided (greater than 5 years) in a malaria endemic area? (See Appendix C).

Yes No

33. Had Chagas disease and/or any positive test for *T. cruzi*?

Yes No

34. Had babesiosis?

Yes No

35. Received a dura matter (or brain covering) graft?

Yes No

36. Born/lived/traveled in Africa or had sexual contact with anyone who was born in or lived in certain countries in Africa after 1977? (Review list of countries in Africa. See Appendix B).

Yes No

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37. Received a blood transfusion or any medical treatment that involved blood in certain countries in Africa after 1977? (Review list of countries in Africa. See Appendix B).

Yes No

38. Had a transplant or other medical procedure that involved being exposed to live cells, tissues, or organs from an animal? Did you live with or have sex with someone who had?

Yes No

39. Tested positive for HTLV, had adult T-cell leukemia, or had unexplained paraparesis (partial paralysis affecting the lower limbs)?

Yes No

40. Had an autoimmune disease such as systemic lupus erythematosus, rheumatoid arthritis, sarcoidosis, etc.?

Yes No

41. Had cancer or undergone chemotherapy?

Yes No

42. Had been diagnosed with dementia or any degenerative or demyelinating disease of the central nervous system or a neurological disease such as Creutzfeldt-Jacob disease, multiple sclerosis, or Alzheimer's disease, or encephalitis of unknown etiology?

Yes No

43. Had received a pituitary-derived human growth hormone or any kind of growth hormone?

Yes No

44. Have hemophilia or related clotting disorders who have received human-derived clotting factor concentrates, or received factor VIII or factor IX concentrate, which was not heat-treated or otherwise virally inactivated?

Yes No

45. Have a known coagulation or platelet disorder?

Yes No

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46. Been significantly exposed to substances that may be transferred in toxic amounts (e.g., lead, mercury, gold)?

Yes No

47. Had or have any acute respiratory disease (e.g., pneumonia)?

Yes No

48. Have active tuberculosis or history of therapy for tuberculosis?

Yes No

49. Had or have any infectious skin disease (bacterial or fungal in origin) that creates a risk of contamination of the cord blood (stem) cells?

Yes No

50. Abused alcohol or drugs (intravenous, oral, prescription, non-prescription)?

Yes No

51. Have you, any of your relatives, the baby's biological father or any of the baby's other relatives had or been diagnosed with Variant Creutzfeldt-Jakob disease any other form of CJD?

Yes No

52. Have you recently experienced any of the following symptoms and they were **unexplained**? Check all that apply. If none apply, check "None Apply To Me".

- Muscle weakness or paralysis
- Persistent white spots or sores in the mouth
- Night sweats
- Lumps in your neck, armpits, or groin lasting more than a month
- Blue or purple spots on or under the skin or mucous membrane
- Jaundice
- Weight loss
- Hepatomegaly or enlarged liver
- Persistent diarrhea
- General rash

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- ○ Persistent cough or shortness of breath
- ○ Fever, headaches, body aches, or eye pain
- ○ Temperature higher than 100.5°F (38.06°C) for more than 10 days
- ○ Fast heartbeat
- ○ Neck stiffness
- ○ Episodes of stupor, disorientation, or tremors
- ○ None Apply To Me

53. Are you aware of any possible disease you may have that would be transmissible, or have a medical condition (i.e., malignancy) which may affect/or be affected adversely by the collection process?

○ Yes ○ No

Signature for Health History Questionnaire:

I certify that I have answered the health history questions above truthfully and to the best of my knowledge.

Signature of Birth Mother

Print Birth Mother's Name (full legal name)

Date Signed

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Appendix A – Medication List

Please tell us if you have EVER taken any of these medications:

- **Growth Hormone from Human Pituitary Glands**- used usually for children with delayed or impaired growth.
- **Insulin from Cows (Bovine, or Beef, Insulin)**- used to treat diabetes
- **Hepatitis B Immune Globulin**- given following an exposure to hepatitis B
    - **Note**: This is different from the hepatitis B vaccine, which is a series of 3 injections given over a 6-month period to prevent future infection from exposures to hepatitis B.
- **Unlicensed Vaccine**- usually associated with a research protocol.

Appendix B – Country Definition List

Travel:

United Kingdom: England, Northern Ireland, Scotland, Wales, Isle of Man, Channel Islands, Gibraltar, Falkland Islands.
Europe: 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, United Kingdom (see above), Yugoslavia, Montenegro, Serbia.
Africa: Benin, Cameroon, Central African Republic, Chad, Congo, Equatorial Guinea, Gabon, Kenya, Niger, Nigeria, Senegal, Togo, Zambia.

Appendix C – Websites

Malaria:

A list of malaria endemic areas can be found on the Centers for Disease Control (CDC) website:
https://www.cdc.gov/malaria/travelers/country_table/a.html

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Appendix D – Educational Materials

PLEASE READ THIS INFORMATION <u>BEFORE</u> YOU COMPLETE THE QUESTIONNAIRE! If you have any questions now or at any time during the screening process, please call 800-998-4226.

<u>ACCURACY AND HONESTY ARE ESSENTIAL!</u>

Your **complete honesty** in answering all questions is very important for the safety of the anyone who may receive the stem cells. **All information you provide is confidential.**

<u>DONOR ELIGIBILITY – SPECIFIC INFORMATION. Why we ask questions about sexual contact:</u>

Sexual contact may cause contagious diseases like HIV to get into the bloodstream and be spread through transfusions or transplants to someone else.

<u>Definition of "sexual contact":</u>

The words "have sexual contact with" and "sex" are used in some of the questions asked of you, and apply to <u>any</u> of the activities below, whether or not a condom or other protection was used:

1. Vaginal sex (contact between penis and vagina)

2. Oral sex (mouth or tongue on someone's vagina, penis, or anus)

3. Anal sex (contact between penis and anus)

<u>HIV/AIDS RISK BEHAVIORS AND SYMPTOMS</u>

AIDS is caused by HIV. HIV is spread mainly through sexual contact with an infected person OR by sharing needles or syringes used for injecting drugs.

<u>INFORM VIACORD IF YOU:</u>

- **Have AIDS or have ever had a positive HIV test**
- Have used needles to take drugs, steroids, or anything not prescribed by your doctor in the past 5 years.
- Are a male who has had sexual contact with another male, even once, in the past 5 years.
- Have taken money, drugs or other payment for sex in the past 5 years.
- Have had sexual contact in the past 12 months with anyone described above.
- Have had syphilis or gonorrhea in the past 12 months.
- In the last 12 months have been in juvenile detention, lockup, jail or prison for more than 72 hours.
- Have any of the following conditions that can be signs or symptoms of HIV/AIDS:
    - Unexplained weight loss or night sweats
    - Blue or purple spots in your mouth or skin
    - Swollen lymph nodes for more than one month
    - White spots or unusual sores in your mouth
    - Cough that won't go away or shortness of breath
    - Diarrhea that won't go away
    - Fever of more than 100.5^{o} F for more than 10 days

Remember that you <u>CAN</u> give HIV to someone else even if you feel well and have a negative HIV test. This is because tests cannot detect infections for a period of time after a person is exposed to HIV. **If you think you may be at risk for HIV/AIDS please inform ViaCord.**