

Medical Questionnaire (Maternal)

	YES	NO
Do you have HIV/AIDS?	<input type="checkbox"/>	<input type="checkbox"/>
Are you at Risk of HIV/AIDS?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have Hepatitis A, B or C at present?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had Hepatitis A, B or C in the past?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had malaria in the past 3 years?	<input type="checkbox"/>	<input type="checkbox"/>
Are you diabetic?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any known cancer(s)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any cancer(s) in the past?	<input type="checkbox"/>	<input type="checkbox"/>
Have you undergone a graft or an organ transplant?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a sexually transmitted disease?	<input type="checkbox"/>	<input type="checkbox"/>
Are you at risk of having a sexually transmitted disease?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a blood transfusion within the last year?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any tattoo or piercing on your body within 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been told you should never give blood?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have Creutzfeld-Jacob Disease (CJD)?	<input type="checkbox"/>	<input type="checkbox"/>
Does anyone in your family have CJD?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>

If you have answered yes to any of the above questions, please provide details below (you may use additional sheets of paper in order to provide as much detail as possible):

I hereby declare that the information provided in this medical questionnaire is correct to the best of my knowledge. I also give consent to Cells Limited to forward this questionnaire to their Medical Advisor at Cryo-Save, as per due procedure. I understand that this questionnaire shall be maintained in my records and would be subject to strict controls as per the Data Protection Act.

Mother's Signature _____

Mother's Date of Birth _____

Print Name: _____

Address: _____

Dated: _____