

**INDIVIDUAL ACCOUNT  
CLIENT INFORMATION HEALTH QUESTIONNAIRE  
(ALL INFORMATION IS STRICTLY CONFIDENTIAL)**

**1. Mother's Information (Mother of unborn child)**

- Surname: \_\_\_\_\_ First Name and Initials: \_\_\_\_\_
- Maiden Name : \_\_\_\_\_
- Date of Birth: yy/\_\_\_\_\_ mm/\_\_\_\_\_ dd \_\_\_\_\_ Expected Due Date : yy/\_\_\_\_\_ mm/\_\_\_\_\_ dd \_\_\_\_\_
- Healthcare Insurance No: \_\_\_\_\_ (for sample identification only)
- Occupation : \_\_\_\_\_ Work Phone #: ( \_\_\_\_\_ )
- Home Phone #:#: ( \_\_\_\_\_ ) Cell Phone #: ( \_\_\_\_\_ )
- Email : \_\_\_\_\_
- Scheduled Cesarean Section : Yes                      No
- Multiple Births (i.e. Twins): Yes                      No
- **Permanent Mailing Address:**  
    Apartment No. / Home Address: \_\_\_\_\_  
    City / Town : \_\_\_\_\_ Province : \_\_\_\_\_ Postal Code : \_\_\_\_\_
- Citizenship: \_\_\_\_\_ Place of Birth : \_\_\_\_\_
- Country of Permanent Residence : \_\_\_\_\_
- Of which ethnic group do you consider yourself a member? Please circle on:  
**Caucasian    African    Asian    European    First Nation    Middle Eastern    Hispanic    Other**  
    If Other, please specify: \_\_\_\_\_

**2. Father's Information (Father of unborn child)**

- Surname: \_\_\_\_\_ First Name and Initials: \_\_\_\_\_
- Date of Birth: yy/\_\_\_\_\_ mm/\_\_\_\_\_ dd \_\_\_\_\_ Expected Due Date : yy/\_\_\_\_\_ mm/\_\_\_\_\_ dd \_\_\_\_\_
- Occupation : \_\_\_\_\_ Work Phone #: ( \_\_\_\_\_ )
- Home Phone #:#: ( \_\_\_\_\_ ) Cell Phone #: ( \_\_\_\_\_ )
- Email : \_\_\_\_\_
- Citizenship: \_\_\_\_\_ Place of Birth : \_\_\_\_\_
- Country of Permanent Residence : \_\_\_\_\_
- Of which ethnic group do you consider yourself a member? Please circle on:  
**Caucasian    African    Asian    European    First Nation    Middle Eastern    Hispanic    Other**  
    If Other, please specify: \_\_\_\_\_

3. Delivery Site and Medical Professional Information

- Delivery Hospital: \_\_\_\_\_
- Delivery Hospital Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_
- Attending Delivery Doctor's / Nurse's Name : \_\_\_\_\_
- Attending Delivery Doctor's / Nurse's Office Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_

The following questions are to be answered by the mother and father of the unborn child (biological parents). Answer YES or NO to the questions, by marking an X corresponding box. An incomplete questionnaire may result in regulatory restrictions being applied to the utilization and /or storage of your child's umbilical cord blood stem cells. Please contact Tran-Scell Biologics Pvt. Ltd., if you have any questions or concerns regarding the completion of this questionnaire.

All information is strictly confidential

4. Health Questionnaire

Mother  
YES NO      Father  
YES NO

Are you feeling healthy and well today?

• HAVE YOU:

1. (a) had any complications with this pregnancy?

(b) had any complications with any other pregnancy?

2. prior to this pregnancy, had any health issues?

3. been prescribed maternal medications for any reason, with the exception of vitamins, iron supplements?

4. conceived as a result of using either donor sperm, donor ovum or surrogacy? If 'YES' attach family medical history, if available.

5. ever attempted to collect cord blood using your current name or a different name at this cord blood bank?

• HAVE YOU EVER:

6. received human pituitary derived growth hormones?

7. received a dura mater (or brain covering) graft?

8. been diagnosed with a blood or bleeding disorder (i.e. leukemia)?

9. had seizures, convulsions, or fainting spells?

10. been diagnosed with malaria or rabies?

11. been deferred or refused as a blood donor

12. had any infections, surgery or serious illness such as heart and lung disease, cancer, leukemia, lymphoma, melanoma, diabetes, chest pains, asthma or shortness of breath?

13. had hepatitis, yellow jaundice, liver disease, or a positive blood test for hepatitis A, B, or C?

4. Health Questionnaire

Mother  
YES NO

Father  
YES NO

• HAVE YOU EVER:

14. been HLA tissue typed?

15. had clinical or laboratory evidence (a positive test) of HIV, HTLV-I, HTLV-II, HPV or syphilis?

16. had AIDS or any of its' complications, (progressive multifocal Leukoencephalopathy or lymphoma); had a sexual partner who has had AIDS (HIV) or any of its' complications or have been at Risk for AIDS?

**PLEASE EXPLAIN ANY 'YES' ANSWERS TO THE QUESTIONS.**

(Document the question number with corresponding explanation. Attach additional pages if necessary.)

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**I (we) certify that I (we) have answered the questions truthfully and to the best of my (our) knowledge.**

\_\_\_\_\_  
**Print Name of Mother** (of unborn child)

\_\_\_\_\_  
**Signature of Mother** (of unborn child)

\_\_\_\_\_  
**Date (yy/mm/dd)**

\_\_\_\_\_  
**Print Name of Mother** (of unborn child)

\_\_\_\_\_  
**Signature of Mother** (of unborn child)

\_\_\_\_\_  
**Date (yy/mm/dd)**

**Tran-Scell Biologics Pvt. Ltd recommends you discuss with your delivering physician / nurse your intention to have your child's umbilical cord blood collected.**

**Mothers Surname:** \_\_\_\_\_ **First Name:** \_\_\_\_\_