Mother's Health History Questionnaire

Why Completing This Form Is So Important:

- Without this information, ViaCord will be unable to release your 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 by your Child or a family member such as a parent, sibling, child, grandparent, aunt, uncle, niece, or nephew.
- ViaCord is required by federal regulations to ask questions to assess the potential risk for exposure to certain infectious diseases.

Who Should Complete This Form?

- Biological Mothers should complete all relevant portions.

What You Need to Know Before Answering:

- The Health History Questionnaire contains questions that are similar to those asked when someone donates blood.
- It also contains questions about behaviors and travel history that you may find to be sensitive and of a personal nature.
- Each question will need to be answered to the best of your ability.
- The information provided is confidential and will only be shared with you, your physician, or the Child's physician.
- ViaCord may be required to release or make available information regarding certain positive test results, such as HIV, AIDS, hepatitis C, or other infectious diseases to federal, state, or local government agencies.
- You will be asked to provide consent for a maternal blood sample.
- See Appendices for Definition of Terms, Medication List, Country Definition List, Vaccination List and your submission options if you choose to forego electronic signature.

Office Use Only
VID Number:

1.0 Mother's Information

First Name

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

2.0 Obstetric Care/Delivery Information

OB/CNM First Name

OB/CNM Last Name

Address

State

Zip Code

Mother's Current Health

The following questions pertain to the current health of the mother.

Please answer EITHER "Yes" or "No" for each.

3.0 Do you currently have an infectious skin disease?

○ Yes ○ No

If YES, please explain.

3.1 Are you currently taking an antibiotic?

○ Yes ○ No

If YES, please answer below.

Antibiotic?	Reason for Taking?

3.2 Do you currently have any medical condition that could be affected adversely by the collection procedure? (Such conditions may include: cancer, diabetes, blood disease, bleeding problems, lung disease, heart disease, chest pain, stroke, seizure, or multiple sclerosis.)

Please consult your physician for any identified medical condition applicable to this question.

○ Yes ○ No

3.3 Did you undergo any chemotherapy during your pregnancy?

○ Yes ○ No

3.4 Mother's Clinical Symptoms

If you have had any of the following clinical or physical symptoms and they are UNEXPLAINED, check the box. If you have none of these symptoms check None of The Above 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
- ☐ Cough or shortness of breath
- ☐ Headaches, body aches, or eye pain
- ☐ Temperature higher than 100.5 degrees F (38.0 degrees C) for more than 10 days
- ☐ Fast heart beat
- ☐ Neck stiffness
- ☐ Episodes of stupor, disorientation, or tremors
- ☐ NONE OF THE ABOVE APPLY TO ME

3.5 Are you now or have you ever taken any medications on the Medication List (Please refer to the Medication List in Appendix C)?

○ Yes ○ No

If YES, please identify below:

Medication?	Last Dose Taken?

Travel

The following questions pertain to areas in which you have lived or to which you have traveled. Please refer to the Country Definition List in Appendix D.

4.0 Have you traveled outside of the United States or Canada in the last 3 years?

○ Yes ○ No

If YES, Please list all countries in which you have traveled or lived even if you do not see them on Appendix D and include approximate dates (month/year):

Countries traveled/lived?	Month/Year traveled/lived?

4.1 Since 1980, have you spent more than a total of 3 months in the United Kingdom or Europe (this includes living, traveling, or serving at a US Military base)? (Refer to the Country Definition List in Appendix D)

○ Yes ○ No

4.2 Between 1980 through 1996 have you lived in or traveled to Europe as a member of the US Military, a civilian military employee, or a dependent of a member of the US Military? (Refer to the Country Definition List in Appendix D)

○ Yes ○ No

4.3 Since 1980, have you received a transfusion of blood, platelets, cryoprecipitate or granulocytes in the United Kingdom or Europe? (Please refer to the Country Definition List in Appendix D)

Yes No

4.4 Have you lived in or traveled to a Zika affected area at any time during your pregnancy? A list of areas with active transmission of Zika can be found on the Centers for Disease Control (CDC) website (http://www.cdc.gov/zika/areasatrisk.html)

Yes No

The Past 12 Months

Thinking back over the past twelve months, have you:

5.0 Received blood, blood factor products, derivatives, or a tissue/organ transplant?

Yes No

5.1 Come into contact with someone else's blood (e.g., accidental needle stick)?

Yes No

5.2 Had a tattoo, any type of piercing (ear or body), acupuncture, or had a needle gun used on you?

Yes No

5.3 Received shots including Rh immune globulin, or vaccinations/immunizations? (Please refer Appendix E Vaccination/Immunization List)

Yes No

If YES, please list what you received and when:

Shots Received?	Date Received?

5.4 Been diagnosed with the West Nile Virus, Dengue, Chikungunya, or Zika virus?

Yes No

If YES, please specify…

5.5 Been in close contact with a person who was vaccinated for smallpox and you developed a rash or other symptoms related to exposure?

Yes No

5.6 Been diagnosed with Syphilis or Gonorrhea?

Yes No

5.7 Lived in the same household as another person who has been diagnosed with Hepatitis B or clinically active Hepatitis C?

Yes No

5.8 Been in jail, prison, lock up, or juvenile detention for more than 72 hours?

Yes No

5.9 Been bitten by an animal suspected of having rabies within the past 6 months?

Yes No

5.10 Had sexual contact with a person who has Hepatitis or Jaundice (not Infant Jaundice)?

Yes No

5.11 Have you had sexual contact with a person with a history of ever testing positive for HIV?

Yes No

5.12 Had sexual contact with a person who takes money or drugs or other payment in exchange for sex?

Yes No

5.13 Had sexual contact with a man who has ever had sexual contact with another man?

Yes No

5.14 Had sexual contact with a person who has taken intravenous drugs not prescribed by a physician?

Yes No

5.15 Had sexual contact at any time during your pregnancy with a person who has been diagnosed with Zika virus infection within the last 6 months?

Yes No

5.16 Had sexual contact at any time during your pregnancy with a person who lived in or traveled to a Zika affected area within the last 6 months? A list of areas with active transmission of Zika can be found on the Centers for Disease Control (CDC) website at http://www.cdc.gov/zika/areasatrisk.html.

Yes No

Ever

Have you ever:

6.0 Been diagnosed with, or tested positive for HTLV, Hepatitis B, or Hepatitis C?

○ Yes ○ No

If YES, please specify…

6.1 Been diagnosed with, or tested positive for HIV?

○ Yes ○ No

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

○ Yes ○ No

6.3 Been diagnosed with Tuberculosis, Malaria, Chagas Disease, Babesiosis, or Acute Respiratory Disease?

○ Yes ○ No

If YES, please specify:

☐ Tuberculosis ☐ Malaria ☐ Babesiosis

☐ Chagas Disease ☐ Acute Respiratory Disease

6.4 Been diagnosed with any form of Creutzfeldt-Jakob Disease (CJD)?

Yes No

6.5 Have a history of Ebola virus infection or disease?

Yes No

6.6 Had head or brain surgery with a transplanted brain covering (dura mater)?

Yes No

6.7 Been diagnosed with dementia, or any degenerative or demyelinating disease of the central nervous system?

Yes No

6.8 Had a transplant or medical procedure involving exposure to organs, tissues, or living cells from an animal?

Yes No

6.9 Had intimate contact with a recipient of a transplant or medical procedure involving exposure to organs, tissues, or living cells from an animal? (Intimate contact includes contact with blood, saliva, and body fluids.)

Yes No

6.10 Been deferred as a blood donor for a reason other than anemia or being underweight?

Yes No

If YES, please explain…

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

Yes No

6.12 Taken money, drugs or other payment in exchange for sex?

Yes No

7.0 Family Genetic History (required for Biological Mother only)

Has anyone in your maternal or paternal family:

Been diagnosed with any of the following: Aplastic Anemia, Fanconi Anemia, Thalassemia, Chronic Granulomatosis Disease (CGD), Sickle Cell Anemia, Hunter Syndrome, Hurler Syndrome, or any other storage disorder, severe combined immunodeficiency syndrome or blood/bleeding disorders or other genetic disorders?

Yes No

If YES, please explain…

7.1 Had Creutzfeldt-Jakob Disease (CJD)?

Yes No

INFORMED CONSENT FOR MATERNAL BLOOD SAMPLE

I am pregnant with a child. If I am the child's Biological Mother, Egg Donor, or if I am a Gestational Carrier for the biological child of others, I understand and agree to the following:

- I must be assessed by a physician prior to providing this informed consent.
- I must provide samples of my own blood drawn at the time of the child's delivery. The blood sample will be collected by a doctor, nurse, or mid-wife at the time of delivery.
- I must provide the medical history in the Health History Questionnaire. If I am the Biological Mother, I must also fill out the relevant portions of the Health History Questionnaire that contain a genetic history. The Gestational Carrier should fill out the relevant portions of the Health History Questionnaire to the extent the Gestational Carrier is aware of the Egg Donor's genetic history. The Adoptive Parent(s) should fill out the relevant portions of the Health History Questionnaire to the extent the Adoptive Parent(s) are aware of the Biological Mother's genetic history.

I understand that there are risks to having a sample of my own blood drawn, which may include bruising, redness, discomfort, or inflammation around the needle site as well as, in very limited cases, more significant complications.

I authorize ViaCord to test my blood for certain infectious diseases including but not limited to:

- Human Immunodeficiency Virus (HIV)
- Hepatitis B Virus
- Hepatitis C Virus
- Human T-Lymphotrophic Virus (HTLV)
- Cytomegalovirus (CMV)
- Syphilis
- And any other infectious/communicable disease as required under federal or state law.

I understand that testing may result in a decision to store the Newborn Stem Cells, but they may only be released for transplant or other treatment with the approval of the ViaCord Medical Director and the treating physician. I understand that I will only be contacted by ViaCord in the event that test results for my sample are positive for HIV, Hepatitis B and C Virus, HTLV, Syphilis, and any other relevant communicable disease as required under federal or state law.

I authorize ViaCord to provide me with test results and to furnish them to my physician and the Child's physician, if applicable, and as described above. The test results may also be used for research purposes and for analyses and in publications, provided that they are aggregated with other data and do not contain donor identification. For Adoption/Surrogate Cases: ViaCord may not disclose any health information about the Biological Mother/Gestational Carrier to anyone but the Biological Mother/Gestational Carrier and her physician. Any communication about the Biological Mother/Gestational Carrier's health information must be through channels established by your surrogate/adoption contract.

Appropriate confidentiality will be maintained for all patient records concerning the maternal blood sample. ViaCord may be required to release or make available information regarding certain positive test results, such as

HIV, AIDS, Hepatitis C, or other infectious disease to the U.S. Food and Drug Administration, the U.S. Department of Health and Human Services, the Center for Disease Control, or other federal, state, or local government agencies.

I understand that I have the right to have my questions answered. If I have any questions regarding this Informed Consent or the Health History Questionnaire, I may contact ViaCord Customer Service at 800-998-4226.

I understand that I have that right to withdraw my consent to collect the maternal blood samples prior to the collection or testing of the samples and that by withdrawing my consent, the Newborn Stem Cells will not be collected, processed, and/or stored, as applicable.

I certify that I have read and understand the Informed Consent and answered the Health History questions above truthfully and to the best of my knowledge.

Signature of Mother

Print Mother's Name (full legal name)

Date Signed

Appendix A – Returning Your Forms

Please sign, date, and return ALL pages of the Health History Questionnaire to ViaCord within seven days of your order. If you choose to forego electronic signature, you may sign, and return by email. EMAIL your completed form to: FORMS@Viacord.com

Appendix B – Definition of Terms

The following terms will be used throughout this Health History Questionnaire:

- Newborn Stem Cells refer to the cord blood stem cells or cord tissue stem cells, either alone or collectively, that are found in the umbilical cord of the child who is being delivered.
- Biological Mother refers to a woman who is pregnant with a child and the child she is giving birth to shares her DNA.
- Biological Father refers to a man who shares DNA with a child.
- Gestational Carrier refers to a woman who is pregnant with a child and the child she is giving birth to may or may not NOT share her DNA.
- Egg Donor refers to a woman who donates her egg to a Gestational Carrier.
- Adoptive Parent(s) refer to someone who enters into a contract with a third- party for the guardianship rights of a Child.

Appendix C – Medication List

Please tell us if you are now taking or if you have EVER taken any of the following medications:

Accutane©, Absorica, Amnesteem, Claravis, Myorisan, Sotret, Zenatane (isotretinoin) for treatment of severe acne, Soriatane© (acitretin) for treatment of severe psoriasis, Human-derived clotting factor concentrates, Insulin from a cow source, Growth hormone from human pituitary glands (not infertility hormones), Tegison© (etretinate) for treatment of severe psoriasis, Proscar© (finasteride) for treatment of prostate gland enlargement, Avodart©, Jalyn (dutasteride) for treatment of prostate enlargement, Erivedge® (Vismodegib), Propecia© (finasteride) for baldness.

If you would like to know why these medicines affect the therapeutic use of the newborn stem cells, please keep reading:

- If you have taken or are taking Proscar©, Avodart©, Jalyn, Propecia, Accutane©, Absorica, Amnesteem, Claravis, Erivedge®, Myorisan, Sotret, Soriatane©, Tegison, or Zenatane these medications can cause birth defects.
- Growth hormone from human pituitary glands was prescribed for children with delayed or impaired growth. The hormone was obtained from human pituitary glands, which are found in the brain. Some people who took this hormone developed a rare nervous system condition called Creutzfeldt-Jakob Disease (CJD, for short).
- Insulin from cows (bovine, or beef, insulin) is an injected material used to treat diabetes. If this insulin was imported into the US from countries in which "Mad Cow Disease" has been found, it could contain material from infected cattle. There is concern that "Mad Cow Disease" is transmitted by transfusion.
- Experimental Medication is usually associated with a research protocol and the effect on blood is unknown.

Appendix D – Country Definition List

Please list all countries in which you have traveled or lived even if you do not see them on the list.

A list of areas with active transmission of Zika can be found on the Centers for Disease Control (CDC) website (http://www.cdc.gov/zika/ areasatrisk.html).

United Kingdom: England, Gibraltar, Northern Ireland, The Channel Islands, The Falkland Islands, The Isle of Man, Scotland, Wales. 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. Africa: Benin, Cameroon, Central African Republic, Chad, Congo, Equatorial Guinea, Gabon, Kenya, Niger, Nigeria, Senegal, Togo, Zambia. Others: All countries in South America, Central America, Caribbean, Puerto Rico, Mexico and Pacific Islands.

Appendix E – Vaccination/Immunization List

- Live vaccines (e.g., Measles, Mumps, Herpes Zoster)
- Vaccinations for Smallpox, vaccine typhoid, yellow fever, Japanese Encephalitis
- Hepatitis B Immune Globulin (for exposure) (not Rh immune globulin)
- Experimental medications/vaccines
- Rabies Vaccine (for exposure)

If you would like to know why these vaccines/immunizations affect the therapeutic use of the newborn stem cells, please keep reading:

- Hepatitis B Immune Globulin (HBIG) is an injected material used to prevent infection following an exposure to hepatitis B. HBIG does not prevent hepatitis B infection in every case.
- Unlicensed (Experimental) Vaccine is usually associated with a research protocol and the effect on blood is unknown.