A CRYO-SAVE PARTNER

# Medical Questionnaire (Maternal)

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

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):



**Cells Limited 221-225 Station Road | Harrow | HA1 2TH | United Kingdom**
**Freephone: 0800 11 CELLS (23557) | Fax: 0845 226 0866 | Email: info@cellslimited.com**

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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, and applicable laws of England and Wales.

Mother's Signature Dated _____

Mother's Name: _____

Client ID: _____

Address: _____

_____

Post Code: _____

Country: _____



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