ANAMNESTIC QUESTIONNAIRE

Dear customer, you have read the information notes for the storage of peripheral blood mononuclear fraction and wish to cryopreserve it for possible autologous use.
We would be grateful if you would answer the following questions truthfully by ticking the corresponding box. Please indicate any doubts or specify details in the "NOTES" box under D or contact the SSCB for information on +41 91 960 22 20 or send an email to sscb@cellssolutions.com.

Deadline for submitting the questionnaire
The anamnestic questionnaire must be received by email to the SSCB before the arrival of your blood sample at the laboratory or, together with the peripheral blood sample, attached to the transport kit.

Method of delivery of the questionnaire
Transmission can be made by post to

SSCB - Swiss Stem Cells Biotech AG, Via Pizzamiglio 12 CH - 6833 Vacallo (Switzerland)
or **by e-mail to: sscb@cellssolutions.com**

A. Information about the patient		
Surname		
Name		
Date of birth		
Via		
Location		ZIP/NAP:
Telephone/email		

B. Ethnic information about the patient			
Which ethnic group do you belong to? Please tick the corresponding box			
African	AFNA	North Africa	☐
	AFSS	Sub-Saharan Africa	☐
Asian	AS	Central Asia	
		North-East Asia Japan, Korea	
		Oceania, Pacific Islands, Australia	☐
		Southeast Asia, China, Vietnam	
		Middle East, Turkey	
Caucasian	CAU	Europe, North America,	☐
Hispanic	HI	Central America, South America, Caribbean	☐
Mixed	MX		☐
More	OT		☐
Unknown	Unknown		☐

C. ANAMNESI

General questions	Yes	NO	Checked by SSCB
1. Were you adopted as a child?	☐	☐	
2. During the past 4 weeks have you been ill, undergone medical treatment or had a fever with a temperature above 38° C? If yes, please indicate the cause (if known)	☐	☐	
3. a) Have you used any medication (e.g. tablets, injections, suppositories) during the last week? If so, please specify:	☐	☐	
b) Have you been on psoriasis medication in the last 3 years? If you specify the name of the medicine:	☐	☐	
4. a) Have you undergone immunotherapy (plasma, cells or serum of human or animal origin)?	☐	☐	
b) Have you been vaccinated in the last 4 weeks? Influenza ☐ Hepatitis B ☐ Pertussis ☐ Rubella ☐ Rabies ☐ Tetanus ☐ Covid-19 ☐ More☐ which one? ..... When?	☐	☐	
5. Do you suffer or have you suffered in the past from any of the following diseases or symptoms? If yes, please specify (disease, time of onset, treatment, cured or not)	☐	☐	
(a) Hypertension:	☐	☐	
(b) Cardiovascular disease:	☐	☐	
(c) Lung disease:	☐	☐	
d) Disease of the digestive system:	☐	☐	
e) Disease of the urogenital system:	☐	☐	

f) Disease of the nervous system:	☐	☐	
g) Disease of the immune system: (e.g. allergy, chronic inflammatory disease, autoimmune disease):	☐	☐	
(h) Infectious disease:	☐	☐	
(i) Contact with a person suffering from an infectious disease: Which disease? ..... When?.....	☐	☐	
(j) Blood disease:	☐	☐	
k) Tumour disease, cancer:	☐	☐	
l) Diabetes: Type I ☐ Type II☐ Gestational diabetes ☐	☐	☐	
m) Thyroid disease: Hashimoto's thyroiditis ☐ Basedow's disease ☐ Other ☐ Please specify: ..... Type of treatment: ..... From when to when:	☐	☐	
(n) Other illness:	☐	☐	
6. Over the past 12 months you have: a) suffered an accident ☐ underwent an operation ☐ if you specify:	☐	☐	
b) received a blood transfusion (red blood cell concentrates, of platelets, plasma) If so when? ..... For what reason? ..... In which country?	☐	☐	

7.	Risk exposure Creutzfeldt-Jakob disease: (a) have you or a member of your family been affected or suspected of being affected by Creutzfeldt-Jakob disease? If yes, please specify who: ..... b) Have you received a human tissue transplant? c) Have you received an animal tissue transplant? d) Have you had brain or spinal cord surgery?	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	
8.	Tropical viruses (including: Chikungunya, Dengue, West Nile and Zika viruses) a) Have you travelled, stayed outside Europe in the last 6 months? If so where? ..... When did you return? ..... Did you present symptoms (e.g. fever) on site or after your return? ....b) Have you or your sexual partner been infected with the Zika virus in the last 4 months?	☐ ☐	☐ ☐	
9.	Malaria risk exposure: a) Have you already suffered from one or more bouts of malaria? If so when? ..... b) Have you travelled to a malaria region in the last 3 years? If so where? ..... When?.....	☐ ☐	☐ ☐	
10.	Exposure to the risk of Chagas disease a) Have you ever contracted Chagas' disease? b) Were you or your mother born, raised or lived for more than 6 months outside Europe? If so, who? ..... In which country?	☐ ☐	☐ ☐	
11.	Have you suffered from any of the following diseases in the past? ☐ Tuberculosis? ☐ Borreliosis? ☐ Brucellosis? ☐ Bone infection? ☐ Q-fever? ☐ Toxoplasmosis? ☐ Babesiosis? ☐ Chagas' disease? ☐ Leishmaniasis? If so when?	☐	☐	
12.	Over the past two months you have suffered: ☐ A tattoo? ☐ A gastro-colonoscopy? ☐ An acupuncture treatment? ☐ A depilation with needles? ☐ Permanent make-up? ☐ A piercing? ☐ A wound with a dirty needle? If yes, when: ..... Were sterile instruments used (professional service)? ☐ YES ☐ NO	☐	☐	
13.	a) Have you suffered from hepatitis (jaundice) in the past	☐	☐	

which one? Hepatitis A ☐ Hepatitis B ☐ Hepatitis C ☐ Hepatitis E ☐ b) Has anyone in your family or circle of friends or your sexual partner suffered from hepatitis in the last 12 months? If yes, please specify who: ..... Which one? Hepatitis A ☐ Hepatitis B☐ Hepatitis C ☐ Hepatitis E ☐	☐	☐	
14. a) In the last 12 months have you stayed for at least 6 months in a country with a high incidence of HIV? If so, where? ..... b) During your stay were you exposed to a potential risk of (e.g. through sexual intercourse and/or medical or paramedical interventions such as blood transfusion, tattooing, piercing)?	☐ ☐	☐ ☐	
15. Have you been exposed to any of the following risk situations? a) Change of sexual partner within the last 4 months b) Sexual intercourse in return for the acceptance of money, drugs or medicines in the last 12 months. c) sexual relations with a partner who has had sex with men in the last 12 months d) Injections of drugs currently or in the past? e) Positive test for AIDS, syphilis or hepatitis B and C?	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	
16. Over the past 12 months, have you had sexual relations with partners who have been exposed: (a) to one of the risk situations mentioned in paragraph 15 b) have received blood transfusions in countries whose population is heavily affected by the AIDS epidemic? c) Have they been exposed to the risk of HIV infection in another way in a country with a high incidence of HIV (sexual intercourse, tattooing, piercing)?	☐ ☐ ☐	☐ ☐ ☐	
17. In the last 12 months have you had any symptoms or been treated for Chlamydia, genital herpes, syphilis, or other sexually transmitted diseases?	☐	☐	
18. Have any cases of the following diseases occurred in your family? If yes, please specify the degree of relationship a) Red blood cell diseases (e.g. thalassaemia, sickle-cell anaemia, aplastic anaemia) Which one? ..... ☐father ☐ mother ☐ brothers or sisters b) Platelet diseases (e.g. thrombocytosis, thrombocytopenia) Which one? ..... ☐father ☐ mother ☐ brothers or sisters c) Metabolic diseases (e.g. Tay-sachs, Fabri's, Gaucher, Nieman-Pick, diabetes, etc.). Which one? ..... ☐father ☐ mother ☐ brothers or sisters d) Congenital immune deficiency/immunodeficiency. ☐father ☐ mother ☐ brothers or sisters e) Acquired/hereditary immune system diseases (e.g. Lupus, Basedow's disease) Which one? ..... ☐father ☐ mother ☐ brothers or sisters f) Malignant blood diseases (e.g. leukaemia, myeloma, myelodysplastic syndrome, etc.). Which one? ..... ☐father ☐ mother ☐ brothers or sisters g) Other types of cancer. Which one?	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐	

☐father ☐ mother ☐ brothers or sisters h) genetic, haemorrhagic or thrombophilic coagulation diseases (e.g. haemophilia von Willebrand disease) Which one? ..... ☐father ☐ mother ☐ brothers or sisters (i) Other illness Which one? ..... ☐father ☐ mother ☐ brothers or sisters	☐ ☐	☐ ☐	

D: Comments on the questionnaire (patient)

Indicate additional details or doubts concerning the completion of the questionnaire by specifying the number of the question to which they relate.

Question No.

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Question No.

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Question No.

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Question No.

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I confirm the accuracy of my personal data and that I have answered all questions correctly and truthfully.

Full name: .... Date of birth: .....

Date and signature: .....

E. Checking of the questionnaire by qualified personnel

Information and observations.

Question No.

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Question No.

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Question No.

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Question No.

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Questionnaire checked: Date..... Seen.....

Evaluation of the SSCB medical service: ☐ Eligible for

☐ Not eligible for conservation

Comments: .....

Date and signature .....

F. Doctor's assessment of the patient (optional)

After reading the medical questionnaire and the patient's medical records, I certify that at present there are no signs to suspect present or past high-risk behaviour for transmission of infectious diseases (HIV, HTLV, hepatitis B or C, or other sexually transmitted diseases). To the best of my knowledge, I confirm that this patient is suitable for the collection and storage of peripheral blood mononuclear fraction. In the event of any new health information that may compromise this process I assure to provide it to the bank.

Full name: .....

Date and signature: .....