HEALTH HISTORY RECORD

Key Biologics, LLC

1256 Union Avenue, Suite 200 · Memphis, TN 38104

SUBJECT ID NUMBER		BIRTH DATE MMDDYYYY	BLOOD TYPE	CMV	DATE
LAST NAME	FIRST NAME	MIDDLE INITIAL	SEX	RACE	LAST VISIT
CURRENT MAILING ADDRESS			PERMANENT MAILING ADDRESS (IF DIFFERENT FROM CURRENT)		
CITY		STATE ZIP	CITY	STATE	ZIP
PRIMARY PHONE		ALTERNATE PHONE	E-MAIL ADDRESS		
EMERGENCY CONTACT NAME, PHONE NUMBER, RELATIONSHIP					

INFORMED CONSENT: I agree to have whole blood, blood components, or bone marrow collected by Key Biologics, LLC. I consent to the use or disposition of my blood or bone marrow for purposes that have been discussed with me or in any manner deemed appropriate by Key Biologics, LLC. The medical history provided by me and shown on this form is true and accurate to the best of my knowledge. An explanation of the collection procedure has been provided to me. I understand the risks involved and my questions have been answered satisfactorily. I understand my whole blood, blood components or bone marrow along with information concerning my medical history will be used in research or other activities. My name and other identifying information will be de-linked from the materials prior to their use in order to protect my confidentiality unless I specifically agree to have such identifying information linked in a manner that will disclose my identity. I understand my blood will be tested for infectious diseases and I will be notified of abnormal findings that would result in permanent deferral from voluntary donations to the general public. I also understand that there are circumstances in which infectious disease tests are not performed. Test results will be kept confidential and will not be released without written consent, except as required by applicable law or the order of a court of competent jurisdiction and if I am in the military service, to applicable military commands. If this testing indicates I should no longer donate blood for transfusion because of a risk of transmitting the AIDS or hepatitis virus or other infectious diseases, my name will be entered on a list of permanently deferred blood donors and the test results and my name and contact information will be provided to the Shelby County Health Department as required by law. I have reviewed and understand the information in the educational materials provided to me and understand people engaging in behavior known to be a high-risk for acquiring HIV should not donate blood for transfusion to the general public. (**SIGNATURE ON BACK OF FORM**)

Your contact information will be entered into a database that is confidentially maintained and will be used to contact you regarding future opportunities to participate as a donor and/or as a participant in research studies performed at Key Biologics, LLC. Please indicate your agreement to be contacted by checking the YES box and enter your initials below.
If you do not wish to be contacted about these opportunities, check the NO box and enter your initials below. If you check NO, we must still retain your contact information in our files in the event we need to contact you related to your current and/or past donations.
□ YES □ NO Please enter your initials ________

Collection Type		Unit Information	Phlebotomy	Subject Registration
❑ PRE SCREEN	❑ Sample	Unit Number		
❑ Whole Blood	❑ MNC			
❑ SRCE LEUKO	❑ AUTO PBSC	Bag Mfg.		Form Review 1
❑ Plateletpheresis	❑ Bone Marrow	Lot #		
❑ Red Blood Cells	❑ Plasma			Form Review 2
❑ OTHER: ________________________		Segment #		

Physical Exam

HCT: Female: 38 - 55% Male: 39 – 55%	BP: 180-100 / 90-50	Pulse 50 – 100 ____________ Rhythm regular? Yes No	Temp: ≤ 99.5° F ________° F	Height ______ ft ______in	Weight Whole Blood ≥ 130lbs Other ≥ 110lbs __________ lbs	Arms condition: L – OK R - OK	Initials:

CUSTOMER:	Start Time	Phleb	Bag Weight (gm)	Reaction Code
				1 2 3
PROTOCOL:	Stop Time	Phleb		Other
			Venipuncture Site(s)	
Deferral/Restriction · Effective Date	Failure:		R AC _________ L AC _________	

Additional Comments:

Post Collection Instructions were provided to subject. Initials __________

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#	Answer to the best of your knowledge	NA	Y	N
1	Are you feeling healthy and well today?		☐	☐
2	Are you currently taking an antibiotic?		☐	☐
3	Are you currently taking any other medication for an infection?		☐	☐
4	Have you ever taken any medications on the Medication Deferral List in the time frames indicated? (Review the Medication Deferral list)		☐	☐
5	Have you read the educational materials today?		☐	☐
6	In the past 48 hours have you taken aspirin or anything that has aspirin in it?		☐	☐
7	In the past 8 weeks have you donated blood, platelets or plasma?		☐	☐
8	In the past 12 weeks have you had any vaccinations or other shots?		☐	☐
9	In the past 12 weeks have you had contact with someone who was vaccinated for smallpox in the past 8 weeks?		☐	☐
10	In the past 16 weeks have you donated a double unit of red cells using an apheresis machine?		☐	☐
11	In the past 12 months have you had a blood transfusion?		☐	☐
12	In the past 12 months have you come into contact with someone else's blood?		☐	☐
13	In the past 12 months have you had an accidental needle-stick?		☐	☐
14	In the past 12 months have you had sexual contact with anyone who has HIV/AIDS or has had a positive test for the HIV/AIDS virus?		☐	☐
15	In the past 12 months have you had sexual contact with a prostitute or anyone else who takes money or drugs or other payment for sex?		☐	☐
16	In the past 12 months have you had sexual contact with anyone who has ever used needles to take drugs or steroids, or anything not prescribed by their doctor?		☐	☐
17	**Male donors**: In the past 12 months, have you had sexual contact with another male?	NA ☐	☐	☐
18	**Female donors**: In the past 12 months have you had sexual contact with a male who has had sexual contact with another male in the past 12 months?	NA ☐	☐	☐
19	In the past 12 months have you had sexual contact with a person who has hepatitis?		☐	☐
20	In the past 12 months have you lived with a person who has hepatitis?		☐	☐
21	In the past 12 months have you had a tattoo?		☐	☐
22	In the past 12 months have you had ear or body piercing?		☐	☐
23	In the past 12 months have you been in juvenile detention, lockup, jail, or prison for more than 72 consecutive hours?		☐	☐
24	In the past 3 years have you been outside the United States or Canada?		☐	☐
25	From 1980 through 1996, did you spend time that adds up to three (3) months or more in the United Kingdom? (Review list of countries in the UK)		☐	☐
26	From 1980 through 1996, were you a member of the U.S. military, a civilian military employee, or a dependent of a member of the U.S. military?		☐	☐
27	From 1980 to the present, did you spend time that adds up to five (5) years or more in Europe? (Review list of countries in Europe)		☐	☐
28	From 1980 to the present, did you receive a blood transfusion in the United Kingdom or France? (Review country lists.)		☐	☐
29	Have you EVER received money, drugs, or other payment for sex?		☐	☐
30	**Female donors**: Have you EVER been pregnant or are you pregnant now?	NA ☐	☐	☐
31	Have you EVER had a positive test for the HIV/AIDS virus?		☐	☐
32	Have you EVER used needles to take drugs, steroids, or anything not prescribed by your doctor?		☐	☐
33	Have you EVER used clotting factor concentrates?		☐	☐
34	Have you EVER had hepatitis or any positive test for hepatitis?		☐	☐
35	Have you EVER had malaria?		☐	☐
36	Have you EVER had Chagas' disease and/or a positive test for *T. cruzi*?		☐	☐
37	Have you EVER had babesiosis?		☐	☐
38	Have you EVER received a dura mater (or brain covering) graft?		☐	☐
39	Have you EVER had any type of cancer, including leukemia?		☐	☐
40	Have you EVER had any problems with your heart or lungs?		☐	☐
41	Have you EVER had a bleeding condition or a blood disease?		☐	☐
42	Have any of your relatives had Creutzfeldt-Jakob disease?		☐	☐
43	In the past 12 months have you been told by a healthcare professional that you have West Nile Virus infection or any positive test for West Nile Virus?		☐	☐
44	In the past 12 months have you had a transplant or graft from someone other than yourself, such as organ, bone marrow, stem cell, cornea, sclera, bone, skin, or other tissue?		☐	☐
45	In the past 12 months have you had or been treated for HPV or genital herpes, syphilis, gonorrhea or sexually transmitted infections?		☐	☐
46	Have you EVER tested positive for HTLV, had adult T-cell leukemia or had unexplained paraparesis (partial paralysis affecting the lower limbs)?		☐	☐
47	Have you EVER been diagnosed with any neurological disease?		☐	☐
48	Have you EVER had a transplant or other medical procedure that involved being exposed to live cells, tissues, or organs from an animal?		☐	☐
49	Has your sexual partner or a member of your household EVER had a transplant or other medical procedure that involved being exposed to live cells, tissues, or organs from an animal?		☐	☐
50	In the past 6 months, have you been in any of the areas on the list of countries with active transmission of Zika virus? (Review list of countries).		☐	☐
51	In the past 6 months have you been diagnosed with Zika virus infection?		☐	☐
52	In the past 6 months, have you had sexual contact with a male who is known to have either of the risk factors listed in question 50 or 51?		☐	☐

Comments/Explanatory Notes (use front of form as needed)

X Subject Signature:______________________________ Witness/Reviewer: ______________________________