

Medical History Questionnaire

Your Name: _____ Estimated Due Date: _____ Delivering Hospital: _____

Pregnancy History:

Number of Pregnancies (Including Current): _____ Number of Live Births: _____ Number of Miscarriages: _____ Number of Stillborn: _____

Ultrasound? Yes No One fetus Twins Multiple **note: this program is for single births only**

Have you ever had an abnormal result from a prenatal test (ie. Amniocentesis, blood test, ultrasound)? Yes No

If yes, which test was abnormal and what was the test result? _____

Name of your Obstetrician/Midwife/Clinic where you are receiving your care: _____

Any Diagnosed Infections? Yes No If Yes, specify diagnosis: _____

Gestational diabetes? Yes No Current pregnancy Previous pregnancy: Treatment: _____

Was a donor egg used for this pregnancy? Yes No If yes, is a medical history available for the donor? Yes No

Was donor sperm used for this pregnancy? Yes No If yes, is a medical history available for the donor? Yes No

Medications taken during pregnancy other than prenatal vitamins and iron _____

Comments: _____

Pediatrician (for Baby) Name: _____ Telephone Number: _____

Mother's Medical History

If the answer is yes, please specify or circle the correct option and indicate the date or year it occurred

1. Have you ever donated or attempted to donate cord blood using your current name or a different name, to this cord blood bank? If yes, when? _____ Yes No
2. Have you, for any reason, been deferred or refused as a blood or cord blood donor, or told not to donate blood or cord blood? If yes, when and why? _____ Yes No
3. Have you taken any of the following medications: _____ Yes No
 - A. Hepatitis B Immune Globin (HBIG) in the last 12 months?
 - B. Insulin from cows (bovine or beef insulin) since 1980?
 - C. Growth hormone from human pituitary glands ever?
4. **In the past 12 weeks** have you had any shots or vaccinations? If yes, what? _____ Yes No
5. **In the past 8 weeks** have you had contact with someone who has recently received the smallpox vaccine? _____ Yes No
6. **In the past 4 months**, have you experienced **two or more** of the following: a fever (>100.5 F or 38.0 C), headache, muscle weakness, skin rash on trunk of the body, swollen lymph gland? _____ Yes No
If yes, which symptoms and when? _____
7. **In the past 12 months** have you had a major illness or surgery? If yes, please describe: _____ Yes No
8. Have you ever had any type of cancer, including leukemia? _____ Yes No
9. Have you ever had a bleeding condition or blood disease, including sickle cell disease? _____ Yes No
10. Have you ever had a bleeding problem, such as hemophilia or other clotting factor deficiencies, and received human-derived clotting factor concentrates? _____ Yes No
11. During your pregnancy, have you been diagnosed with or had a positive test for West Nile Virus? _____ Yes No
12. Have you ever had yellow jaundice, liver disease, viral hepatitis or a positive test (including screening tests) for hepatitis? _____ Yes No

- 13. Have you ever been diagnosed with or had a positive test for a parasitic blood disease such as Chagas disease or Babesiosis?
14. Have you been diagnosed with Creutzfeldt-Jakob Disease (CJD) or variant CJD or do you have a degenerative neurological condition such as dementia where the cause has not been identified?
15. Have any of your blood relatives ever been diagnosed with Creutzfeldt-Jakob Disease (CJD), or have you been told that your family has an increased risk for CJD?
16. Have you received a dura mater (brain covering) graft?
17. Have you ever had a transplant or other medical procedure that involved being exposed to live cells, tissues, or organs from an animal?
18. Have you ever lived with or had sexual contact with anyone who had a transplant or other medical procedure that involved being exposed to live cells, tissues, or organs from an animal?
19. In the past 3 years have you had malaria?
20. In the past 3 years have you been outside the U.S. or Canada? If yes, where, when, how long?

IN THE PAST 12 MONTHS:

- 21. Have you had a blood transfusion?
22. Have you had a transplant such as organ, bone marrow, stem cell, cornea, bone or other tissue?
23. Have you had a tissue graft such as bone or skin?
24. Have you had a tattoo? If yes, answer question 25. If no, skip to question 26
25. Were shared instruments, needles or inks used for the tattoo?
26. Have you had an ear, skin, or body piercing using shared instruments or needles?
27. Have you had an accidental needle stick or have you come into contact with someone else's blood through an open wound (for example, a cut or sore), non-intact skin, or mucous membrane (for example, into your eye, mouth, etc)?
28. Have you had or been treated for any sexually transmitted disease including syphilis and gonorrhea? If yes, which disease and when?
29. Have you given money, drugs, or other payment to anyone to have sex with you?
30. Have you had sex with anyone who has taken money, drugs, or other payment in exchange for sex in the past 5 years?
31. Have you had sexual contact or lived with a person who has active or chronic viral hepatitis or yellow jaundice?
32. Have you had sex, even once, with anyone who has used a needle to take drugs, steroids, or anything else not prescribed by a doctor in the past 5 years?
33. Have you had sex with a male who has had sex with another male, even once, in the past 5 years?
34. Have you had sex, even once, with anyone who has taken human-derived clotting factors for a bleeding problem in the past 5 years?
35. Have you had sex, even once, with anyone who has HIV/AIDS or tested positive for AIDS virus?
36. Have you been in juvenile detention, lockup, jail or prison for more than 72 continuous hours?

IN THE PAST 5 YEARS:

- 37. Have you received money, drugs, or other payment for sex?
38. Have you used a needle, even once, to take drugs, steroids, or anything else that were not prescribed for you by a doctor?
39. Do you have AIDS or have you ever tested positive for HIV (including screening tests)?
40. Do you have any of the following?
A. Unexplained night sweats?
B. Unexplained blue or purple spots on or under the skin or mucous membranes?
C. Unexplained weight loss?
D. Unexplained persistent diarrhea?
E. Unexplained cough or shortness of breath?
F. Unexplained temperature higher than 100.5°F (38.0°C) for more than 10 days?
G. Unexplained persistent white spots or sores in the mouth?
H. Lumps in your neck, armpits, or groin lasting longer than one month?
41. Have you ever tested positive for HTLV (including screening tests)?
42. Do you understand that if a person has the AIDS virus, they can give it to someone else even though they feel well and have a negative AIDS test?

For questions 43 through 49, please refer to the chart below for a list of countries involved:

Reference for Questions 43 & 46: Countries defined as Europe

Albania	Germany	Poland	United Kingdom: England, Northern Ireland, Scotland, Wales, the Island of Man, the Channel Islands, Gibraltar, or the Falkland Islands
Austria	Greece	Portugal	
Belgium	Hungary	Romania	
Bosnia-Herzegovina	Ireland (Republic of)	San Marino	
Bulgaria	Italy	Slovak Republic	
Croatia	Liechtenstein	Slovenia	
Czech Republic	Luxembourg	Spain	
Denmark	Macedonia	Sweden	
Finland	Netherlands (Holland)	Switzerland	
France	Norway	Turkey	

43. **Since 1980**, have you ever lived in, or traveled to Europe? _____ Yes No
If yes, answer questions 44-46, if no go to question 47.
44. **From 1980 through 1996**, did you spend time that adds up to 3 months or more in the U.K. (England, Northern Ireland, Scotland, Wales, the Isle of Man, the Channel Islands, Gibraltar, or the Falkland Islands)? _____ Yes No
45. **Since 1980** have you received a transfusion of blood or blood components while in the U.K. or France?__ Yes No
46. **Since 1980**, have you spent time that adds up to 5 years or more in Europe, including time spent in the U.K. between 1980 and 1996)? (See above for listing of countries)? _____ Yes No
47. **From 1980 through 1996**, were you a member of the US military, a civilian military employee or a dependent of a member of the US military? **If yes please answer questions 48 and 49, if no go to question 50.** _____ Yes No
48. **From 1980 through 1990**, did you spend a total time of 6 months or more associated with a military base in any of the following countries: UK, Belgium, Netherlands, or Germany? _____ Yes No
49. **From 1980 through 1996**, did you spend a total time of 6 months or more associated with a military base in any of the following countries: Spain, Portugal, Turkey, Italy, or Greece? _____ Yes No

Reference for Questions 50-52: African Countries at Risk for HIV-1 group O

Benin Cameroon Chad Gabon Kenya Niger Nigeria Senegal Togo Zambia
 Central African Republic (previously named Central African Empire)
 Congo (refers to the Republic of the Congo. This does not include the Democratic Republic of the Congo, previously named Zaire).
 Equatorial Guinea (includes the territory of Rio Muni, and the islands of Corisco, Elobey, Ferrando Po Bioko and Annonbon)

50. **Since 1977**, were you born in, have you lived in, or have you traveled to any African country listed above?__ Yes No
51. **If in one of the African countries listed above**, did you receive a blood transfusion or any medical treatment with a product made from blood while you were there? _____ Yes No
52. Have you had sexual contact with anyone who was born in or lived in any African country listed **since 1977**? Yes No

Family History

Baby's siblings (live born): # of Brothers: Full _____ Half _____ # of Sisters: Full _____ Half _____

Baby's Mother's siblings (live born): # of Brothers: Full _____ Half _____ # of Sisters: Full _____ Half _____

Baby's father's siblings (live born): # of Brothers: Full _____ Half _____ # of Sisters: Full _____ Half _____

Except by marriage, are you and the baby's father related (e.g. first cousins)? Yes No
 If Yes, what relationship? _____

Have you or the father of the baby had any children, brothers or sisters who died within the first 10 years of life? Yes No
 If yes, list family member and cause of death: _____

Were you or the baby's father adopted at birth or early childhood? Yes No If yes, mother or father of baby? _____
 If yes, what knowledge do you have of the medical history for the biological mother or father? _____

Family Medical History

Cancer/Leukemia: Has the MOTHER OF BABY, FATHER OF BABY, or BABY'S SIBLING been diagnosed with any cancer or leukemia including:

Brain, nervous system, bone, joint, kidney (including renal pelvic), skin, thyroid, Hodgkin's lymphoma, Non-Hodgkin's lymphoma, acute or chronic myelogeneous/myeloid leukemia, acute or chronic lymphocytic/lymphoblastic leukemia, other or unknown cancer
 Yes No If Yes, list family member, type of cancer and age at diagnosis

Acquired Immune/Auto Immune System Disorders: Has the MOTHER OF BABY, FATHER OF BABY, or BABY'S SIBLING been diagnosed with:

HIV/AIDS, or an autoimmune disorder **CLASSIFIED AS SEVERE** including: Crohn's Disease, Ulcerative Colitis, Lupus, Multiple Sclerosis (MS), Rheumatoid Arthritis, or other or unknown immune system disorder
 Yes No If Yes, list family member and disease

For the remainder of the questionnaire, describe the relationship between the baby and the immediate family member with the disease. Please refer to the following codes:

- BM** Baby's Mother
- BF** Baby's Father
- BS** Baby's Sibling (full or half brother or sister)
- BGP** Baby's Grandparents (grandmother or grandfather)
- BMS** Baby's Mother's Siblings*
- BFS** Baby's Father's Siblings*

* Parent's siblings (BMS and BFS) refer to the baby's aunts and uncles who are blood relatives only. Do not include in-laws by marriage.

Red Blood Cell Disease: Diamond-Blackfan Syndrome, Elliptocytosis, G6PD or other red cell enzyme deficiency, Spherocytosis
 Yes No If Yes, list affected family member (by the relationship to the baby) and disease.

White Blood Cell Disease: Chronic Granulomatous Disease, Kostmann Syndrome, Schwachman-Diamond Syndrome, Leukocyte Adhesion Deficiency (LAD)
 Yes No If Yes, list affected family member (by the relationship to the baby) and disease.

Immune Deficiencies: ADA or PNP Deficiency, Combined Immunodeficiency Syndrome (CID), Common Variable Immunodeficiency Disease (CVID), DiGeorge Syndrome, Hereditary Hemophagocytic Lymphohistiocytosis (HLH) including FEL, Hypoglobulinemia, Nezeloff Syndrome, Severe Combined Immunodeficiency (SCID), Wiskott-Aldrich Syndrome
 Yes No If Yes, list affected family member (by the relationship to the baby) and disease.

Platelet Disease: Amegakaryocytic Thrombocytopenia, Glanzmann Thrombasthenia, Hereditary Thrombocytopenia, Platelet Storage Pool Disease, Thrombocytopenia with absent radii (TAR), Ataxia-Telangiectasia, Fanconi Anemia
 Yes No If Yes, list affected family member (by the relationship to the baby) and disease.

Other Blood Disease or Disorder
 Yes No If Yes, list affected family member (by the relationship to the baby) and disease.

Hemoglobin Problems: Sickle cell disease, such as sickle-cell anemia or sickle thalassemia, alpha thalassemia, beta thalassemia
 Yes No If Yes, list affected family member (by the relationship to the baby) and disease.

Metabolic/Storage Disease: Hurler Syndrome (MPS I), Hurler-Scheie Syndrome (MPS I H-S), Hunter Syndrome (MPS II), Sanfilippo Syndrome (MPS III), Morquio Syndrome (MPS IV), Maroteaux-Lamy Syndrome (MPSVI), Sly Syndrome (MPS VII), I-cell disease, Globoid Leukodystrophy (Krabbe Disease), Metachromatic Leukodystrophy (MLD), Adrenoleukodystrophy (ALD), Sandhoff Disease, Tay-Sachs Disease, Gaucher Disease, Niemann-Pick Disease, Porphyria, other or unknown metabolic/storage disease
 Yes No If Yes, list affected family member (by the relationship to the baby) and disease.

Has any family member had the following: if yes, list the relationship to baby

- Required chronic blood transfusions? Yes No _____
- Been told they have hemolytic anemia? Yes No _____
- Had their spleen removed to treat a blood disorder? Yes No _____
- Had their gallbladder removed before age 30? Yes No _____
- Had Creutzfeldt-Jakob disease (CJD)? Yes No _____

Other diseases affecting the family, including cancer, leukemia and auto immune system disorders; list relationship to baby and disease

Comments or additional information: _____

In answering the above questions, have you answered for both your family and the baby's father's family? Yes No

In the event that an illness affecting the immune system or a blood related disease should develop in your baby, please call the Cord Blood Bank at (314) 268-2787 or 1-888-453-2673, as this could impact the person receiving this product for transplantation.

I understand what is involved in participating in this program, completed this form to the best of my knowledge, called if I had any questions, and it is my desire to donate the umbilical cord blood to the St. Louis Cord Blood Bank.

Form completed by _____ date completed _____

Ethnic Background

ETHNICITY/RACE OF MOTHER AND FATHER OF BABY (check all that apply)

Asian

- | | | |
|--------------------------|--------------------------|--------------------------|
| Mother | Father | |
| <input type="checkbox"/> | <input type="checkbox"/> | 01 Chinese |
| <input type="checkbox"/> | <input type="checkbox"/> | 02 Filipino (Pilipino) |
| <input type="checkbox"/> | <input type="checkbox"/> | 04 Japanese |
| <input type="checkbox"/> | <input type="checkbox"/> | 05 Korean |
| <input type="checkbox"/> | <input type="checkbox"/> | 06 South Asian |
| <input type="checkbox"/> | <input type="checkbox"/> | 45 Vietnamese |
| <input type="checkbox"/> | <input type="checkbox"/> | 07 Other Southeast Asian |

White

- | | | |
|--------------------------|--------------------------|------------------------------------|
| Mother | Father | |
| <input type="checkbox"/> | <input type="checkbox"/> | 51 Eastern European |
| <input type="checkbox"/> | <input type="checkbox"/> | 52 Mediterranean |
| <input type="checkbox"/> | <input type="checkbox"/> | 59 Middle Eastern |
| <input type="checkbox"/> | <input type="checkbox"/> | 53 North Coast of Africa |
| <input type="checkbox"/> | <input type="checkbox"/> | 54 North American |
| <input type="checkbox"/> | <input type="checkbox"/> | 55 Northern European |
| <input type="checkbox"/> | <input type="checkbox"/> | 56 Western European |
| <input type="checkbox"/> | <input type="checkbox"/> | 57 White Caribbean |
| <input type="checkbox"/> | <input type="checkbox"/> | 58 White South or Central American |
| <input type="checkbox"/> | <input type="checkbox"/> | 61 Other White |

Black or African American

- | | | |
|--------------------------|--------------------------|------------------------------------|
| Mother | Father | |
| <input type="checkbox"/> | <input type="checkbox"/> | 12 African |
| <input type="checkbox"/> | <input type="checkbox"/> | 13 African American |
| <input type="checkbox"/> | <input type="checkbox"/> | 14 Black Caribbean |
| <input type="checkbox"/> | <input type="checkbox"/> | 15 Black South or Central American |

American Indian or Alaska Native

- | | | |
|--------------------------|--------------------------|--|
| Mother | Father | |
| <input type="checkbox"/> | <input type="checkbox"/> | 33 Alaska Native or Aleut |
| <input type="checkbox"/> | <input type="checkbox"/> | 34 North American Indian |
| <input type="checkbox"/> | <input type="checkbox"/> | 46 American Indian South or Central American |
| <input type="checkbox"/> | <input type="checkbox"/> | 47 Caribbean Indian |

Native Hawaiian or Other Pacific Islander

- | | | |
|--------------------------|--------------------------|---------------------------|
| Mother | Father | |
| <input type="checkbox"/> | <input type="checkbox"/> | 48 Guamanian |
| <input type="checkbox"/> | <input type="checkbox"/> | 60 Hawaiian |
| <input type="checkbox"/> | <input type="checkbox"/> | 49 Samoan |
| <input type="checkbox"/> | <input type="checkbox"/> | 50 Other Pacific Islander |

Ethnicity of Baby: Please check one Hispanic/Latino Not Hispanic or Latino

Mother's Birthplace: _____
 (country)
 Mother's Mother's Birthplace: _____
 (country)
 Mother's Father's Birthplace: _____
 (country)

Father's Birthplace: _____
 (country)
 Father's Mother's Birthplace: _____
 (country)
 Father's Father's Birthplace: _____
 (country)

Demographic Information

BABY'S MOTHER:

Name _____ Maiden Name _____
 Address _____
 Street address City State Zip code
 Birth date _____ Email address _____
 Home telephone number _____ Cell number _____

BABY'S FATHER:

Name _____
 Address _____
 Birth date _____ Phone Number _____

It may be necessary to contact you in the future to verify, clarify or update the information provided on this form.

THANK YOU FOR HELPING US SAVE LIVES

Addendum: CORD BLOOD MATERNAL SCREENING QUESTIONNAIRE

Part I: SARS: Please seek medical attention and call the Cord Blood Bank if you should develop any of these symptoms during the last 1 (one) month of your pregnancy or in the month following delivery.

DEFINITION: Suspected SARS (Severe Acute Respiratory Syndrome)

Respiratory illness of unknown etiology with onset since February 1, 2003, which meets the following criteria:

- Measured temperature > 100.4°F (>38°C), **AND**
 - One or more clinical findings of respiratory illness (e.g. cough, shortness of breath, difficulty breathing, hypoxia, or radiographic findings of either pneumonia or acute respiratory distress syndrome), **AND**
 - Travel within 10 days of onset of symptoms to an area with documented cases or suspected community transmission of SARS (affected areas), **OR** close contact within 10 days of onset of symptoms with either a person with a respiratory illness who traveled to a SARS-affected area or a person known to be a suspect SARS case.
 - Travel includes transit in an airport in an area with documented or suspected community transmission of SARS.
 - Close contact is defined as having cared for, having lived with, or having had direct contact with respiratory secretions and/or body fluids of a patient known to be a suspect SARS case.
 - Probable SARS affected areas include, but are not limited to: China (mainland); Hong Kong; Hanoi, Vietnam; Singapore; Toronto, Canada; Taiwan.
- ❖ SARS may be transmitted through blood and tissue donation. SARS cannot be transmitted to you or your baby as a result of the cord blood donation process.

Part II: WNV: Please seek medical attention and call the Cord Blood Bank if you should develop any of these symptoms during the last 1 (one) month of your pregnancy or in the month following delivery.

DEFINITION: Suspected WNV (West Nile Virus)

Viral infection transmitted to humans by a mosquito bite, which meets the following criteria:

- Measured temperature > 100.5°F (>38 °C), **AND**
 - Headache, **and possibly**
 - One or more clinical findings (flu-like symptoms, eye pain, body aches, generalized weakness, new skin rash, or swollen lymph nodes)
 - Convulsions, coma or paralysis
- ❖ The above may be symptoms of West Nile Virus infection which is known to be transmitted through blood and tissue donation. West Nile Virus cannot be transmitted to you or your baby as a result of the cord blood donation process.

I understand the information given on this form and will comply with the request to report symptoms to the Cord Blood Bank after seeking medical attention should any of the above symptoms occur.

Participant Name
(print) _____

Date _____

