St. Louis Cord Blood Bank SSM Cardinal Glennon Children's Medical Center St. Louis University Department of Pediatrics The First Gift	MEDICAL HISTORY QUESTIONNAIRE CL.03A.19
Cellular Therapy Laboratory & St. Louis Cord Blood Bank 3662 Park Avenue, St. Louis MO 63110, 314-268-2787	

St. Louis Cord Blood Bank (SLCBB) Phone Number: 314-268-2787 or 1-888-453-2673 **Fax Number: 314-268-4197**

Your Name:	***SLCBB only Reviewed By/Date:***
Estimated Due Date:	
Delivering Hospital:	

PREGNANCY HISTORY

1.	Number of Pregnancies (including current): ____ Number of Live Births: ____ Number of Miscarriages: ____ Number of Stillborn: _____		
2.	Ultrasound? If yes, please indicate: ☐ One Fetus ☐ Twins ☐ Multiple **(Note: This program is for single births only)**	☐ Yes	☐ No
3.	Have you ever had an abnormal result from a prenatal test (i.e. Amniocentesis, blood test, ultrasound)? **If yes**, which test was abnormal and what was the test result?	☐ Yes	☐ No
4.	Name of your Obstetrician/Midwife/Clinic where you are receiving your care:		
5.	Any infections during your pregnancy? **If yes**, please specify what infection, when it occurred and the treatment:	☐ Yes	☐ No
6.	Gestational diabetes with current pregnancy? If yes, what treatment:	☐ Yes	☐ No
7.	Was a donor egg used for this pregnancy? **If yes**, is a medical history available for the donor?	☐ Yes ☐ Yes	☐ No ☐ No
8.	Was donor sperm used for this pregnancy? **If yes**, is a medical history available for the donor?	☐ Yes ☐ Yes	☐ No ☐ No
9.	List any Medications taken during pregnancy other than prenatal vitamins and iron:		
10.	Comments:		
11.	Pediatrician (for Baby) Name: Telephone Number:		

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MOTHER'S MEDICAL HISTORY

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 been told not to donate blood or cord blood? **If yes**, when and why?	☐ Yes	☐ No
3.	Have you taken any of the following medications (check all that apply) ☐ Insulin from cows (bovine or beef insulin) since 1980? ☐ Growth hormone from human pituitary glands ever? ☐ Rabies vaccination in the past year?	☐ Yes	☐ No
4.	**In the past 8 weeks**, have you had any shots or vaccinations? **If yes**, please describe:	☐ Yes	☐ No
5.	**In the past 12 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 38.06°C), headache, muscle weakness, skin rash on trunk of the body, or swollen lymph glands? **If yes**, which symptoms and when?	☐ Yes	☐ No
7.	Have you ever had any type of cancer, including leukemia?	☐ Yes	☐ No
8.	**In the past 5 years**, have you had a bleeding problem, such as hemophilia or other clotting factor deficiencies, and received human-derived clotting factor concentrates?	☐ Yes	☐ No
9.	During your pregnancy, have you been diagnosed with or had a positive test for West Nile Virus?	☐ Yes	☐ No
10.	Have you had a past diagnosis of clinical, symptomatic viral hepatitis after age 11?	☐ Yes	☐ No
11.	Have you ever had a parasitic blood disease (for example, Leishmaniasis, Babesiosis, or Chagas disease) or any positive tests for Chagas or T. cruzi, including screening tests?	☐ Yes	☐ No
12.	Have you ever been diagnosed with Creutzfeldt-Jakob Disease (CJD), variant CJD, dementia, any degenerative or demyelinating disease of the central nervous system, or other neurological disease where the cause is unknown?	☐ Yes	☐ No
13.	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?	☐ Yes	☐ No
14.	Have you received a dura mater (brain covering) graft?	☐ Yes	☐ No
15.	Have you ever had a transplant or other medical procedure that involved being exposed to live cells, tissues, or organs from an animal?	☐ Yes	☐ No
16.	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?	☐ Yes	☐ No
17.	**In the past 3 years** have you had malaria?	☐ Yes	☐ No
18.	**In the past 3 years** have you been outside the U.S. or Canada? **If yes**, where, when, how long?	☐ Yes	☐ No

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Questions 19-32 REFER TO THE 12 MONTHS PRIOR TO DELIVERY

19.	**In the 12 months prior to collection of the cord blood unit**, have you had a blood transfusion?	☐ Yes	☐ No
20.	**In the past 12 months,** have you had a transplant or tissue graft from someone other than yourself, such as organ, bone marrow, stem cell, cornea, bone or other tissue?	☐ Yes	☐ No
21.	**In the past 12 months,** have you had a tattoo or ear, skin, or body piercing? **If yes**, answer question 22. **If no**, skip to question 23	☐ Yes	☐ No
22.	**If question #21 was yes**, were shared or non-sterile inks, needles, instruments, or procedures used for the tattoo or piercing?	☐ Yes	☐ No
23.	**In the past 12 months,** 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)?	☐ Yes	☐ No
24.	**In the past 12 months,** have you had or been treated for **any** sexually transmitted disease including syphilis? **If yes**, which disease and when?	☐ Yes	☐ No
25.	**In the past 12 months,** have you given money or drugs to anyone to engage in sex with you?	☐ Yes	☐ No
26.	**In the past 12 months,** have you engaged in sex with anyone who had taken money or drugs for sex in the **past 5 years**?	☐ Yes	☐ No
27.	**In the past 12 months,** have you had sexual contact or lived with a person who has active or chronic viral Hepatitis B or Hepatitis C?	☐ Yes	☐ No
28.	**In the past 12 months,** 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**?	☐ Yes	☐ No
29.	**In the past 12 months,** have you had sex with a male who has had sex with another male, even once, in the **past 5 years**?	☐ Yes	☐ No
30.	**In the past 12 months,** have you had sex, even once, with anyone who has taken human-derived clotting factors for a bleeding problem in the **past 5 years**?	☐ Yes	☐ No
31.	**In the past 12 months,** have you had sex, even once, with anyone who has HIV/AIDS or has had a positive test for the AIDS virus?	☐ Yes	☐ No
32.	**In the past 12 months,** have you been in juvenile detention, lockup, jail or prison for more than 72 continuous hours?	☐ Yes	☐ No
33.	**In the past 5 years**, have you engaged in sex in exchange for money or drugs?	☐ Yes	☐ No
34.	**In the past 5 years**, have you used a needle, even once, to take drugs, steroids, or anything else not prescribed for you by a doctor?	☐ Yes	☐ No

35.	Do you have AIDS or have you ever tested positive for HIV (including screening tests)?	☐ Yes	☐ No
36.	Do you have any of the following?		
a.	Unexplained night sweats?	☐ Yes	☐ No
b.	Blue or purple spots on or under the skin or mucous membranes typical of Kaposi's sarcoma?	☐ Yes	☐ No
c.	Unexplained weight loss?	☐ Yes	☐ No
d.	Unexplained persistent diarrhea?	☐ Yes	☐ No
e.	Unexplained cough or shortness of breath?	☐ Yes	☐ No
f.	Unexplained temperature higher than 100.5°F (38.06°C) for more than 10 days?	☐ Yes	☐ No
g.	Unexplained persistent white spots or sores in the mouth?	☐ Yes	☐ No
h.	Multiple lumps in your neck, armpits, or groin lasting longer than one month?	☐ Yes	☐ No

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37.	Have you ever tested positive for HTLV (including screening tests) or had unexplained paraparesis (partial paralysis affecting the lower limbs)? HTLV refers to Human T-cell Lymphotrophic Virus	☐ Yes	☐ No
38.	**If a person has the AIDS virus, do you understand that the person can give it to someone else even though they feel well and have a negative AIDS test?**	☐ Yes	☐ No

Reference Guide for Questions 39 through 48, please refer to the chart below for a list of countries involved:

Albania	Finland	Luxembourg	Slovenia
Austria	France	Macedonia	Spain
Belgium	Germany	Netherlands (Holland)	Sweden
Bosnia-Herzegovina	Greece	Norway	Switzerland
Bulgaria	Hungary	Poland	Yugoslavia (Federal Republic of):
Croatia	Ireland (Republic of)	Portugal	Kosovo,
Czech Republic	Italy	Romania	Montenegro,
Denmark	Liechtenstein	Slovak Republic	Serbia

United Kingdom (UK): England, Northern Ireland, Scotland, Wales, the Isle of Man, the Channel Islands, Gibraltar, or the Falkland Islands

39.	**Since 1980**, have you ever lived in, or traveled to any country considered to be at risk for transmission of vCJD (variant Creutzfeldt-Jakob Disease? (refer to chart) **If yes, answer questions 40 through 42, if no go to question 43**	☐ Yes	☐ No
40.	**From 1980 through 1996**, did you spend time that adds ups to 3 months or more in the United Kingdom? (England, Northern Ireland, Scotland, Wales, the Isle of Man, the Channel Islands, Gibraltar, or the Falkland Islands)?	☐ Yes	☐ No
41.	**Since 1980** have you received a transfusion of blood or blood components while in the UK or France?	☐ Yes	☐ No
42.	**Since 1980,** have you spent time that adds up to 5 years or more (including time spent in the UK between 1980 and 1996), in any country considered to be at risk for transmission of vCJD (variant Creutzfeldt-Jakob Disease)? (refer to chart)	☐ Yes	☐ No
43.	**From 1980 through 1996**, were you a member of the US military, a civilian military employee, or a dependent of either a member of the US military or civilian military employee?	☐ Yes	☐ No
44.	**From 1980 through 1990**, did you spend a total of 6 months or more associated with a military base in any of the following countries: UK, Belgium, Netherlands, or Germany?	☐ Yes	☐ No
45.	**From 1980 through 1996**, did you spend a total of 6 months or more associated with a military base in any of the following countries: Spain, Portugal, Turkey, Italy, or Greece?	☐ Yes	☐ No

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Reference Guide for Questions 46-48: African Countries at Risk

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)

46.	**Since 1977**, were you born in, have you lived for longer than one year in, or have you traveled to any African country considered to be at risk for transmission of HIV-1 group O? (refer to chart)	☐ Yes	☐ No
47.	**While in one of the African countries listed in the chart,** did you receive a blood transfusion or any medical treatment with a product made from blood while you were there?	☐ Yes	☐ No
48.	Have you had sexual contact with anyone who was born in or lived in any African country listed in the chart above **since 1977?**	☐ Yes	☐ No

FAMILY RECORD

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)? If yes, what relationship?	☐ Yes	☐ No
Have you or the father of the baby had any children, brothers, or sisters who died within the first 10 years of life? If yes, list family member and cause of death:	☐ Yes	☐ No
Were you and/or the baby's father adopted at birth or early childhood? If yes, mother or father of baby? **If yes, what knowledge do you have of the medical history for the biological mother or father?**	☐ Yes	☐ No

FAMILY MEDICAL HISTORY

<u>Cancer/Leukemia</u> : 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 myelogenous/myeloid leukemia, acute or chronic lymphocytic/lymphoblastic leukemia, other or unknown cancer? If yes, list family member, type of cancer and age at diagnosis:	☐ Yes	☐ No
<u>Acquired Immune/Auto Immune System Disorders:</u> 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? If yes, list family member and disease:	☐ Yes	☐ No

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

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.

<u>Red Blood Cell Disease</u> If Yes, list affected family member (by relationship to the baby) and disease.	Diamond-Blackfan Syndrome, Elliptocytosis, G6PD or other red cell enzyme deficiency, spherocytosis?	☐ Yes	☐ No
<u>White Blood Cell Disease</u> If Yes, list affected family member (by relationship to the baby) and disease.	Chronic Granulomatous disease, Kostmann Syndrome, Schwachman-Diamond Syndrome, Leukocyte Adhesion Deficiency (LAD)?	☐ Yes	☐ No
<u>Immune Deficiencies</u> If Yes, list affected family member (by relationship to the baby) and disease.	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
<u>Platelet Disease</u> If Yes, list affected family member (by relationship to the baby) and disease.	Amegakaryocytic Thrombocytopenia, Glanzmann Thromboasthenia, Hereditary Thrombocytopenia, Platelet Storage Pool Disease, Thrombocytopenia with absent radii (TAR), Ataxia-Telangiectasia, Fanconi Anemia?	☐ Yes	☐ No

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Other Blood Disease or Disorder	If yes, list affected family member(by relationship to the baby) and the disease:	☐ Yes	☐ No
Hemoglobin Problems If Yes, list affected family member (by relationship to the baby) and disease.	Sickle cell disease, such as sickle-cell anemia or sickle thalassemia, alpha thalassemia, beta thalassemia.	☐ Yes	☐ No
Metabolic/Storage Disease If Yes, list affected family member (by relationship to the baby) and 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
Has any family member had the following → If Yes, list affected family member (by relationship to the baby) and disease.	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 gall bladder 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: If yes, list relationship to baby and disease:		☐ Yes	☐ No
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

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

Since certain HLA types may be more common in each ethnic group, the information below will help in selecting a cord blood unit for transplant.

ASIAN	Mother	Father
Chinese	☐	☐
Filipino (Philipino)	☐	☐
Japanese	☐	☐
Korean	☐	☐
South Asian	☐	☐
Vietnamese	☐	☐
Other Southeast Asian	☐	☐
BLACK OR AFRICAN AMERICAN		
African	☐	☐
African American	☐	☐
Black Caribbean	☐	☐
Black South or Central American	☐	☐
NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER		
Guamanian	☐	☐
Hawaiian	☐	☐
Samoan	☐	☐
Other Pacific Islander	☐	☐

WHITE OR CAUCASIAN	Mother	Father
Eastern European	☐	☐
Mediterranean	☐	☐
Middle Eastern	☐	☐
North Coast of Africa	☐	☐
North American	☐	☐
Northern European	☐	☐
Western European	☐	☐
White Caribbean	☐	☐
White South or Central American	☐	☐
Other White	☐	☐
AMERICAN INDIAN OR ALASKA NATIVE		
Alaska Native or Aleut	☐	☐
North American Indian	☐	☐
American Indian South or Central American	☐	☐
Caribbean Indian	☐	☐

ETHNICITY OF BABY: Please check one: ☐ Hispanic/Latino ☐ Not Hispanic or Latino

BIRTHPLACE (country):

Baby's Mother's Birthplace:_________________________ Baby's Father's Birthplace: _________________________

Mother's Mother's Birthplace: ________________________ Father's Mother's Birthplace: ________________________

Mother's Father's birthplace: _________________________ Father's Father's Birthplace: _________________________

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Demographic Information

Baby's Mother:

Name:		Maiden Name:
Address: (street) (city) (state) (zip code)		
Birth Date:	Email address:	Last 4 digits SS#:
Home telephone #:	Cell #:	Alternate #:

Baby's Father:

Name:	Birth Date:
Address: (street) (city) (state) (zip code)	Phone #:

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

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** ___________________

THANK YOU FOR HELPING US SAVE LIVES!