

Cord Blood Family Medical History Questionnaire

National Marrow Donor Program®



Place NMDP CBU ID
Bar Code Label Here

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NMDP CBU ID

Place Local CBU ID
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Local CBU ID

Place NMDP Maternal ID
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NMDP Maternal ID

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Local Maternal ID

REFERENCE

Please read questions carefully and answer to the best of your knowledge.

/ /

Today's Date

Baby's Mother's Initials

1. Were you and/or the baby's father adopted at early childhood? Yes No
 - 1A. If yes, is a family medical history available for you and/or the baby's father? Yes No
2. Are you and the baby's father related, except by marriage? (e.g. first cousins) Yes No
3. Did this pregnancy use either a donor egg or donor sperm? Yes No
 - 3A. If yes, is a family medical history questionnaire available for the egg or sperm donor? Yes No
4. Have you ever had an abnormal result from a prenatal test (e.g. amniocentesis, blood test, ultrasound)? Yes No

If yes, answer the following questions. If no, skip to question 5.

 - 4A. Which test was abnormal?
 - 4B. What was the abnormal test result?
 - 4C. Was a diagnosis made? Yes No

If yes, specify diagnosis:
5. Have you had any children who died within the first 10 years of life? Yes No
 - 5A. If yes, what was the cause?
6. Have you ever had a stillborn child? Yes No
 - 6A. If yes, what was the cause?



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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 Grandparent (grandmother or grandfather)
- BMS** Baby's Mother's Sibling*
- BFS** Baby's Father's Sibling*

*(Parents' siblings (BMS and BFS) refer to the baby's aunts and uncles by blood and do not include aunts and uncles who are in-laws of the parents.)

7. Cancer or leukemia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	BM	BF	BS
If yes, please specify all that apply in 7A-7J. If no, skip to question 8.					
7A. Brain or other nervous system cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7B. Bone or joint cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7C. Kidney (including renal pelvic) cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7D. Thyroid cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7E. Hodgkin's lymphoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7F. Non-Hodgkin's lymphoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7G. Acute or chronic myelogenous/myeloid leukemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7H. Acute or chronic lymphocytic/lymphoblastic leukemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7I. Skin cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7J. Other cancer/leukemia:					
Specify type: <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specify type: <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Answer Questions 8–12 for any Blood Disorders or Diseases. If yes, please specify as applicable.

8. Red Blood Cell Disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	BM	BF	BS	BGP	BMS	BFS
8A. Diamond-Blackfan Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8B. Elliptocytosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8C. G6PD or other red cell enzyme deficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8D. Spherocytosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. White Blood Cell Disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	BM	BF	BS	BGP	BMS	BFS
9A. Chronic Granulomatous Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9B. Kostmann Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9C. Schwachman-Diamond Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9D. Leukocyte Adhesion Deficiency (LAD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. Immune Deficiencies?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	BM	BF	BS	BGP	BMS	BFS
10A. ADA or PNP Deficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10B. Combined Immunodeficiency Syndrome (CID), Common Variable Immunodeficiency Disease (CVID)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Immune Deficiencies (continued)	BM	BF	BS	BGP	BMS	BFS
10C. DiGeorge Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10D. Hereditary Hemophagocytic Lymphohistiocytosis (HLH) including FEL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10E. Hypoglobulinemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10F. Nezeloff Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10G. Severe Combined Immunodeficiency (SCID)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10H. Wiskott-Aldrich Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Platelet Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No	BM	BF	BS	BGP	BMS	BFS
11A. Amegakaryocytic Thrombocytopenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11B. Glanzmann Thrombasthenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11C. Hereditary Thrombocytopenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11D. Platelet Storage Pool Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11E. Thrombocytopenia with absent radii (TAR)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11F. Ataxia-Telangiectasia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11G. Fanconi Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Other Blood Disease or Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specify type: <input type="text"/>						
Hemoglobin Problems	BM	BF	BS	BGP	BMS	BFS
13. Sickle cell disease, such as sickle-cell anemia or sickle thalassemia? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Thalassemia, such as alpha thalassemia or beta-thalassemia? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Metabolic/Storage Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No	BM	BF	BS	BGP	BMS	BFS
If yes to question 15, please specify all that apply in 15A–15Q. If no , skip to question 16.						
15A. Hurler Syndrome (MPS I)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15B. Hurler-Scheie Syndrome (MPS I H-S)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15C. Hunter Syndrome (MPS II)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15D. Sanfilippo Syndrome (MPS III)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15E. Morquio Syndrome (MPS IV)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15F. Maroteaux-Lamy Syndrome (MPS VI)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15G. Sly Syndrome (MPS VII)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15H. I-cell disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15I. Globoid Leukodystrophy (Krabbe Disease)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15J. Metachromatic Leukodystrophy (MLD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15K. Adrenoleukodystrophy (ALD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>





Metabolic/Storage Diseases (continued)	BM	BF	BS	BGP	BMS	BFS
15L. Sandhoff Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15M. Tay-Sachs Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15N. Gaucher Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15O. Niemann-Pick Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15P. Porphyria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15Q. Other or unknown metabolic/storage disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specify type: <input type="text"/>						
Acquired Immune System Disorders	BM	BF	BS			
16. HIV/AIDS? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
17. Severe autoimmune disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No						
If yes, please specify all that apply in questions 17A–17D. If no, skip to question 18.						
17A. Crohn's Disease or Ulcerative Colitis	<input type="checkbox"/>					
17B. Lupus	<input type="checkbox"/>					
17C. Multiple Sclerosis (MS)	<input type="checkbox"/>					
17D. Rheumatoid Arthritis	<input type="checkbox"/>					
18. Other or unknown immune system disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Specify type: <input type="text"/>						
Answer Questions 19–25	BM	BF	BS	BGP	BMS	BFS
19. Required chronic blood transfusions? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Been told you or family member(s) have hemolytic anemia? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Had spleen removed to treat a blood disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Had gallbladder removed before age 30? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Had Creutzfeldt-Jakob disease (CJD)? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Other serious or life-threatening diseases affecting the family? ... <input type="checkbox"/> Yes <input type="checkbox"/> No						
If yes, list affected family member(s) and type of disease.						
Specify type: <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specify type: <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specify type: <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. In answering these questions, have you answered for both your family and the baby's father's family? <input type="checkbox"/> Yes <input type="checkbox"/> No						

REFERENCE