

Cord Blood Bank First, Last Name DOB: _____

Family Medical History Questionnaire (FMHQ)

Cord Blood Bank Use Only:	
NMDP CBU ID: _____	Local CBU ID: _____
NMDP Maternal ID: _____	Local Maternal ID: _____
Today's Date: _____	Baby's Mother's Initials: _____

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

1. Were you and/or the baby's father adopted at early childhood? If yes, is a family medical history available for you and/or the baby's father?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Are you and the baby's father related, except by marriage? (e.g. first cousins)	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Did this pregnancy use either a donor egg or donor sperm? If yes, is a family medical history questionnaire available for the egg or sperm donor?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you had an abnormal result from a prenatal test (e.g. amniocentesis, blood test, ultrasound)? If yes, answer the following questions. If no, skip to question 5. a. Which test was abnormal? _____ b. What was the abnormal test result? _____ c. Was a diagnosis made? If yes, specify diagnosis: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you had any children who died within the first 10 years of life? If yes, what was the cause? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you ever had a stillborn child? If yes, what was the cause? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

d. Leukocyte Adhesion Deficiency (LAD)	<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
a. ADA or PNP Deficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. 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"/>
c. DiGeorge Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Hereditary Hemophagocytic Lymphohistiocytosis (HLH), including FEL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Hypoglobulinemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Nezeloff Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Severe Combined Immunodeficiency (SCID)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. 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
a. Amegakaryocytic Thrombocytopenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Glanzmann Thrombasthenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Hereditary Thrombocytopenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Platelet Storage Pool Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Thrombocytopenia with absent radii (TAR)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Ataxia-Telangiectasia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. 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 disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No Specify type: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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 a-q. If no, skip to question 16.						
a. Hurler Syndrome (MPS I)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. 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"/>

c. Hunter Syndrome (MPS II)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Sanfilippo Syndrome (MPS III)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

15. Metabolic/storage disease continued.	BM	BF	BS	BGP	BMS	BFS
e. Morquio Syndrome (MPS IV)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Maroteaux-Lamy Syndrome (MPS VI)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Sly Syndrome (MPS VII)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. I-cell disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Globoid Leukodystrophy (Krabbe Disease)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Metachromatic Leukodystrophy (MLD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Adrenoleukodystrophy (ALD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Sandhoff Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Tay-Sachs Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Gaucher Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. Niemann-Pick Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p. Porphyria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q. Other or unknown metabolic/storage disease Specify type: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 a-d. If no, skip to question 18.						
a. Crohn's Disease or Ulcerative Colitis	<input type="checkbox"/>					
b. Lupus	<input type="checkbox"/>					
c. Multiple Sclerosis (MS)	<input type="checkbox"/>					
d. Rheumatoid Arthritis	<input type="checkbox"/>					
18. Other or unknown immune system disorder Specify type: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

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"/>

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21. Had spleen removed to treat 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"/>
	BM	BF	BS	BGP	BMS	BFS
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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, list affected family member(s) and type of disease.						
Specify type: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specify type: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specify type: _____	<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						

RN Review: _____

Date: _____

Donor has completed this form to the best of their knowledge

Cord Blood Donor: _____

Date: _____