

**CORD BLOOD COLLECTION: DEMOGRAPHIC AND HEALTH HISTORY**

<p><b>MOTHER'S NAME:</b></p> <p>_____</p> <p align="center">First                      Middle                      Last</p> <p>Date of Birth: _____ SSN: _____</p> <p>Occupation: _____</p> <p>Due Date: _____</p>	<p><b>FATHER'S NAME:</b></p> <p>_____</p> <p align="center">First                      Middle                      Last</p> <p>Date of Birth: _____ SSN: _____</p> <p>Occupation: _____</p>
<p><b>ADDRESS:</b></p> <p>_____</p> <p align="center">Street                                      Apt.#</p> <p>_____</p> <p align="center">City                      State                      Zip Code</p>	<p><b>ADDRESS:</b></p> <p>_____</p> <p align="center">Street                                      Apt.#</p> <p>_____</p> <p align="center">City                      State                      Zip Code</p>
<p><b>TELEPHONE NUMBERS:</b></p> <p><b>Home:</b> _____</p> <p><b>Work:</b> _____ <b>Ext.</b> _____</p> <p><b>Cell:</b> _____</p> <p><b>Email:</b> _____</p>	<p><b>TELEPHONE NUMBERS:</b></p> <p><b>Home:</b> _____</p> <p><b>Work:</b> _____ <b>Ext.</b> _____</p> <p><b>Cell:</b> _____</p> <p><b>Email:</b> _____</p>

**HOSPITAL INFORMATION**

<p><b>DELIVERY HOSPITAL:</b></p> <p><b>NAME:</b> _____</p> <p><b>Address:</b> _____</p> <p>_____</p> <p align="center">Street                                      Apt.#</p> <p>_____</p> <p align="center">City                      State                      Zip Code</p> <p><b>Phone:</b> _____</p>	<p><b>OB/CNM INFORMATION:</b></p> <p><b>NAME:</b> _____</p> <p><b>Address:</b> _____</p> <p>_____</p> <p align="center">Street                                      Apt.#</p> <p>_____</p> <p align="center">City                      State                      Zip Code</p> <p><b>Phone:</b> _____ <b>Fax:</b> _____</p>
--	---

**CORD BLOOD STORAGE HEALTH HISTORY**

<b>INDICATE YES OR NO TO QUESTIONS BELOW</b>	<b>MOTHER</b>		<b>FATHER</b>	
	YES	NO	YES	NO
01 Have you ever had viral hepatitis, jaundice, or a positive blood test for viral hepatitis?  If "yes" specify which type and when:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
02 In the past 12 months, have you received a blood transfusion, an organ or tissue transplant, had an accidental needle stick or come in contact with someone else's blood? If "yes" please give details:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
03 In the past 12 months, have you lived with or had sexual contact with anyone who has active or chronic viral hepatitis or yellow jaundice? If "yes" please describe type and whether active or chronic:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
04 Have you ever had a positive test for the HIV (AIDS) or HTLV viruses? If "yes" which and when:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
05 In the past 3 years, have you immigrated to the U.S.? If "yes" when and from where:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
06 Have you ever had Babesiosis or Chagas disease?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
07 Have you or anyone in your family had Creutzfeldt-Jakob Disease (CJD) or been told that you may be at risk for CJD?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

NAME: \_\_\_\_\_

INDICATE YES OR NO (continued)	MOTHER		FATHER	
	Yes	No	Yes	No
08 Have you ever had brain surgery? If so, have you received a dura mater (or brain covering) graft?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
09 Have you ever received human pituitary-derived growth hormone?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10 Since 1980, have you knowingly obtained and been injected with a non U.S. licensed drug product made from cattle, such as bovine beef insulin?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11 From 1980 through 1996, did you spend time that adds up to three (3) months or more in the United Kingdom? If "yes" please indicate where and when:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12 From 1980 to present, did you spend time that adds up to five (5) years or more in Europe? If "yes" please indicate where and when:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13 From 1980 to present, did you receive a blood transfusion in the United Kingdom or France? If "yes" please indicate where and when:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14 In the past 3 months, have you been exposed to any infectious diseases? If "yes" please indicate where and when:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15 Do you have any genetic disorders? If "yes" please describe:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16 Do any siblings/family members have any genetic disorders? If "yes" please describe:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17 Do you use drugs or alcohol? If "yes" please describe:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18 Do you have a history of Cancer? If so, which type and when:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19 Do you currently have an acute respiratory disease? If "yes" please describe:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20 Do you currently have an active infectious skin disease? If "yes" please describe:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21 Do you or have you had tuberculosis? If "yes" please give date, diagnosis and treatment you've received:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22 Do you have any blood clotting disorders (coagulation or platelet disorders)? If "yes" please describe:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23 In the past three years, have you traveled outside the United States or Canada? If "yes" where and when?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24 In the past three years, have you travelled to any area where malaria prophylaxes are recommended? If "yes" where and when?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
25 In the past 8 weeks, have you had any vaccinations or other shots? If "yes" please describe:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
26 In the past 8 weeks, have you had contact with someone who had a smallpox vaccination? If "yes" please describe:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Signature of Mother: \_\_\_\_\_ Signature of Father: \_\_\_\_\_ Date: \_\_\_\_\_

**MAZE Lab Use Only**

Biohazardous:  yes  no Reason: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

Signature of MAZE Cord Blood Laboratories Physician: \_\_\_\_\_ Date: \_\_\_\_\_