



Adhesive label

Medical Questionnaire Umbilical Cord Blood Donation

You have read the **Umbilical Cord Blood Donation Information Sheet** and would like to become a cord blood donor. Thank you for providing truthful answers to the following questions by checking the requisite boxes. You will be helping to keep safe not only yourself but also the patients who will be receiving your child's cord blood. The questions concern you, the child's mother. Where information about the child's father, siblings (brothers and sisters) or other relatives is required, it will be specifically mentioned.

At the end of the questionnaire (section D) there is space for further information, comments on individual questions or other relevant information.

A. CHILD'S MOTHER'S DETAILS	
Surname	
First name	
Date of birth	
Street	
ZIP / City	
Phone / E-Mail	

B. PARENTS' ETHNICITY DETAILS				
Which ethnic group do you belong to? Please check.				
African	AFNA	North Africa	Child's mother <input type="checkbox"/>	Child's father <input type="checkbox"/>
	AFSS	Sub-Saharan Africa	Child's mother <input type="checkbox"/>	Child's father <input type="checkbox"/>
Asian	AS	Central Asia: Russian Far East, Kazakhstan, Uzbekistan, Kyrgyzstan, Tajikistan	Child's mother <input type="checkbox"/>	Child's father <input type="checkbox"/>
		North-East Asia: Japan, North and South Korea	Child's mother <input type="checkbox"/>	Child's father <input type="checkbox"/>
		Oceania: Pacific islands except Japan, Australia, New Zealand, Taiwan, Aleutian Islands	Child's mother <input type="checkbox"/>	Child's father <input type="checkbox"/>
		South-East Asia: China, Mongolia, Myanmar, Laos, Cambodia, Thailand, Vietnam, Taiwan	Child's mother <input type="checkbox"/>	Child's father <input type="checkbox"/>
		South-West Asia: Middle East, Turkey	Child's mother <input type="checkbox"/>	Child's father <input type="checkbox"/>
		South Asia: India, Pakistan, Bangladesh, Sri Lanka, Bhutan, Nepal	Child's mother <input type="checkbox"/>	Child's father <input type="checkbox"/>
Caucasian	CAU	Europe, Greenland, Iceland, Russia, Australia, New Zealand, North America (USA, Canada)	Child's mother <input type="checkbox"/>	Child's father <input type="checkbox"/>
Hispanic	HI	Central America, South America, Caribbean	Child's mother <input type="checkbox"/>	Child's father <input type="checkbox"/>
Mixed	MX		Child's mother <input type="checkbox"/>	Child's father <input type="checkbox"/>
Other	OT		Child's mother <input type="checkbox"/>	Child's father <input type="checkbox"/>
Unknown	UK		Child's mother <input type="checkbox"/>	Child's father <input type="checkbox"/>



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C. HEALTH QUESTIONNAIRE

		Yes	No
1.	a) Were you and/or the baby's father adopted as a child?	<input type="checkbox"/>	<input type="checkbox"/>
	b) Did you become pregnant using donor eggs or donor sperm, or as a surrogate mother?	<input type="checkbox"/>	<input type="checkbox"/>
	c) Do you know or can you find out the medical history of the child's father?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Have you been ill in the last 4 weeks or had a fever over 38.5°C? If so, please specify the cause (if known)	<input type="checkbox"/>	<input type="checkbox"/>
3.	a) Have you taken medication during your pregnancy (e.g. tablets, injections, suppositories)? Please specify	<input type="checkbox"/>	<input type="checkbox"/>
	b) In the last 3 years have you taken Acitretin (Neotigason® / Soriatane®), e.g. for psoriasis?	<input type="checkbox"/>	<input type="checkbox"/>
4.	a) Have you ever received immunotherapy (e.g. medication derived from human or animal plasma, cells or serum)? If so, please specify	<input type="checkbox"/>	<input type="checkbox"/>
	b) Have you been vaccinated in the last 4 weeks against any of the following? Flu <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Whooping cough <input type="checkbox"/> <input type="checkbox"/> Tetanus <input type="checkbox"/> Rabies <input type="checkbox"/> Other vaccination(s) <input type="checkbox"/> ? Please specify German measles	<input type="checkbox"/>	<input type="checkbox"/>
5.	Do you have or have you had any of the following illnesses or symptoms? If so, please specify (diagnosis, date, treatment, stating whether resolved or still present)	<input type="checkbox"/>	<input type="checkbox"/>
	a) High blood pressure before or during pregnancy (e.g. pre-eclampsia, HELLP syndrome):	<input type="checkbox"/>	<input type="checkbox"/>
	b) Cardiovascular disease:	<input type="checkbox"/>	<input type="checkbox"/>
	c) Respiratory disease:	<input type="checkbox"/>	<input type="checkbox"/>
	d) Gastrointestinal disease:	<input type="checkbox"/>	<input type="checkbox"/>
	e) Kidney, bladder and urinary or genital tract disease:	<input type="checkbox"/>	<input type="checkbox"/>
	f) Neurological disease:	<input type="checkbox"/>	<input type="checkbox"/>
	g) Immune system disease (e.g. allergy, chronic inflammatory disease, autoimmune disease):	<input type="checkbox"/>	<input type="checkbox"/>
	h) Infectious disease:	<input type="checkbox"/>	<input type="checkbox"/>



<i>Adhesive label</i>		Yes	No
i)	Contact with a person with a contagious or infectious disease? Which disease? Date	<input type="checkbox"/>	<input type="checkbox"/>
j)	Blood disease:	<input type="checkbox"/>	<input type="checkbox"/>
k)	Cancer:	<input type="checkbox"/>	<input type="checkbox"/>
l)	Diabetes: Type I <input type="checkbox"/> Type II <input type="checkbox"/> Gestational <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m)	Thyroid disease: Hashimoto's thyroiditis <input type="checkbox"/> Hyperthyroidism <input type="checkbox"/> Other <input type="checkbox"/> Please specify: Treatment? From when to when?	<input type="checkbox"/>	<input type="checkbox"/>
n)	Other disease:	<input type="checkbox"/>	<input type="checkbox"/>
6.	In the last 12 months have you had:	<input type="checkbox"/>	<input type="checkbox"/>
a)	An accident <input type="checkbox"/> Surgery <input type="checkbox"/> If so, please specify:	<input type="checkbox"/>	<input type="checkbox"/>
b)	A blood transfusion (e.g. packed red cells, platelet concentrate, plasma)? If so, when? Why? In which country?	<input type="checkbox"/>	<input type="checkbox"/>
7.	Creutzfeldt-Jakob disease risk		
a)	Have you or a blood relative been found or suspected to have Creutzfeldt-Jakob disease? Child's mother <input type="checkbox"/> Child's father <input type="checkbox"/> Other relative <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b)	Have you ever had a human tissue transplant? If so, please specify:	<input type="checkbox"/>	<input type="checkbox"/>
c)	Have you ever had an animal tissue transplant? If so, please specify:	<input type="checkbox"/>	<input type="checkbox"/>
d)	Have you ever had brain or spinal cord surgery? If so, please specify:	<input type="checkbox"/>	<input type="checkbox"/>
8.	Tropical virus risk (including Chikungunya, Dengue, West Nile and Zika virus)		
a)	Have you traveled outside Switzerland in the last 6 months? If so, where? When did you get back? Did you have symptoms (e.g. fever) during your stay or have you had any since your return?	<input type="checkbox"/>	<input type="checkbox"/>
b)	During your pregnancy were you ever diagnosed with Chikungunya, West Nile or Dengue infection?	<input type="checkbox"/>	<input type="checkbox"/>
c)	Have you or your partner been diagnosed with Zika infection in the last 4 months?	<input type="checkbox"/>	<input type="checkbox"/>



Adhesive label		Yes	No
9.	Malaria risk		
a)	Have you ever had malaria? If so, when?	<input type="checkbox"/>	<input type="checkbox"/>
b)	Have you visited a malaria risk area in the last 3 years? If so, where? When?	<input type="checkbox"/>	<input type="checkbox"/>
10.	Chagas disease risk		
a)	Have you ever had Chagas disease?	<input type="checkbox"/>	<input type="checkbox"/>
b)	Were you or your mother (the child's grandmother) born or raised outside Europe or have you lived outside Europe for more than 6 months? If so, which or both of you? In which country?	<input type="checkbox"/>	<input type="checkbox"/>
11.	Have you ever had:	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Tuberculosis <input type="checkbox"/> Lyme disease <input type="checkbox"/> Brucellosis <input type="checkbox"/> Osteomyelitis <input type="checkbox"/> Q fever <input type="checkbox"/> Toxoplasmosis <input type="checkbox"/> Babesiosis <input type="checkbox"/> Leishmaniasis	<input type="checkbox"/>	<input type="checkbox"/>
	If so, when?		
	Does any close contact (e.g. carer or member of the same household) have open tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>
12.	In the last 2 months have you had:	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> A tattoo <input type="checkbox"/> Gastroscopy / colonoscopy <input type="checkbox"/> Acupuncture <input type="checkbox"/> Permanent make-up <input type="checkbox"/> Piercing <input type="checkbox"/> Microblading <input type="checkbox"/> Contact with another person's blood (via needle stick injury or splatter in the eye, mouth or other) If so, when?	<input type="checkbox"/>	<input type="checkbox"/>
	Were sterile instruments used? <input type="checkbox"/> Yes <input type="checkbox"/> No		
13.	a) Have you ever had jaundice or hepatitis? If so, please specify: Hepatitis A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> E <input type="checkbox"/> Jaundice:	<input type="checkbox"/>	<input type="checkbox"/>
	b) Has your partner had hepatitis or jaundice in the last 12 months? Please specify: Hepatitis A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> E <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
14.	a) Have you spent at least 6 of the last 12 months in a country with a high HIV rate? If so, where?	<input type="checkbox"/>	<input type="checkbox"/>
	b) Did you incur a risk of HIV during your stay (e.g. through sex or medical or paramedical procedures such as blood transfusion, tattooing or piercing)?	<input type="checkbox"/>	<input type="checkbox"/>



<i>Adhesive label</i>		Yes	No
15.	Do one or more of the following risk situations apply to you?	<input type="checkbox"/>	<input type="checkbox"/>
	a) Change in sexual partner in the last 4 months	<input type="checkbox"/>	<input type="checkbox"/>
	b) Sex in exchange for money, drugs or medicaments in the last 12 months	<input type="checkbox"/>	<input type="checkbox"/>
	c) Sex with a partner who had had sex with men in the previous 12 months	<input type="checkbox"/>	<input type="checkbox"/>
	d) Intravenous drug use in the last 12 months	<input type="checkbox"/>	<input type="checkbox"/>
	e) Positive test for HIV, syphilis or hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>
16.	In the last 12 months have you had sex with partners who have:	<input type="checkbox"/>	<input type="checkbox"/>
	a) incurred any of the risks itemized in Question 15?	<input type="checkbox"/>	<input type="checkbox"/>
	b) had a blood transfusion in a country with a high HIV rate?	<input type="checkbox"/>	<input type="checkbox"/>
	c) incurred any other HIV risk (e.g. through sex, tattooing or piercing) in a country with a high HIV rate?	<input type="checkbox"/>	<input type="checkbox"/>
17.	In the last 12 months have you had symptoms of, or been treated for, chlamydia, genital herpes, syphilis, or any other sexually transmitted disease? Please specify:	<input type="checkbox"/>	<input type="checkbox"/>
18.	Do any of the following diseases run in your family? If so, please indicate their relationship to the child	<input type="checkbox"/>	<input type="checkbox"/>
	a) Red blood cell disease (e.g. thalassemia, sickle cell anemia etc) Please specify Child's father <input type="checkbox"/> Child's sibling <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Aplastic anemia Child's father <input type="checkbox"/> Child's sibling <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b) Platelet disease (e.g. immune thrombocytopenia purpura) Please specify Child's father <input type="checkbox"/> Child's sibling <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	c) Genetic bleeding disorder (e.g. hemophilia, von Willebrand disease, factor V Leiden mutation) Please specify Child's father <input type="checkbox"/> Child's sibling <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	d) Metabolic and lysosomal storage disease (e.g. cystic fibrosis, gout, Tay-Sachs, Fabry's disease, Gaucher's disease, Niemann-Pick disease) Please specify Child's father <input type="checkbox"/> Child's sibling <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	e) Diabetes type I: Child's father <input type="checkbox"/> Child's sibling <input type="checkbox"/> Diabetes type II: Child's father <input type="checkbox"/> Child's sibling <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	f) Congenital or acquired immunodeficiency Please specify Child's father <input type="checkbox"/> Child's sibling <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



		Yes	No
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g)	Malignant blood disease (e.g. leukemia, multiple myeloma, myelodysplastic syndrome, essential thrombocythemia etc.) Please specify Child's father <input type="checkbox"/> Child's sibling <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h)	Cancer Please specify Child's father <input type="checkbox"/> Child's sibling <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i)	Other disease Please specify Child's father <input type="checkbox"/> Child's sibling <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D. COMMENTS ON THE QUESTIONNAIRE (Mother)

Question:

Question:

Question:

Question:

Question:

Question:

I confirm that my personal details are correct and that I have been truthful in completing the questionnaire

Mother

Surname: First name: Date of birth:

Date: Signature:

Father (optional)

Surname: First name: Date of birth:

Date: Signature:



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Questionnaire review by qualified staff

E. TO BE COMPLETED AT RECRUITMENT

Comments on Section C “Medical Questionnaire”:

Question:

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Question:

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Question:

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Question:

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Question:

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Questionnaire reviewed (at recruitment): Date: Signature

Maternity Unit (please check):

Aarau: Basel: Bern: Geneva: Tessin:

F. TO BE COMPLETED AT UMBILICAL CORD BLOOD COLLECTION

Having reviewed the pregnant patient’s medical questionnaire and medical history, I hereby certify that there is currently no physical evidence of present or past HIGH RISK BEHAVIOR for communicable infectious disease (HIV, HTLV, hepatitis B or C, or sexual communicable disease). Based on the documentation / medical history available to me, I confirm that this donor is able to donate her baby’s umbilical cord blood at birth. Should fresh health information emerge that could impact this donation, I undertake to forward it to the umbilical cord blood bank.

Physician:

Surname: First name:

Date: Physician’s signature: