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Medical Questionnaire
Public Cord Blood Bank Switzerland

You have just read the **information sheet for cord blood donation** and you would like to donate your child's cord blood. We thank you for answering the following questions with the greatest sincerity by marking with a cross in the check box required. By doing so you will contribute to your own security and to the security of the recipient of your child's cord blood.

A. CHILD'S MOTHER'S INFORMATION

Name	
First Name	
Date of Birth	
Street	
ZIP / City	
Phone / E-Mail	

B. PARENTS' ETHNIC INFORMATION

Which ethnic group do you belong to? Please fill in according to the enclosed list.

Child……………………………………………………………………………

Child's mother…………………………………………………………………..

Child's father……………………………………………………………………

C. HEALTH QUESTIONNAIRE

			Yes	**No**	**Visa**
1.	a)	Were you and/or the child's father adopted at early childhood?	☐	☐	
	b)	Did conception result from fertilization using either donor sperm, donor ovum or surrogacy?	☐	☐	
2.		During the past 4 weeks have you been ill, received medical care, or had a temperature of more than 38°C (or 100°F)?	☐	☐	
3.	a)	During the past 4 weeks, have you taken any medicines (tablets, injections, suppositories)? If so, please specify ………………………………………………………………………………..	☐	☐	
	b)	Have you taken Roaccutan® (acne) or Propecia® (baldness) during the past 4 weeks?	☐	☐	
	c)	During the past 3 years, have you taken Neotigason® / Soriatane (treatment of psoriasis)?	☐	☐	
4.	a)	Did you ever receive an immunotherapy (plasma, cells or serum of human or animal origin)?	☐	☐	

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		Yes	No	Visa
	b) Have you been vaccinated against Rabies, Hepatitis B or Tetanus during the last 12 months?	☐	☐	
	c) Have you had another vaccination during the last 4 weeks? Please specify? ……………………………………… When? ………………………………	☐	☐	
5.	Have you ever had any of the health problems or disorders mentioned below? If yes, please specify on page 5, under E — Child's mother / Child's father a) cardiovascular ☐ ☐ b) breathing, lungs ☐ ☐ c) stomach/intestines ☐ ☐ d) urinary tract, kidneys, genital ☐ ☐ e) neurological ☐ ☐ f) immune system ☐ ☐ g) infections ☐ ☐ h) malignant blood disease, please specify (s. question 17) ……………………………………………………… ☐ ☐ i) cancer, please specify (s. question 17) ……………………………………………………….. ☐ ☐ j) other, (e.g., diabetes) please specify ……………………………………………………… ☐ ☐	☐	☐	
6.	During the past 12 months have you had ☐ an illness? ☐ an accident? ☐ surgery? If yes, please specify……………………………………………………………………	☐	☐	
7.	a) Have you ever received graft(s) of human or animal tissues?	☐	☐	
	b) Have you ever had an operation on the brain or spinal cord?	☐	☐	
	c) Before 01.01.1986, were you ever treated with growth hormones?	☐	☐	
	d) Has any member of your family had Creutzfeldt-Jakob disease or are you aware of a high risk in your family of this disease? Child's mother Child's father	☐ ☐	☐ ☐	
	e) Between 01.01.1980 and 31.12.1996, did you ever stay for a period of 6 months or more in the United Kingdom (UK) (England, Wales, Scotland, Northern Ireland, Isle of Man, Channel Island, Gibraltar, Falkland Islands)?	☐	☐	
	f) Did you receive one or more blood transfusions since 01.01.1980?	☐	☐	
8.	During the past 6 months, did you travel outside Europe? Where? ………………………… On what date did you return to Switzerland? …………………………………………………….. During this period did you have any clinical symptoms (e.g. fever)?	☐ ☐	☐ ☐	
9.	a) Have you ever had malaria fever or malaria crisis? If yes, please specify on page 5, under E	☐	☐	
	b) Were you born/did you grow up/have you lived more than 6 months in a country where malaria is endemic?	☐	☐	
10.	Have you had any of the following diseases? ☐ tuberculosis? ☐ borreliosis? ☐ brucellosis? ☐ bone infection? ☐ Q fever? ☐ toxoplasmosis? ☐ babesiosis? ☐ Chagas disease? ☐ leishmaniasis? If yes, when? ………………………………………………………………………………	☐	☐	

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		Yes	No	Visa
11.	During the past 6 months have you undergone: ☐ tattooing? ☐ a gastro-, colonoscopy? ☐ acupuncture? ☐ electric epilation? ☐ permanent make-up? ☐ body piercing? ☐ injury by a blood-contaminated product/device? If so, when? ……………………………………………………………………………… Sterile instruments ☐ yes ☐ no	☐	☐	
12.	a) Have you ever had jaundice (hepatitis) or a positive test for hepatitis?	☐	☐	
	b) Has anyone who lives in the same domicile as you, or your sexual partner, had jaundice (hepatitis) during the last 12 months?	☐	☐	
13.	Have you been exposed to one of the following risk situations?	☐	☐	
	a) Change of sexual partner in the past 4 months or sexual intercourse (with or without protection) with several partners in the last 12 months	☐	☐	
	b) During the past 12 months, stay of at least 6 months in countries where AIDS is epidemic	☐	☐	
	c) Had your partner sexual intercourse with men since 1977?	☐	☐	
	d) Sexual intercourse for money since 1977	☐	☐	
	e) Intravenous drug abuse at present or in the past	☐	☐	
	f) Positive test for HIV, syphilis, or jaundice (hepatitis B and C)	☐	☐	
14.	During the past 12 months, have you had sexual intercourse with partners exposed to one of the risk situations mentioned under 13 or who received blood transfusions in countries where AIDS is epidemic?	☐	☐	
15.	During the past 12 months, have you shown evidence of or been treated for Chlamydia, genital herpes, syphilis or any other sexually transmitted disease?	☐	☐	
16.	Before 01.01.01986, did you receive hormone injections as treatment of sterility?	☐	☐	
17.	Is there in the family a history of the following diseases? If yes, please specify degree of relationship.	☐	☐	
	a) Red Blood Cell disease (e.g. thalassemia, sickle cell disease etc.) ☐ Child's father ☐ Child's mother ☐ sibling ☐ grandparents			
	b) White Blood Cell disease ☐ Child's father ☐ Child's mother ☐ sibling ☐ grandparents			
	c) Platelet disease (e.g. essential thrombocythosis, thrombocytopenia etc.) ☐ Child's father ☐ Child's mother ☐ sibling ☐ grandparents			
	d) Metabolic/storage disease (e.g. Tay-Sachs, Fabry's, Gaucher, Niemann-Pick, diabetes etc.) ☐ Child's father ☐ Child's mother ☐ sibling ☐ grandparents			
	e) Immunodeficiencies ☐ Child's father ☐ Child's mother ☐ sibling ☐ grandparents			
	f) Acquired/inherited autoimmune system disorders (e.g. Lupus, M. Basedow, etc.) ☐ Child's father ☐ Child's mother ☐ sibling ☐ grandparents			
	g) Malignant blood disorders (e.g. leucemia, multiple myeloma, myelodysplastic syndrome, etc.) ☐ Child's father ☐ Child's mother ☐ sibling ☐ grandparents			
	h) Other cancers including multiple tumours ☐ Child's father ☐ Child's mother ☐ sibling ☐ grandparents			
	i) Inherited bleeding disorders (e.g. hemophilia, von Willebrand disease, etc.) ☐ Child's father ☐ Child's mother ☐ sibling ☐ grandparents			

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I confirm the accuracy of my personal data and that I filled out the questionnaire truthfully.

Mother:

Name:………………………………………… First name:…………………………… Date of birth:……………………………..

Date:………………………………………… Signature:………………………………………………………………………………

Father (facultative):

Name:………………………………………… First name:…………………………… Date of birth:……………………………..

Date:………………………………………… Signature:……………………………………………………………………………...

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Verification of the medical questionnaire by medical personnel

D. TO BE FILLED OUT BY THE MATERNITY CLINIC

Remarks to section C "Health Questionnaire":

Question …….. : ………

Question …….. : ………

Question …….. : ………

Questionnaire controlled by maternity clinic: Date: ………………………………………Visa: …………………………………..

Delivery Institution (please tick appropriate):
Basel: ☐ Bern: ☐ Geneva: ☐ Tessin: ☐ Aarau: ☐

After having reviewed the Medical Questionnaire and the future mother's medical records, I hereby certify that there are no physical signs to suggest present or past HIGH RISK BEHAVIOUR for transmissible infectious diseases (HIV, HTLV, hepatitis B or C and sexually transmitted diseases) at the moment and that all responses to the Medical Questionnaire are accurate to the best of my knowledge. According to the answers I confirm that this donor is able to donate her child's cord blood at birth to the *Public Cord Blood Bank Switzerland.* In the event of new health information that may arise and which might affect this donation I assure to provide such information to the *Public Cord Blood Bank Switzerland.*

Name of Physician: ……………………………………….. First Name: ………………………………………………………......

Date: …………………………………………………. Signature of Physician: …………………………………………………

E. TO BE FILLED OUT BY THE CORD BLOOD BANK OR THE BLOOD TRANSFUSION SERVICE

Questionnaire controlled and approved by:
☐ Cord Blood Bank ☐ Blood Transfusion Service

Name: ………………………………………………….. First Name: ………………………………………………………......

Date: …………………………………………………. Signature: ……………………………………………………………

F. TO BE FILLED OUT BY THE CORD BLOOD BANK

Cord Blood Bank (please tick appropriate):
Basel: ☐ Geneva: ☐

Criteria to donate Cord Blood are fulfilled:
☐ Yes ☐ No

Name: ………………………………………………….. First Name: ………………………………………………………......

Date: …………………………………………………. Signature: ……………………………………………………………

AF	African
AFNA	North Africa
AFSS	Sub-Saharan Africa
AS	Asian
ASCE	Central Asia (Eastern Russia, Kazakhstan, Uzbekistan, Kyrgyzstan, Tajikistan)
ASNE	Northeast Asia (Japan, North Korea, South Korea)
ASOC	Oceania (Pacific Islands excluding Japan; Australia, Taiwan, Sakhalin, Aleutian Islands)
ASSE	Southeast Asia (China, Mongolia, Burma, Laos, Cambodia, Thailand, Vietnam, Taiwan)
ASSO	Southern Asia (India, Pakistan, Bangladesh, Sri Lanka, Bhutan, Nepal)
ASSW	Southwest Asia (Middle East, Turkey)
CA	Caucasian
CAAU	Australia, New Zealand
CAER	Eastern Russia
CAEU	Europe (Mainland Europe, Greenland, Iceland, Western Russia)
CANA	North America (USA, Canada, Mexico)
HI	Hispanic
HICA	Central America, Caribbean
HISA	South America
MX	Multiple / Mixed
OT	Other
UK	Unknown