



ANNUAL UPDATE FORM

Participant Name: _____

IFAR number: _____

General Health:

Current height: _____ (in) Current weight: _____ (lbs) Current H.C. _____ (cm)

Date of measurements: _____

Has the participant had any infections in the interim? Y/N If Y please circle all that apply:

Pneumonia Bronchitis CMV

Strep throat Otitis media EBV

Other: _____

Has the participant had surgery in the interim? Y/N

Date: _____ Location: _____ Reason: _____

Date: _____ Location: _____ Reason: _____

Has the participant been hospitalized in the interim? Y/N

Date admitted: _____ Date discharged: _____ Location: _____ Reason: _____

Date admitted: _____ Date discharged: _____ Location: _____ Reason: _____

Is the participant followed by any new physician(s): Yes No

Name Specialty Hospital Phone Number

Name Specialty Hospital Phone Number

Has the participant had the HPV vaccine since the last follow-up? Yes No

If yes, age at time of vaccine? _____

Is the participant involved in any other research studies? Yes No

Location of other research study: _____ PI: _____

Hematologic Testing:

Has participant had blood counts since last follow-up? Yes No I do not know

Date: _____ WBC: _____ ANC: _____ ALC: _____ HGB: _____ MCV: _____ Retic: _____ Plts: _____

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Has the participant had a bone marrow aspirate since last follow-up? Yes No

Date: _____ Cellularity: _____ % Blasts: _____ Dysplasia: _____ Cytogenetics: _____

Has the participant had a bone marrow biopsy since last follow-up? Yes No

Date: _____ Cellularity: _____ Dysplasia: _____

Genetic/Diagnostic Testing:

Has the participant had chromosome breakage assays in the interim? Y N

If yes: _____
 Date Laboratory Result

Has the participant had complementation testing in the interim? Y N

If yes: _____
 Date Laboratory Result

Has the participant had molecular FA testing in interim? Y N

If yes: _____
 Date Laboratory Result

Has the participant had any other genetic testing in the interim? Y N

If yes: _____
 Date Laboratory Result

Treatment (in the interim):

Has the participant had RBC transfusions? Y/N # of transfusions: _____

Has the participant had platelet transfusions? Y/N # of transfusions: _____

Has the participant had androgen therapy? Y/N Date started: _____ Date ended: _____
 Type of androgen: _____ Dose: _____

Has the participant had treatment for diabetes? Y/N Date started: _____ Date ended: _____
 Type therapy: _____ Dose: _____

Has the participant had any other hormone therapy? Y/N
 Hormone: _____ Date started: _____ Date ended: _____

Transplant:

Has participant had a BMT since last follow-up? Y/N If yes, please answer the following:

Date of BMT: _____

Location: MSKCC MN Cincinnati Duke
 J. Hopkins CHB Hackensak Other: _____

Donor: Degree of HLA match: _____
 Related/Unrelated If related, relationship to proband: _____

Type of donation: BM PSC cord blood

BMT Prep: Chemo used? Y/N Agent: _____ Dose: _____
 Radiation used? Y/N Dose: _____
 Immunosuppressant agent? Y/N Agent: _____ Dose: _____

Complications: Fevers Infection Rash
 BK Virus EBV CMV



Nausea Mouth sores Diabetes

Other: _____

Please describe: _____

Has the participant had GvHD? Y/N Acute/Chronic Grade: _____

Symptoms: _____

Cancer:

Has the participant been diagnosed with cancer? Y/N If yes, please answer the following:

Site of cancer: Neck Mouth Pharynx Esophagus Skin
 (circle all that apply): Liver Lung Kidney Prostate Anal
 Colon Breast Cervix Vulva Ovary
 Blood Other: _____

Other types of cancer: medulloblastoma neuroblastoma retinoblastoma

Other type of cancer: _____

Subsite: _____

Date of diagnosis: _____

Is the cancer: new recurrence metastasis Stage: _____ HPV: pos/neg/unk

Did participant have surgery? Y/N Date: _____ Tx Center: _____

Did participant have chemo? Y/N Date: _____ Tx Center: _____
 Medication: _____ Dose: _____ Frequency: _____

Did participant have radiation? Y/N Date: _____ Tx Center: _____
 Frequency: _____ Radiation dose: _____

Changes in family members:

Have any additional siblings been born in the interim? Yes No

Date of birth: _____ Gender: M/F Affected with FA: Y/N

Have any family members in the IFAR died in the interim? Yes No I do not know

Relationship to proband: _____ Name: _____

Date of death: _____ Cause of death: _____

Other

Completed by: _____

Date: _____

Email address: _____

Telephone: _____