**NIH RUNX1 Natural History Study Intake Form**

Please complete this form and return it to our research nurse prior to your visit. If you do not understand the meaning of some of these questions, do not worry; these questions will be reviewed with you during your initial appointment.

**Name:**

**Age:**

**DOB:**

**Height:**

**Weight:**

1. **Describe any history of bleeding** *(e.g. nose bleeds, difficult wound healing, heavy periods)* **or bruising?**
2. **Have you ever received treatment for bleeding? (***What and when***)**
3. **Have you ever had a blood or platelet transfusion?** *(Please list any dates and reasons)*
4. **Have you ever had a bone marrow biopsy?** *(Please list any dates and results)*
   1. If so, what kind of sedation did you have (Local vs conscious sedation (twilight) vs anesthesia)? How did it go?
5. **Have you ever had a bone marrow transplant?** *(Please list any dates)*
6. **Do you have a personal history of cancer?** *(If so what type and when?)*

Please describe if you have had any of the following:

1. **Any constitutional symptoms?** (*e.g. swollen lymph nodes, fevers, chills night sweats, weight loss or gain, current or ongoing pain)*
2. **Any gastrointestinal symptoms?** (*e.g. reflux, diarrhea, constipation, nausea, vomiting, difficulty swallowing, blood in stool or urine?)*
3. **Any issues with your heart or lungs?** (*e.g. heart defects, shortness of breath on exertion or when lying flat, swelling in lower extremities, reactive airway disease, asthma, wheezing, exercise intolerance, previous pulmonary function tests (PFTs) or inhaler use*)
4. **Any issues with your eyes or ears?** *(e.g. visual changes, hearing loss, ringing in ears)*
5. **Any issues with your skin or hair**? (*e.g. eczema, psoriasis, abnormal moles, mealnomas, hair loss, birthmarks or rough, scaly, raised, or discolored areas of skin)*
6. **Any issues with your teeth?** *(e.g. frequent cavities)* **Have you had your wisdom teeth removed?**
7. **Any issues with your immune system?** *(e.g. frequent infections, fevers, allergies, sinusitis, pneumonia, antibiotic resistant organisms)* **Have you had your tonsils and/or adenoids removed?**
8. **Any issues with your endocrine system?** (*e.g. hormone imbalance, abnormal menstruation, diabetes, thyroid issues or fatigue*)
9. **Any neurological symptoms?** *(e.g. numbness or burning in your fingers or toes, weakness, headaches, memory issues, seizures, issues with balance)*
10. **Any issues with your muscles or bones?** (*e.g. flat feet, hyperextensibility, fractures, non-cancerous lesions such as lipomas, moles, polyps, breast or uterine masses)*
11. **Any issues with learning, growth or development?**
12. ***For female participants:* Have you ever been pregnant? If so, did you have any complications with your pregnancy?**
13. **Have you ever had any surgeries? When were they? *(****This includes small procedures like wisdom teeth removal, hernias, biopsies/excisions of lumps, bumps, or nodules)* **Did you have any difficulties with surgeries?**
14. **Have you ever had any hospitalizations? When?**
15. **What medications or supplements do you take regularly and how long have you been taking them?**

**Family History:**

1. **Are there other members of your family with confirmed *RUNX1* mutation? Who are they?**
2. **Has anyone in your family ever been diagnosed with myelodysplastic syndrome (MDS), leukemia, lymphoma, or multiple myeloma?**
3. **Has anyone in your family been diagnosed with other types of cancer** *(e.g. breast, colon, thyroid, melanoma etc.)***?**
4. **Has anyone else in your family had a history of bleeding, bruising or painful periods?**