BE THE MATCH®

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Donor Health History Screening Questionnaire **GRID:** _____

Registry Donor ID: _____

For Use at HR ☐ **CT** ☐ **Workup** ☐ **Other:** _____ **Form Creation Date:** 02/21/2022

Last Name	First Name	Middle Initial

Height _____ ft/in. ☐ m/cm. ☐	Weight _____ lb. ☐ kg. ☐	DOB	Age

INSTRUCTIONS:

Birth Sex: Male ☐ **Female** ☐

- Read each question as written. The donor should answer to the best of their knowledge. Use the additional guidance in parenthesis to gather more information to evaluate a "yes" response.
- Mark each response clearly as "yes" or "no" or "NA".
- For #1, explain a "no" response. For all other questions, **explain any "yes" response** in the space provided by the question or in the applicable Comment Section, 1 or 2. Include details such as type/name of any medications, when event(s) occurred, type of surgery, current status, etc., which will assist in evaluation.
- All information is confidential. This questionnaire is to protect the donor, as well as safeguard the potential recipient.
- This form must be completed with information provided by the potential donor. A friend, family member, or anyone else may not complete it in their place.
- Any questions should be discussed with the donor center staff.

SECTION 1: General Assessment and Donor Safety

1. Are you in good health?	**Yes** ☐	**No** ☐
2. Do you have an infection now, or are you currently taking antibiotics?	**Yes** ☐	**No** ☐
3. Are you currently taking any other medication, including over-the-counter medications, vitamins, herbal products, medicinal marijuana or CBD oil, or investigational drugs? (***If YES,*** list each drug and the reason for their use, if known.)	**Yes** ☐	**No** ☐
4. In the past 12 months, have you needed treatment in an emergency room, been hospitalized, or had surgery?	**Yes** ☐	**No** ☐

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5. In the past 12 months, have you received a blood transfusion or human tissue transplant, such as cornea or bone?	**Yes** ☐	**No** ☐
6. Have you ever had a blood transfusion from a source other than your own blood?	**Yes** ☐	**No** ☐
Questions 7 - 10 FOR FEMALE DONORS ONLY – male donors do not complete		
7. Do you plan to or is there any chance that you will become pregnant in the next 6 months?	**Yes** ☐	**No** ☐
8. How many times have you been pregnant? If **ZERO,** do not answer #9 & #10**,** go to #11. **Total pregnancies:**		
9. In the past 6 weeks, have you been pregnant or are you now pregnant?	**Yes** ☐	**No** ☐
10. Have you had any health problems associated with or caused by pregnancy?	**Yes** ☐	**No** ☐
11. Have you ever <u>received</u> an organ, bone marrow, or stem cell transplant or <u>donated</u> bone marrow, stem cells, or an organ, such as a kidney?	**Yes** ☐	**No** ☐
12. Have you or any of your blood relatives ever had problems with general anesthesia or regional anesthesia such as an epidural or spinal block?	**Yes** ☐	**No** ☐
13. Do you have any food, drug, latex or environmental allergies?	**Yes** ☐	**No** ☐
14. Have you ever had neck, back, hip, or spine problems? (***If YES,*** please describe current status, treatments and any related surgeries. Include pain level and any limitations to range of motion or activities.)	**Yes** ☐	**No** ☐
15. Have you ever had breathing problems, including asthma, COPD, sleep apnea, tuberculosis, or shortness of breath?	**Yes** ☐	**No** ☐

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16. Have you ever had a heart attack, heart-related chest pains, heart disease, heart surgery or been diagnosed with atrial fibrillation or any other abnormal heart rhythm?	**Yes** ☐	**No** ☐
17. Have you ever had cancer, including leukemia? (***If YES,*** describe stage, treatment, and any recurrence.)	**Yes** ☐	**No** ☐
18. Have you ever had a parasitic blood disease, such as leishmaniasis or babesiosis?	**Yes** ☐	**No** ☐
19. Do you have an autoimmune disorder such as diabetes, psoriasis, Crohn's, Hashimoto's, Raynaud's, or a condition causing inflammation in the eye such as iritis or episcleritis?	**Yes** ☐	**No** ☐
20. Have you ever had brain surgery or head trauma, such as a concussion, skull fracture or traumatic brain injury (also called TBI)? (***If YES,*** describe <u>each</u> injury, dates, symptoms or any loss of consciousness.)	**Yes** ☐	**No** ☐
21. Have you ever had a stroke, a blood clot (also called deep vein thrombosis or DVT) or do you have a bleeding or clotting disorder such as Factor Five Leiden?	**Yes** ☐	**No** ☐
22. In the past 4 weeks, have you had any vaccinations (other than smallpox) or any kind of shot?	**Yes** ☐	**No** ☐
23. Are you planning to receive any vaccinations (including smallpox) or shots?	**Yes** ☐	**No** ☐

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24. In the past 3 years**,** have you had malaria?	**Yes** ☐	**No** ☐
25. In the past 3 years, have you lived* outside the United States or Canada? (***If YES,*** list where, when, and for how long. Include details such as dates, cities, countries, and modes of transportation (car, plane, bus, etc.) while in the countries. Note if you took anti-malaria medication. Note if you were sick at all while you were there or after you returned to the U.S.; if so, what were your symptoms and did you seek any medical attention?) * defined as being in a location(s) 12 months or more	**Yes** ☐	**No** ☐
26. In the past 12 months, have you traveled* outside the United States or Canada? (***If YES,*** please list where, when and for how long. Include details such as dates, cities, countries, and modes of transportation (car, plane, bus, etc.) while in the countries. Note if you took anti-malaria medication. Note if you were sick at all while you were there or after you returned to the U.S.; if so, what were your symptoms and did you seek any medical attention?) * defined as being in a location(s) less than 12 months	**Yes** ☐	**No** ☐
27. Do you have a mental health condition such as Depression, Anxiety or Panic Attacks, Bipolar Disorder, Schizophrenia, Borderline Personality Disorder, or Post-Traumatic Stress Disorder (PTSD)? (***If YES,*** please list specific diagnosis and who is managing your care. Do you receive any other forms of treatment/care beyond medications? Do you receive Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) as a result of this diagnosis?)	**Yes** ☐	**No** ☐

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28. Do you see a physician for anything other than a routine physical? Is there any other <u>past or present</u> health information that we have not discussed yet, for example, a serious injury, past surgery, or chronic medical condition?	**Yes** ☐	**No** ☐

SECTION 1 Comment Section (include number of question when recording comment)

Continue to next page.

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SECTION 2: Communicable Disease Assessment

29. In the past 120 days (4 months), have you had a positive test for West Nile Virus?		**Yes** ☐	**No** ☐
30. Have you ever been told by a healthcare professional that you had or might have had West Nile Virus? If ***YES***, answer #30A. If ***NO***, do not answer #30A; go to #31.		**Yes** ☐	**No** ☐
30A. When were you told this? *(Date)*			
31. In the past 8 weeks, have you received a smallpox vaccination? If ***YES***, answer #31A – #31C. If ***NO***, do not answer #31A – #31C; go to #32.		**Yes** ☐	**No** ☐
31A. When did you receive the vaccination? *(Date)*			
31B. Has the vaccination scab fallen off your skin by itself?	**Yes** ☐	**No** ☐	
31C. Did you have any illness or complications due to the vaccination such as an eye infection or a rash, an allergic reaction, sores away from the vaccination site?	**Yes** ☐	**No** ☐	
32. Have you had close contact with the vaccination site of anyone who has received the smallpox vaccine in the past 3 months? If ***YES***, answer #32A - #32C. If ***NO***, do not answer #32A - #32C; go to #33.		**Yes** ☐	**No** ☐
32A. When did the person receive the vaccination? *(Date)*			
32B. When was the close contact? *(Date)*			
32C. Have <u>you</u> had any new skin rash or sores or an eye infection since the time of contact?	**Yes** ☐	**No** ☐	
33. Have you been diagnosed with Creutzfeldt - Jakob disease (CJD) or variant CJD?		**Yes** ☐	**No** ☐
34. Have any of your blood relatives been diagnosed with Creutzfeldt - Jakob disease or have you been told that your family has an increased risk for this disease?		**Yes** ☐	**No** ☐
35. Do you have a degenerative neurological condition such as dementia or any other disease of the central nervous system where the cause is unknown?		**Yes** ☐	**No** ☐
36. Have you ever had a dura mater (or brain covering) transplant for a head or brain injury?		**Yes** ☐	**No** ☐
37. Have you ever received growth hormone made from human pituitary glands?		**Yes** ☐	**No** ☐
38. Have you ever had Chagas disease or any positive tests for Chagas or T. cruzi, *including screening tests*?		**Yes** ☐	**No** ☐
39. Do you have HIV or AIDS or have you ever tested positive for the HIV virus, *including screening tests?*		**Yes** ☐	**No** ☐
40. Do you have any of the following? • <u>unexplained</u> weight loss, night sweats, or persistent diarrhea • <u>unexplained</u> persistent cough or shortness of breath • <u>unexplained</u> persistent white spots or unusual sores in the mouth • <u>unexplained</u> temperature higher than 100.5°F (38.0°C) for more than ten days • blue or purple spots on or under the skin or mucous membranes • lumps in the neck, armpits, or groin lasting longer than one month		**Yes** ☐	**No** ☐
41. Have you ever tested positive for HTLV (Human T-lymphotropic virus)*, including screening tests?*		**Yes** ☐	**No** ☐

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42. Have you ever tested positive for hepatitis, *including screening tests,* or have you ever had yellow jaundice, liver disease, or hepatitis since the age of 11 years?		**Yes** ☐	**No** ☐
43. Have you ever tested positive for syphilis, *including screening tests,* or ever been treated for syphilis?		**Yes** ☐	**No** ☐
44. Have you, any of your sexual partners, or any members of your household ever had a xenotransplant or a medical procedure that involved being exposed to *live* cells, tissues, or organs from an animal donor?		**Yes** ☐	**No** ☐
45. In the past 12 months**,** have you had a tattoo? (***If YES***, provide date of tattoo application and if you have any signs of infection. If multiple tattoo applications, provide the most recent date. Note if performed in licensed establishment.)		**Yes** ☐	**No** ☐
46. In the past 12 months**,** have you had an ear, skin, or body piercing using shared instruments or needles?		**Yes** ☐	**No** ☐
47. In the past 12 months, have you had an accidental needle stick or have you come into contact with someone else's blood through an open wound, non-intact skin (for example, a cut or sore), or mucous membrane (for example, into your eye or mouth)?		**Yes** ☐	**No** ☐
48. In the past 12 months, have you lived with or had sexual contact with anyone having yellow jaundice, hepatitis, or have you received Hepatitis B Immune Globulin (HBIG)?		**Yes** ☐	**No** ☐
49. In the past 12 months, have you had sex, even once, with anyone who has used a needle to take drugs, steroids, or anything else not prescribed by a doctor in the past 5 years?		**Yes** ☐	**No** ☐
50. In the past 12 months, have you given money, drugs, or other payment for sex OR have you had sex, even once, with anyone who has taken money, drugs or other payment in exchange for sex in the past 5 years?		**Yes** ☐	**No** ☐
51. In the past 12 months, have you had sex, even once, with anyone who has HIV or AIDS or tested positive for the HIV virus?		**Yes** ☐	**No** ☐
52. In the past 12 months**,** have you been held in a jail, prison, juvenile detention, or lockup for more than 72 continuous hours?		**Yes** ☐	**No** ☐
53. **FEMALE DONORS ONLY:** In the past 12 months, have you had sex with a male who has had sex, even once, with another male in the past 5 years?	If **MALE**, mark NA ☐	**Yes** ☐	**No** ☐
54. **MALE DONORS ONLY:** In the past 5 years, have you had sex, even once, with another male?	If **FEMALE**, mark NA ☐	**Yes** ☐	**No** ☐
55. In the past 5 years, have you taken money, drugs, or other payment in exchange for sex?		**Yes** ☐	**No** ☐
56. In the past 5 years, have you used a needle, even once, to take drugs, steroids, or anything else not prescribed by a doctor?		**Yes** ☐	**No** ☐

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57. Since 1980 to the present, have you ever lived in or traveled to countries in Europe? (See reference list on next page.) If ***YES***, answer #57A - #57C. If ***NO***, do not answer #57A - #57C; go to #58.		**Yes** ☐	**No** ☐
57A. From 1980 through 1996, did you spend time that adds up to 3 months or more in the United Kingdom (UK) (England, Northern Ireland, Scotland, Wales, Isle of Man, Channel Islands, Gibraltar, or Falkland Islands)? If born after 1996, mark ***NO***.	**Yes** ☐	**No** ☐	
57B. Since 1980, did you receive a transfusion of blood or blood components while in the UK or France?	**Yes** ☐	**No** ☐	
57C. Since 1980, have you spent time that adds up to 5 years or more in Europe, including time spent in the UK between 1980 and 1996?	**Yes** ☐	**No** ☐	
58. From 1980 through 1996, were you a member of the U.S. military or their dependent or a civilian military employee or their dependent? If born after 1996, mark ***NO***. If ***YES***, answer #58A & #58B. If ***NO***, do not answer #58A & #58B; go to Section 4.		**Yes** ☐	**No** ☐
58A. Did you spend a total of 6 months or more between 1980 and 1990 at a military base in Belgium, Netherlands or Germany?	**Yes** ☐	**No** ☐	
58B. Did you spend a total of 6 months or more between 1980 and 1996 at a military base in Spain, Portugal, Turkey, Italy or Greece?	**Yes** ☐	**No** ☐	

***IMPORTANT* – TO COMPLETE THIS FORM, CONTINUE TO SECTION 4.**

SECTION 2 Comment Section (include number of question when recording comment)

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SECTION 3: Donor Center Staff Review (Completed by Donor Center Staff)

3A. This form was reviewed for completeness. Information affecting donation was assessed and my evaluation is documented where necessary. If further assessment was required appropriate staff was notified. Case Management (CM) has been informed of significant information, if applicable.

This form was completed by the following method:

- ☐ 3A.1 I performed an oral interview with the donor (including reading Section 4) and completed this form. Complete Section 3C if interpreter was used during interview.
- ☐ 3A.2 This form was self-administered by the donor and I reviewed the recorded information. Complete Section 3B (before donor clearance) if at **workup** stage.

If at workup and 3A.1 is selected, complete this section:

After full completion of this form and review of **SECTION 4 (Verification and Authorization)**, donor verbally confirmed to the undersigned Donor Center Staff member on this date _____ that donor has heard, understands, and agrees with the statements in that section, and that donor's verbal verification and authorization in that regard is equivalent to donor's written signature. **NOTE**: *Verbal approval allows release of document to PE provider prior to donor's signature. Donor at workup **must** still review and sign this document.*

Staff Printed Name	Signature	Date of Interview

If <u>at workup</u> and 3A.2 is marked, complete this section before donor clearance.

3B. I reviewed and verbally verified answers with the donor. I addressed any questions the donor had and clarified health information, as needed, to perform the assessment. CM has been informed of significant information, if applicable.

Staff Printed Name	Signature	Date of Document Review

3C. Interpreter assistance used (Translator Name or Service)

_____

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PLEASE READ CAREFULLY

SECTION 4: Donor Verification and Authorization

- I have had the opportunity to ask questions about the information requested on this questionnaire.
- I understand that the requested information is important because if I am at risk for infection due to AIDS or other communicable disease agents or diseases, my donated cells may transmit these diseases to the patient receiving these cells.
- I have truthfully answered all of the questions on this questionnaire.
- I authorize the release of the information on this questionnaire to Be The Match® operated by the National Marrow Donor Program, its agents and representatives, and Be the Match® network or non-network centers, where the release of the information is used in connection with and to further the possible donation of my cells to a patient. I understand that any information identifying me will remain confidential. I also understand that the potential recipient of my donation may be advised of any communicable disease risks.
- I understand that authorizing this release of information is voluntary and that I can refuse to sign this document.

By signing I acknowledge that I have read, understand and agree with the above.

Donor Name (print): _____

Donor Signature: _____ Date: _____

Reference List for Question #57		
Country	**Country**	**Country**
Albania	Ireland (Republic of)	Sweden
Austria	Italy	Switzerland
Belgium	Liechtenstein	United Kingdom: England, Northern Ireland, Scotland, Wales, Isle of Man, Channel Islands, Gibraltar, Falkland Islands
Bosnia-Herzegovina	Luxembourg	
Bulgaria	Macedonia	
Croatia	Netherlands (Holland)	
Czech Republic	Norway	
Denmark	Poland	
Finland	Portugal	
France	Romania	Yugoslavia (Federal Republic of) Kosovo, Montenegro, Serbia
Germany	Slovak Republic	
Greece	Slovenia	
Hungary	Spain	