Donor ID: **Date:**

Questionnaire prior to a stem cell or lymphocyte donation		
General medical history		
1.	In the last 12 months, have you consulted a doctor or any other healthcare specialist (for example: a physiotherapist, psychologist, dentist)? If yes, please specify:	yes/no
2.	Within the next 2 months, do you have an appointment to visit a doctor or any other healthcare specialist (for example: a physiotherapist, psychologist, dentist)? If yes, please specify :	yes/no
3.	Have you ever had to consult a medical specialist (a doctor in a hospital or clinic)? If yes, please specify :	yes/no
4.	Have you ever had an operation, undergone research or had any other kind of medical treatment in a hospital? If yes, please specify:	yes/no
5.	Have you ever had any complications or side-effects caused by anaesthesia or any other medical treatment? If yes, please specify :	yes/no
Medication, intoxication		
6.	Do you use any medication, alternative medication and/or (food) supplements? If yes, please provide the name and dosage:	yes/no
7.	Have you ever used the following medication? ☐ In the last 5 years: Etretinate / Tigason / Tegison ☐ In the last 2 years: Acitretin / Neotigason	yes/no
8.	Have you ever been given growth hormones? If yes, do one of the following situations apply to you? ☐ The treatment was before 1985 ☐ The treatment was without a referral from an internist/paediatrician ☐ The treatment was outside the Netherlands	yes/no

9.	In the last 12 months, have you had a vaccination (preventive or after having being exposed to a possible infection)? If yes, please specify	yes/no
10.	Do you smoke or have you ever smoked? If yes, • How many years have you smoked/did you smoke, and how many cigarettes per day? • Do you smoke at the moment?	yes/no
11.	Do you drink alcohol? If yes, how much do you drink per day or per week:	yes/no
12.	Do you use, or have you ever used drugs and/or illegally obtained medication? If yes, which ones and how often:	yes/no
Allergies		
13.	Are you allergic or over-sensitive to one or more of the following? ☐ Certain medication or antibiotics ☐ Iodine ☐ Band aids ☐ Latex ☐ Contrast agent ☐ Food ☐ Pollen / hay fever ☐ Other, namely:	yes/no
Family history		
14.	Does your family have a history of illness? ☐ Hereditary diseases ☐ Chromosomal abnormality or any abnormality in your DNA (certain genetic manipulations) ☐ Haematological disease ☐ Cancer ☐ Bleeding disorder or thrombosis tendency ☐ High blood pressure ☐ Cardiovascular diseases ☐ Cerebral haemorrhage or infarction (stroke) ☐ Brain and nerve disorder ☐ Muscle disease ☐ Diabetes mellitus ☐ Auto-immune sickness (for example rheumatism, Crohn, thyroid disease) ☐ Other, namely:	yes/no

General		
15.	Do you have one or more of the following complaints, or have you had one in the past? ☐ Unexplained weight loss ☐ Unexplained night sweats ☐ Unexplained fever, above 38.0°C, for more than ten days ☐ Lumps in your neck, underarms or groin that lasted longer than a month	yes/no
Heart and blood vessels		
16.	Do you have any cardiovascular diseases, of have you had any in the past? ☐ High blood pressure ☐ Heart attack ☐ Stroke ☐ Other, namely:	yes/no
17.	Have you ever had an ECG (electrocardiogram)?	yes/no
18.	Have you had one or more of the following complaints? ☐ Heart palpitations (when resting or exercising) ☐ Shortage of breath (when resting, when exercising or when lying down) ☐ Pain or pressure on the chest when exercising ☐ Urinating more/more often at night than during the day ☐ Fluid retention in your feet, legs or elsewhere ☐ Pain in your calves when walking	yes/no
Lungs		
19.	Do you have a lung disease, or have you had one in the past? ☐ Pneumonia ☐ Asthma ☐ Chronic bronchitis / emphysema / COPD ☐ Sleep apnea / OSAS ☐ Other, namely:	yes/no
20.	Do you have one of the following complaints? ☐ Unexplained, persistent cough or shortage of breath ☐ Tiredness / sleepiness during the day ☐ Loud snoring while asleep ☐ Breathing pauses while asleep	yes/no
Urinary tract		
21.	Do you have a kidney disease and/or kidney stones, or have you had this in the past?	yes/no
22.	Have you ever had one or more of the following problems with urinating? ☐ Pain when urinating ☐ Blood in your urine ☐ Bladder or kidney infection	yes/no

Gastrointestinal system		
23.	Do you have any gastrointestinal illnesses, or have you had any in the past? ☐ Chronic gastroenteritis (such as Crohn's disease/ulcerative colitis) ☐ Other, namely:	yes/no
24.	Do you have one or more of the following complaints? ☐ Heartburn ☐ Nausea ☐ Vomiting ☐ Feeling bloated ☐ Stomach ache ☐ Problems swallowing ☐ Feeling that food gets stuck in the esophagus	yes/no
25.	Have you ever had one or more of the following problems with your bowel movements? ☐ Constipation ☐ Diarrhoea ☐ Blood in your stools	yes/no
26.	Do you have long-term or recurring abdominal pain?	yes/no
Nervous system		
27.	Do you have a brain or neurological disorder, or have you had one in the past? ☐ Muscle disease ☐ Epilepsy ☐ Multiple sclerosis ☐ Dementia ☐ Parkinson's disease / Parkinson-like symptoms ☐ Other, namely:	yes/no
28.	Do you have one of more of the following complaints, or have you had them in the past? ☐ Loss of strength or (temporary) paralysis ☐ Unexplained pins and needles or loss of sensation ☐ Impaired sight that can't be corrected with eye glasses or contact lenses	yes/no
29.	Do you have long-term, recurring or severe headaches?	yes/no
30.	Have you ever fainted?	yes/no
31.	Have you ever had a concussion?	yes/no
32.	Have you been diagnosed as having Creutzfeldt-Jakob's Disease (CJD) or a variant of Creutzfeldt-Jakob's Disease?	yes/no
33.	Has one of your blood relatives ever been diagnosed as having Creutzfeldt-Jakob's Disease, or has your family ever been told that they have a higher risk of getting it?	yes/no

Skin, eyes and musculoskeletal system		
34.	Do you have a skin disease, or have you had one in the past? ☐ Eczema ☐ Vitiligo ☐ Psoriasis ☐ Other, namely:	yes/no
35.	Do you have persistent white spots / unusual ulcers in your mouth?	yes/no
36.	Do you have a rheumatic disease, or have you ever had one in the past? ☐ Rheumatoid arthritis ☐ Bechterew / Ankylosing spondylitis ☐ Other, namely:	yes/no
37.	Do you have persistent or recurring back or neck complaints?	yes/no
38.	Do you have a condition or complaint affecting your joints (such as pain, redness or swelling), or have you ever had these in the past?	yes/no
39.	Have you ever had a serious eye infection, such as an internal eye infection?	yes/no
Blood, clotting and hormones		
40.	Have you ever had any form of cancer, including leukaemia?	yes/no
41.	Do you have one or more of the following complaints, or have you had them in the past? ☐ Spontaneous bruising ☐ Spontaneous nose bleeds ☐ Wounds that bleed for a long time ☐ Women: heavy blood loss during menstruation	yes/no
42.	Do you have a bleeding or blood clotting disorder?	yes/no
43.	Have you ever had a blood transfusion?	yes/no
44.	Have you ever had thrombosis and/or a pulmonary embolism?	yes/no
45.	Do you have one or more of the following hormonal conditions, or have you ever had one in the past? ☐ Diabetes mellitus ☐ Thyroid disease ☐ Other, namely:	yes/no
Gynaecology and reproduction		
46.	Do you currently have a wish to conceive a child?	yes/no
47.	***Only for female donors:*** is there a chance that you could be pregnant, or that you will be pregnant in the near future?	yes/no
48.	***Only for female donors:*** do you use contraceptive measures? If yes, which one?	yes/no
49.	***Only for female donors:*** have you ever been pregnant? If yes, how often? Year of birth and gender of your children?	yes/no
50.	***Only for female donors:*** are you breastfeeding at the moment?	yes/no

	Psychology	
51.	Do you have a psychological or psychiatric condition, or have you ever had one? If yes, which?	yes/no
	Risk of transmissible infections – general	
52.	Do you currently have a wound or inflammation?	yes/no
53.	In the last 12 months, have you had a tattoo done?	yes/no
54.	In the last 12 months, have you had an ear, skin or any other body piercing done with shared instruments or needles? *NB: sterile instruments and/or single-use instruments, such as a 'piercing gun' from an approved agency, are not considered to be 'shared instruments'.*	yes/no
55.	In the last 12 months, have you had any acupuncture?	yes/no
56.	In the last 12 months, have you accidentally pricked yourself with a needle or come into contact with someone else's blood via an open wound, broken skin or mucous membranes (for example, eye or mouth)?	yes/no
57.	In the last 5 years, have you used a needle to inject drugs, steroids or any other substance that wasn't prescribed by a doctor?	yes/no
58.	Have you ever undergone a transplant with tissue of human origin (for example, brain membrane, hair, bone, cornea, skin, tendon)?	yes/no
59.	Has one of the following people, close to you, ever undergone a medical procedure whereby the living cells, tissue or organs of an animal were used (for example, a pig's heart valve)? ☐ Yourself ☐ A sexual partner ☐ A member of your household	yes/no
60.	Do you have the following conditions, have you ever had them, or have you ever tested positive (including screening tests)? ☐ Tuberculosis ☐ WNV (West Nile virus) ☐ HIV or AIDS ☐ HTLV1 or HTLV2 (Human T-lymphotropic virus) ☐ Syphilis or Lues ☐ Hepatitis B, hepatitis C, or any other hepatitis virus	yes/no
61.	In the last 12 months, have you had sex with someone who has one or more of the following conditions? ☐ HIV or AIDS ☐ HTLV1 or HTLV2 (Human T-lymphotropic virus) ☐ Syphilis or Lues ☐ Hepatitis B, hepatitis C, or any other hepatitis virus ☐ Monkeypox	yes/no

62.	Has anyone in your immediate surroundings ever had tuberculosis?	yes/no
63.	In the last 12 months, have you lived with anyone who has hepatitis or monkeypox?	yes/no
64.	In the last 12 months, have you accepted money, drugs or any other form of payment in exchange for sex?	yes/no
65.	In the last 12 months, have you had sex with anyone who, in the last 5 years, has used a needle to inject drugs or steroids or any other substance that wasn't prescribed by a doctor?	yes/no
66.	In the last 12 months, have you had sex with anyone who, in the last 5 years, has accepted money, drugs or any other form of payment in exchange for sex?	yes/no
67.	***Only for female donors:*** in the last 12 months, have you had sex with a man who, in the last 5 years, has had sex with another man?	yes/no
68.	***Only for male donors:*** in the last 5 years, have you had sex with another man?	yes/no
69.	In the last 12 months, have you been in prison for more than 72 consecutive hours?	yes/no
70.	Have you ever served in the army?	yes/no
Risk of blood-borne infections – outside the Netherlands		
71.	In the last year, have you been outside the Netherlands? • Which country / countries have you been in? • When was that?	yes/no
72.	Do you have foreign travel plans within the next 2 months?	yes/no
73.	Have you ever lived or stayed outside Europe for 6 consecutive months or more?	yes/no
74.	Were you born outside Europe?	yes/no
75.	Is your biological mother from South or Central America (including Mexico and Suriname, but not including the Dutch Antilles)?	yes/no
76.	Between 1980 and 1996, have you spent a total of three months or more in the United Kingdom (England, Northern Ireland, Scotland, Wales, the Isle of Man, the Channel Islands, Gibraltar or the Falkland Islands)?	yes/no
77.	Have you ever had malaria, or have you been positively tested for malaria?	yes/no
78.	Have you ever had Chagas Disease (also known as American trypanosomiasis), or have you ever been positively tested for Chagas Disease?	yes/no
79.	Have you ever had a Zika virus infection, or have you ever been positively tested for the Zika virus? *NB: Zika occurs in parts of Asia, Africa, South America and North America*	yes/no
80.	In the last 12 months, have you had sex with anyone who has had a Zika virus infection, or with anyone who has visited a risk area for the Zika virus?	yes/no
Other subjects		
81.	Are you a blood or plasma donor?	yes/no
82.	Have you ever been turned down after a medical examination, for example, for a blood donation or taking part in scientific research?	yes/no

83.	Does one or more of the following descriptions apply to you? ☐ Had an MRSA bacterial infection in the past ☐ Carrier of MRSA bacteria ☐ Household member and/or partner is infected with MRSA bacteria ☐ Been treated in and/or was admitted to a foreign healthcare institution, in the last 2 months ☐ Professionally or otherwise, been in contact with living veal calves, broiler chickens, or pigs	yes/no
84.	In the last 30 days, have you had any symptoms related to COVID-19? If yes, were you tested and what was the result?	yes/no
85.	In the last 30 days, have you been in contact with anyone who has tested positive for COVID-19?	yes/no
86.	Have you had a COVID-19 vaccination, or will you be receiving one shortly? If yes, • Date of the 1st vaccination: • Date of the 2nd vaccination: • Brand of the vaccine:	yes/no
87.	Have you tested positive for COVID-19 in the past 12 months? If yes, what was the date?	yes/no
88.	Are there any further issues concerning your health that have not been included on this questionnaire, but which you think could be important for the donation?	yes/no

I declare that all of the information I have provided is the honest truth, to the best of my knowledge.

I consent to being kept informed if the examination or the blood test reveal any possible abnormalities that are of essential importance to my health. I consent to my blood being examined for contagious diseases. I understand that Matchis is legally obliged to inform the GGD (Dutch Health Authority) if a notifiable infection, such as hepatitis B or HIV, is found in my blood.

Name of the donor:

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Date:

……

Signature:

……

Appendix for the donor physician

Name of the physician:
Reason for registering as a stem cell donor?
Reason for back-up procedures in the case of a partial rejection / technical failure? (PBSC: day 2, CVC, BM. BM: PBSC)?
General social situation? (relationship / family, home situation)
Work or study?
Sport?

Donor ID: **Date:**

Notes:	
Signature	Date