Gift of Life BONE MARROW FOUNDATION
www.giftoflife.org | 800-9MARROW

headquarters
800 Yamato Road, Suite 101
Boca Raton, Florida 33431 USA

telephone
561.982.2900

coordinating center fax
561.982.2901

donor services fax
561.982.2902

Donor Identification Number

DONOR HEALTH HISTORY SCREENING AT WORKUP STAGE

Last Name:	First Name:		Today's Date:	
Date of Birth:	Sex:	Height:	Weight:	
Street Address:	City:		State:	Postal Code:
Home Phone:	Work Phone:		Mobile Phone:	

Please read each question carefully and answer to the best of your knowledge.

Section 1: General Assessment and Donor Safety		
1. Are you feeling well and healthy today?	☐ **Yes**	☐ **No**
2. Do you have an infection now, or are you currently taking antibiotics? ***If yes***, please list:	☐ **Yes**	☐ **No**
3. Are you currently taking any other medications (including over-the-counter medications, vitamins, herbal products or investigational drugs)? ***If yes***, please list:	☐ **Yes**	☐ **No**
4. In the **past 3 years**, have you taken any of the following medications: Proscar© (finasteride), Avodart© (dutasteride), Propecia© (finasteride), Accutane© (isotretinoin), Soriatane© (acitretin) or Tegison© (etretinate)? If yes, when and for how long?	☐ **Yes**	☐ **No**
5. Do you currently drink alcohol? ***If yes***, specify number of drinks per week:	☐ **Yes**	☐ **No**
6. In the **past 12 months**, have you received a blood transfusion or tissue transplant or **have you ever** received an organ transplant?	☐ **Yes**	☐ **No**
7. **Have you ever** received a transfusion, from a source other than your own blood, including whole blood, packed red blood cells, or platelets?	☐ **Yes**	☐ **No**
Questions 8-11 FOR FEMALE DONORS ONLY:	☐ **N/A: Male donor**	
8. How many times have you been pregnant? _____ (if none, proceed to Question 11)		
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? ***If yes***, please describe:	☐ **Yes**	☐ **No**
11. Do you plan to or is there any chance you will become pregnant within the next 6 months?	☐ **Yes**	☐ **No**
12. In the **past 12 months**, have you needed treatment in an emergency room, had surgery or been hospitalized for any reason? ***If yes***, please describe:	☐ **Yes**	☐ **No**
13. Have you ever received anesthesia? ***If yes***, what type?	☐ **Yes**	☐ **No**
a. ***If yes***, please describe any complications or reactions:		
14. Have any of your blood relatives experienced any difficulties from anesthesia? ***If yes***, please describe:	☐ **Yes**	☐ **No**
15. Do you have any allergies (food, drug, or environmental)? ***If yes***, please list:	☐ **Yes**	☐ **No**
16. Do you have a latex allergy? ***If yes***, please describe signs/symptoms of the allergic reaction:	☐ **Yes**	☐ **No**
17. Have you ever had back, neck or spine problems? *If* ***yes***, does your condition currently require medical treatment? Please describe:	☐ **Yes**	☐ **No**
18. Do you have a lung disease, including asthma? ***If yes***, please explain:	☐ **Yes**	☐ **No**
19. Have you ever suffered from heart-related chest pains?	☐ **Yes**	☐ **No**
20. Have you ever had cancer? ***If yes***, please describe:	☐ **Yes**	☐ **No**
21. Have you ever had Chagas' disease, Babesiosis, or any other parasitic blood disease?	☐ **Yes**	☐ **No**
22. Have you ever had tuberculosis or are you undergoing treatment for it?	☐ **Yes**	☐ **No**
23. In the **past 4 weeks**, have you had any vaccinations (other than smallpox) or any kind of shots? ***If yes***, please list:	☐ **Yes**	☐ **No**

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24. Are you planning to receive any vaccinations (including smallpox) or shots? ***If yes***, please list what kind and when:	☐ **Yes**	☐ **No**
25. In the **past 3 years**, have you had malaria or symptoms of malaria?	☐ **Yes**	☐ **No**
26. In the **past 3 years**, have you traveled or lived outside the United States or Canada? ***If yes***, please list where, when and for how long:	☐ **Yes**	☐ **No**
27. Do you have a past or present medical condition not referred to in any previous question that we should be aware of? (Such as, a head or brain injury, diabetes, fibromyalgia, blood clots or an autoimmune disorder such as psoriasis, multiple sclerosis, iritis, episcleritis or lupus)? ***If yes***, please describe in the Comments section on Page 4.	☐ **Yes**	☐ **No**
Section 2: Communicable Disease Assessment		
28. Have you been diagnosed with West Nile Virus? ***If no*****,** proceed to Question 29. ***If yes***, answer 28a.	☐ **Yes**	☐ **No**
a. When were you diagnosed?		
29. In the **past 120 days**, have you experienced two or more of the following symptoms: a fever (>100.5℉ or 38.0℃), headache, muscle weakness, ey e pain, skin rash on trunk of the body or swollen lymph glands? ***If no*****,** proceed to Question 30. ***If yes***, answer 29a.	☐ **Yes**	☐ **No**
a. When did you notice symptoms?		
30. In the **past 8 weeks**, have you received a smallpox vaccination? ***If no***, proceed to Question 31. ***If yes***, answer 30a-30c.	☐ **Yes**	☐ **No**
a. When did you receive the vaccination? (Date)		
b. Has the vaccination scab fallen off your skin by itself?	☐ **Yes**	☐ **No**
c. Did you have any illness or complications (eye infection, rash, an allergic reaction, or sores away from the vaccination site) due to the vaccination? ***If yes***, please describe in the Comments section on Page 4.	☐ **Yes**	☐ **No**
31. Have you had close contact with the vaccination site of anyone who has received the smallpox vaccine in the past 3 months? (Close contact - touching the vaccination site, touching the bandage or covering of the vaccination site, physical intimacy, handling bedding or clothing that has been in contact with the vaccination site.) ***If no***, proceed to Question 32. ***If yes***, answer 31a-31c.	☐ **Yes**	☐ **No**
a. When did the person receive the vaccination? (provide date)		
b. When was the contact? (provide date)		
c. Have you had any new skin rashes, sores, or an eye infection since the time of contact? **If *yes***, please describe:	☐ **Yes**	☐ **No**
32. Have you ever been diagnosed with Creutzfeldt - Jakob disease (CJD) or do you have a degenerative neurological disease such as dementia or any other disease of the central nervous system?	☐ **Yes**	☐ **No**
33. Have any of your blood relatives ever had Creutzfeldt - Jakob disease (CJD) or have you been told that your family has an increased risk for CJD?	☐ **Yes**	☐ **No**
34. Have you ever had a dura mater (brain covering) transplant for a head or brain injury?	☐ **Yes**	☐ **No**
35. Have you ever received growth hormone made from human pituitary glands?	☐ **Yes**	☐ **No**
36. Do you have HIV or AIDS or have you ever tested positive for the HIV virus, including screening tests?	☐ **Yes**	☐ **No**
37. Do you have any of the following:		
• Unexplained weight loss, night sweats, or persistent diarrhea? ……..	☐ **Yes**	☐ **No**
• Unexplained persistent cough or shortness of breath? ……	☐ **Yes**	☐ **No**
• Unexplained persistent white spots or unusual sores in the mouth? ……..	☐ **Yes**	☐ **No**
• Unexplained temperature higher than 100.5℉ (38.0° C) for more than ten days? ……..	☐ **Yes**	☐ **No**
• Blue or purple spots on or under the skin or mucous membranes? ……	☐ **Yes**	☐ **No**
• Swollen lymph nodes lasting longer than one month? ……..	☐ **Yes**	☐ **No**
• Opportunistic infections? ……	☐ **Yes**	☐ **No**
38. Have you ever tested positive to HTLV (Human T-Lymphotropic Virus), including screening tests or had unexplained paraparesis or had adult T-cell leukemia?	☐ **Yes**	☐ **No**
39. Have you ever tested positive for hepatitis (including screening tests) or have you ever had unexplained jaundice, hepatomegaly, or a past diagnosis of clinical symptomatic viral hepatitis after age 11?	☐ **Yes**	☐ **No**

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40. Have you ever had a bleeding problem, such as hemophilia or other clotting factor deficiencies, and received human-derived clotting factor concentrates?	☐ **Yes**	☐ **No**
41. Have you, any of your sexual partners, or members of your household ever had a transplant or medical procedure involving exposure to live cells, tissues, or organs from an animal (xenotransplant)? (Not including non-living animal products such as a pig heart valve or porcine insulin)	☐ **Yes**	☐ **No**
42. **FOR 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 five years?	☐ **Yes**	☐ **No**
43. In the **past 12 months**, have you had a tattoo? ***If yes*****,** Date of tattoo:	☐ **Yes**	☐ **No**
44. In the **past 12 months**, have you had ear, skin, or body piercing using shared instruments or needles?	☐ **Yes**	☐ **No**
45. 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, or mucous membrane (for example, into your eye, mouth etc.)?	☐ **Yes**	☐ **No**
46. In the **past 12 months**, have you lived with or had sexual contact with anyone having yellow jaundice or hepatitis, or have you received Hepatitis B Immune Globulin (HBIG)?	☐ **Yes**	☐ **No**
47. Have you ever tested positive for syphilis, including screening tests, or ever been treated for syphilis?	☐ **Yes**	☐ **No**
48. 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**
49. In the **past 12 months**, have you given money or drugs for sex OR have you had sex, even once, with anyone who has taken money or drugs in exchange for sex in the past 5 years?	☐ **Yes**	☐ **No**
50. In the **past 12 months**, have you had sex, even once, with anyone who has taken human derived clotting factors in the last 5 years?	☐ **Yes**	☐ **No**
51. In the **past 12 months**, have you had sex, even once, with anyone who has HIV or AIDS or has tested positive for the HIV virus?	☐ **Yes**	☐ **No**
52. In the **past 12 months**, have you been in jail, prison, juvenile detention, or lockup for more than 72 continuous hours?	☐ **Yes**	☐ **No**
53. In the **past 5 years**, have you used a needle, even once, to take any drugs, steroids or anything else not prescribed by a doctor?	☐ **Yes**	☐ **No**
54. In the **past 5 years**, have you taken money, drugs or other payment in exchange for sex?	☐ **Yes**	☐ **No**
55. **FOR MALE DONORS ONLY**: In the **past 5 years**, have you had sex, even once, with another male?	☐ **Yes**	☐ **No**
56. **Since 1977,** were you born in or have you lived in one of the following African countries: Cameroon, Central African Republic, Chad, Congo, Equatorial Guinea, Gabon, Niger, Nigeria, Benin, Kenya, Senegal, Togo or Zambia?	☐ **Yes**	☐ **No**
57. **Since 1977**, have you received a blood transfusion or medical treatment with a blood product in any of the above listed African countries?	☐ **Yes**	☐ **No**
58. Have you had sex with anyone who, since 1977 was born in or lived in any of the above listed African countries?	☐ **Yes**	☐ **No**
59. **Since 1980**, have you at any time been injected with bovine (beef) insulin?	☐ **Yes**	☐ **No**
For Question # 60, please refer to the Reference Table on Page 4.		
60. **Since 1980**, have you ever lived in or traveled to Europe? ***If no***, go to page 4. ***If yes***, answer Questions 60a thru 60d.	☐ **Yes**	☐ **No**
a. **From 1980 thru 1996**, did you spend time that adds up to 3 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**
b. **Since 1980**, have you received a transfusion of blood or blood components while in the UK or France?	☐ **Yes**	☐ **No**
c. **Since 1980**, have you spent time that adds up to 5 years or more in Europe, including time spent in the UK between 1980-1996?	☐ **Yes**	☐ **No**
d. **From 1980 thru 1996,** were you a member of the U.S. military or their dependent or a civilian military employee, or their dependent? ***If no***, go to page 4. ***If yes***, answer 60.d.i and 60.d.ii	☐ **Yes**	☐ **No**
i. **Between 1980-1990,** did you spend a total of 6 months or more at a military base in any of the following countries: Belgium, Netherlands or Germany?	☐ **Yes**	☐ **No**
ii. **Between 1980-1996,** did you spend a total of 6 months or more at a military base in any of the following countries: Spain, Portugal, Turkey, Italy or Greece?	☐ **Yes**	☐ **No**

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Reference for Question #60 (Countries defined as Europe):			
Albania	France	Netherlands	Switzerland
Austria	Germany	Norway	United Kingdom
Belgium	Greece	Poland	England, Northern Ireland,
Bosnia-Herzegovina	Hungary	Portugal	Scotland, Wales, the Isle of Man,
Bulgaria	Ireland (Republic of)	Romania	the Channel Islands, Gibraltar, or
Croatia	Italy	Slovak Republic	the Falkland Islands
Czech Republic	Liechtenstein	Slovenia	Yugoslavia
Denmark	Luxembourg	Spain	(Federal Republic of) Kosovo,
Finland	Macedonia	Sweden	Montenegro, Serbia

Additional Comments:

DONOR VERIFICATION AND AUTHORIZATION

Signature is not mandatory. Verbal verification and authorization is permitted.

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 the Gift of Life Bone Marrow Foundation and its agents and representatives and other medical facilities known as collection centers. This release may only be in connection with the possibility of the 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 statements.

Donor Name:	**Donor Signature:**	**Date:**

The Section below to be completed by Gift of Life Donor Services staff

This form was completed:

☐ Through oral interview performed by Donor Services staff member, including donor's verification and authorization.	☐ Self administered by donor and reviewed by Donor Services staff member.	☐ Using an interpreter.
Donor Services Staff Name:		**Date:**
Donor Services Staff Signature:		

This questionnaire was administered by the Gift of Life Bone Marrow Foundation.

Collection Centers are required to perform their own health history screening in order to establish final donor eligibility and suitability.