Medical Questionnaire and Informed Consent

Medical Questionnaire

Donation Number

You have just read the **information sheet for blood donors** and have declared your willingness to donate blood. Please answer the following questions truthfully by putting a cross in the Yes or No box, as appropriate. This will help considerably to minimise the remaining risks to your own safety and that of the patients who will receive your blood.

Consent form to be completed and signed by the donor:

- I hereby consent to donate my blood.
- I confirm by my signature that I have thoroughly read and understood all of the information sheet for blood donors and that any queries were satisfactorily answered.
- I confirm that my personal data are correct and that the answers to all questions are true and accurate.
- I consent that the blood I donate undergoes testing, which may include genetic methods if necessary, and that a sample of my blood will be stored for possible subsequent tests according to the Federal law on therapeutic products. I agree to be informed about abnormal results.
- I consent that part of my donation may be used for the preparation of medicinal products.
- Personal information given in connection with blood donation is subject to medical secrecy. It may only be used within Swiss Transfusion SRC (T-CH) and the Regional Blood Transfusion Service (RBTS). The Regional Blood Transfusion Service is legally obliged to respect the Data Protection Act and to report notifiable diseases to the authorities.

Name: **First name:** **Date of birth:** **Date:** **Signature:**

		Yes	No	Initials
1.	Have you ever donated blood in the past? If so, give date of last donation _____ Where? _____	☐	☐	
2.	Do you weigh more than 50 kg (or 110 lbs)?	☐	☐	
3.	Are you in good health at present?	☐	☐	
4.	Have you been treated by a dentist or dental hygienist in the past 14 days, e.g. had a dental filling procedure?	☐	☐	
5.	During the past 4 weeks, have you received medical care, had a temperature of more than 38°C (or 100°F) or other minor illnesses such as diarrhea or colds?	☐	☐	
6.	a) During the past 4 weeks, have you taken any medicine (tablets, injections, suppositories) – including without prescription? If so, which? _____	☐	☐	
	b) During the past 4 weeks, have you taken medicine for prostate enlargement or hair loss (e.g. Alocapil®, Finacapil®, Propecia® or Proscar®) or acne (e.g. Roaccutan®, Curakne®, Isotretinoin®, Tretinac® or Toctino®)?	☐	☐	
	c) During the past 4 months, have you taken antiretroviral therapy /PEP/PrEP (e.g. Truvada®, Isentress® Prezista ® or Norvir®)?	☐	☐	
	d) During the past 6 months, have you taken Avodart® or Duodart®to treat prostate enlargement?	☐	☐	
	e) During the past 3 years, have you taken Neotigason®, Acicutan® to treat psoriasis or Erivedge® to treat basal cell carcinoma)?	☐	☐	
	f) During the past 12 months, have you received any blood-derived medications?	☐	☐	
7.	a) Have you ever received any immunotherapy (cells or serum of human or animal origin)?	☐	☐	
	b) During the past 12 months, have you been vaccinated to prevent rabies or tetanus?	☐	☐	
	c) During the past 4 weeks, have you received any other vaccinations? If so, please specify _____ When? _____	☐	☐	
8.	Have you ever had any of the health problems or disorders mentioned below? a) Cardiac/circulatory or lung disease (e.g. high/low blood pressure, heart attack, breathing difficulty, stroke, ministroke (TIA), loss of consciousness)?	☐	☐	
	b) Skin disease (e.g. wound, rash, eczema, fever blister) or allergy (e.g. hay fever, asthma, medicines)?	☐	☐	
	c) Other diseases (diabetes, blood disease, coagulation disease, vascular disease, kidney disease, neurological disease, epilepsy, cancer, osteoporosis)?	☐	☐	
9.	During the past 3 years or since your last blood donation, have you had ☐ a hospital stay? ☐ an accident? ☐ surgery?	☐	☐	
10.	a) Have you ever received graft(s) of human or animal tissues or have you ever had an organ transplant?	☐	☐	
	b) Have you ever had any brain or spinal cord surgery?	☐	☐	
	c) Before 1.1.1986, were you ever treated with growth hormones?	☐	☐	
	d) Have you or has any member of your family had confirmed or suspected Creutzfeldt-Jakob disease?	☐	☐	
	e) Between 1.1.1980 and 31.12.1996, did you ever stay for a total of 6 months or more in the United Kingdom (England, Wales, Scotland, Northern Ireland, Isle of Man, Channel Islands, Gibraltar and the Falkland Islands)?	☐	☐	

	Yes	No	Initials
f) Have you received a blood transfusions since 1.1.1980?	☐	☐	
11. a) During the past 12 months, did you travel outside Switzerland? If yes, where and how long? _____ When did you return to Switzerland? _____	☐	☐	
b) Did you have any signs of illness (e.g., fever) there or since your return? If yes, please specify: _____	☐	☐	
12. a) Were you born outside of Switzerland, did you grow up there or did you live there for 6 months or more? If yes, in which country? _____ If yes, since when have you lived in Switzerland? _____	☐	☐	
b) Was your mother born outside Europe, did she grow up there or did she live there for more than 6 months? If yes, in which country? _____	☐	☐	
13. a) Have you had in the last - 6 months: ☐ toxoplasmosis ☐ mononucleosis ☐ amebiasis ☐ shigellosis ☐ TBE - 12 months: ☐ Schistosomiasis ☐ gonorrhea - 2 years: ☐ osteomyelitis ☐ rheumatic fever ☐ tuberculosis ☐ relapsing fever ☐ Guillain-Barré-Syndrome	☐	☐	
b) Have you ever had any of the following infectious diseases: ☐ malaria ☐ Chagas disease ☐ brucellosis ☐ echinococcosis ☐ leishmaniosis ☐ lymphogranuloma venereum ☐ filariasis ☐ Q fever ☐ babesiosis ☐ Ebola ☐ or other serious infections If yes, which? _____ When? _____	☐	☐	
c) Have you had a tick bite in the past 4 weeks?	☐	☐	
d) Have you had contact with a person who has or had an infectious disease in the last 4 weeks?	☐	☐	
14. During the past 4 months, have you undergone: ☐ tattooing, ☐ body piercing, ☐ electric epilation, ☐ cosmetic treatments (permanent make-up, microblading etc., ☐ gastroscopy, colonoscopy, ☐ acupuncture, ☐ contact with foreign blood (a needle injury, blood splash hitting the eyes, mouth or another part of the body)? If so, when and where? _____	☐	☐	
15. Have you ever had jaundice (hepatitis) or a positive test for hepatitis?	☐	☐	
16. a) Do one or more of the following risk situations apply to you? • Have you changed your sexual partner in the past 4 months? • Have you had sexual contact (protected or unprotected) with more than two people in the past 4 months? • Have you had sexual contact under the influence of synthetic drugs in the past 12 months? • Have you had sexual contact for which you received money or other benefits (drugs or medication)? • Have you taken any drugs by injection? • Have you ever had a positive test for HIV (AIDS), syphilis or jaundice (hepatitis B or C)? • Has your life partner, sex partner or roommate contracted jaundice (hepatitis B or C) in the past 6 months? • Has your sexual partner contracted Zika in the past 3 months?	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	
b) During the past 12 months, have you had sexual intercourse with partners who: • were exposed to any of the risk situations listed in question 16a? c) During the past 4 months, have you had sexual intercourse with partner(s): • who have been in countries where HIV, hepatitis C (HCV), hepatitis B (HBV) is endemic for more than 6 months or have received blood transfusions there? If yes, date of return of the partner: _____	☐ ☐	☐ ☐	
17. *To answer only by women:* • Have you ever been pregnant? If yes, state the date of your last pregnancy _____ • Before 1.1.1986, did you receive hormone injections for infertility treatment?	☐ ☐	☐ ☐	

To be completed by RBTS SRC:

Remarks question ____ :_____

question ____ :_____

question ____ :_____

▶ Questionnaire and signature checked for completeness Date: _____ Initialled BTS: _____

▶ Eligibility to donate blood Yes ☐ No ☐ Reason:_____ Date: _____ Initialled BTS: _____

IDENTITY & OTHER INFORMATION
(Regional data)