

Full-length Donor History Questionnaire – Source Plasma Industry

This document is one component of the full-length PPTA donor history questionnaire documents to be used by source plasma organizations. The full-length PPTA donor history questionnaire documents must be used collectively.

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	Yes	No
Are you		
1. Feeling healthy and well today?	<input type="checkbox"/>	<input type="checkbox"/>
2. Currently taking an antibiotic or other medication for an infection?	<input type="checkbox"/>	<input type="checkbox"/>
3. Currently taking any other medications?	<input type="checkbox"/>	<input type="checkbox"/>
Please read the medication list.		
4. Have you taken any medications on the medication list in the time frames indicated?	<input type="checkbox"/>	<input type="checkbox"/>
Please review the Risk Poster		
5. Did you review the Risk Poster?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have any questions about anything mentioned on the Risk Poster?	<input type="checkbox"/>	<input type="checkbox"/>
In the past six weeks , have you		
7. Female Donors: been pregnant or are you pregnant now?	<input type="checkbox"/>	<input type="checkbox"/>
Alternative Question 7. Female Donors: In the past six months, have you been pregnant or are you pregnant now? (See placement below.)	<input type="checkbox"/>	<input type="checkbox"/>
In the past two months , have you		
8. Had any vaccinations or other shots?	<input type="checkbox"/>	<input type="checkbox"/>
9. Had contact with someone who was vaccinated for smallpox in the past 8 weeks?	<input type="checkbox"/>	<input type="checkbox"/>
10. Donated whole blood, platelets or plasma at another center?	<input type="checkbox"/>	<input type="checkbox"/>
In the past four months , have you		
11. Donated a double unit of red blood cells using an apheresis machine?	<input type="checkbox"/>	<input type="checkbox"/>
Optional Question A. Had surgery or a diagnostic, medical or dental procedure?	<input type="checkbox"/>	<input type="checkbox"/>
Optional Question B. Had acupuncture?	<input type="checkbox"/>	<input type="checkbox"/>
In the past six months , have you		
Alternative Question 7. Female Donors: been pregnant or are you pregnant now?	<input type="checkbox"/>	<input type="checkbox"/>
In the past 12 months , have you		
12. Had a blood transfusion?	<input type="checkbox"/>	<input type="checkbox"/>
13. Received during surgery bone, tissue or skin?	<input type="checkbox"/>	<input type="checkbox"/>
14. Come into contact with someone else's blood?	<input type="checkbox"/>	<input type="checkbox"/>
15. Had an accidental needle-stick?	<input type="checkbox"/>	<input type="checkbox"/>
16. Had sexual contact with anyone who has HIV or has had a positive test for the HIV virus?	<input type="checkbox"/>	<input type="checkbox"/>
17. Had sexual contact with a prostitute or anyone else who takes money or drugs or other payment for sex?	<input type="checkbox"/>	<input type="checkbox"/>
18. Had sexual contact with anyone who has ever used needles to take drugs or steroids, or anything <u>not</u> prescribed by their doctor?	<input type="checkbox"/>	<input type="checkbox"/>

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19. Male Donors: Had sexual contact with another male?	<input type="checkbox"/>	<input type="checkbox"/>
Alternative Question 19. Male donors: Have you ever had sexual contact with another male? (See placement below.)	<input type="checkbox"/>	<input type="checkbox"/>
20. Female Donors: Had sexual contact with a male who had sexual contact with another male, in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
21. Had sexual contact with a person who has hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>
22. Lived with a person who has hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>
23. Gotten a tattoo or had one touched-up?	<input type="checkbox"/>	<input type="checkbox"/>
24. Had an ear or body piercing?	<input type="checkbox"/>	<input type="checkbox"/>
25. Had or been treated for syphilis or gonorrhea?	<input type="checkbox"/>	<input type="checkbox"/>
26. Been in juvenile detention, lockup, jail, or prison for more than 72 consecutive hours?	<input type="checkbox"/>	<input type="checkbox"/>
From 1980 through 1996		
27. Did you spend time that adds up to three months or more in the United Kingdom? (Review map of UK Countries on the travel poster)	<input type="checkbox"/>	<input type="checkbox"/>
28. Were you a member of the U.S. military, a civilian military employee, or a dependent of a member of the U.S. military?	<input type="checkbox"/>	<input type="checkbox"/>
From 1980 to the present, did you		
29. Spend time that adds up to four years or more in France?	<input type="checkbox"/>	<input type="checkbox"/>
30. Receive a blood transfusion in the United Kingdom or France? (Review map of countries on the travel poster)	<input type="checkbox"/>	<input type="checkbox"/>
Have you EVER		
31. Received money, drugs, or other payment for sex?	<input type="checkbox"/>	<input type="checkbox"/>
Alternative Question 19. Male Donors: Had sexual contact with another male?	<input type="checkbox"/>	<input type="checkbox"/>
32. Had a positive test for the HIV?	<input type="checkbox"/>	<input type="checkbox"/>
33. Used needles to take drugs, steroids, or anything <u>not</u> prescribed by your doctor?	<input type="checkbox"/>	<input type="checkbox"/>
34. Had a transplant such as an organ or bone marrow?	<input type="checkbox"/>	<input type="checkbox"/>
35. Received a dura mater (or brain covering) graft?	<input type="checkbox"/>	<input type="checkbox"/>
36. Had any type of cancer, including leukemia?	<input type="checkbox"/>	<input type="checkbox"/>
37. Had any problem with your heart or lungs?	<input type="checkbox"/>	<input type="checkbox"/>
38. Had any problem with your liver or kidneys?	<input type="checkbox"/>	<input type="checkbox"/>
39. Had a bleeding condition or a blood disease?	<input type="checkbox"/>	<input type="checkbox"/>
40. Had a transplant or other medical procedure that involved being exposed to live cells, tissues or organs from an animal?	<input type="checkbox"/>	<input type="checkbox"/>
Optional Question C. Have you ever had any type of nervous system disease?	<input type="checkbox"/>	<input type="checkbox"/>
Optional Question D. Have you ever had a history of recurrent episodes of fainting?	<input type="checkbox"/>	<input type="checkbox"/>
Optional Question E. Have you ever had a history of seizures or convulsions?	<input type="checkbox"/>	<input type="checkbox"/>
Optional Question F. Have you ever been diagnosed with diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
Optional Question G. Have you ever been diagnosed with any other serious active, chronic, or relapsing disease?	<input type="checkbox"/>	<input type="checkbox"/>

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41. Have any of your relatives had Creutzfeld-Jakob disease?

Additional Questions:

Acknowledgment:

1. I have reviewed the educational materials regarding infections that can be transmitted by my donation, such as, Syphilis, HIV, Hepatitis B and C.
2. I agree not to donate if my donation could result in a potential risk to people who receive plasma products.
3. A sample of my blood will be tested for infections that can be transmitted by my donation, such as, Syphilis, HIV, Hepatitis B and C.
4. I understand you will attempt to notify me if for any reason I cannot donate and records will be maintained indicating the reason for the deferral and the deferral time period.
5. I have reviewed the information regarding the potential risks and hazards of donating Source Plasma.
6. I have been given the opportunity to ask questions and understand that I may withdraw from the donation procedure at any time.

Donor Signature: _____ **Date:** _____