



## Medical Questionnaire CT/VT and Medical CheckUp

GRID / RELATED-ID:

Please provide truthful answers to each of the following questions. By doing so you will greatly help to keep residual risks low both for yourself and the blood stem cell recipient.

	Yes	No	Visa
1. Do you feel in good health?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Do you weigh at least 50 kg?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Have you ever donated blood stem cells? If yes, when? _____ Where? _____	<input type="checkbox"/>	<input type="checkbox"/>	
4. In the last 4 weeks have you had to see a doctor or had a temperature above 38°C?	<input type="checkbox"/>	<input type="checkbox"/>	
5. a) In the last 4 weeks have you taken any medication, including over-the-counter remedies (e.g. tablets, injections, suppositories)? Please specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	
b) In the last 6 months have you taken medication for an enlarged prostate (e.g. Avodart® or Duodart®)?	<input type="checkbox"/>	<input type="checkbox"/>	
c) In the last 12 months have you taken Neotigason® or Soriatane® (for psoriasis)?	<input type="checkbox"/>	<input type="checkbox"/>	
d) In the last 2 years have you taken Erivedge® or a generic (for basal cell carcinoma)?	<input type="checkbox"/>	<input type="checkbox"/>	
6. a) In the last 12 months have you been vaccinated against rabies, hepatitis B or tetanus?	<input type="checkbox"/>	<input type="checkbox"/>	
b) Have you had any other vaccinations in the last 4 weeks? Which? _____ When? _____	<input type="checkbox"/>	<input type="checkbox"/>	
7. Do you have or have you ever had any of the following conditions or symptoms? a) heart, circulation or lung problems (e.g. blood pressure too high or too low, heart attack, breathlessness, stroke, pulmonary embolism, loss of consciousness)? Please specify _____	<input type="checkbox"/>	<input type="checkbox"/>	
b) Allergies (e.g. hayfever, asthma, medication induced)? Please specify _____	<input type="checkbox"/>	<input type="checkbox"/>	
c) Other (e.g. diabetes, diseases of the blood, coagulation and circulation, kidney, thyroid or neurological conditions, including epilepsy, cancer)? Please specify _____	<input type="checkbox"/>	<input type="checkbox"/>	
8. In the last 12 months have you had an <input type="checkbox"/> illness? <input type="checkbox"/> accident? <input type="checkbox"/> operation? Please specify _____	<input type="checkbox"/>	<input type="checkbox"/>	
9. a) Have you ever been transplanted with human or animal tissue? Please specify _____	<input type="checkbox"/>	<input type="checkbox"/>	
b) Have you ever had brain or spinal cord surgery? Please specify _____	<input type="checkbox"/>	<input type="checkbox"/>	
c) Were you ever given growth hormone prior to 01.01.1986?	<input type="checkbox"/>	<input type="checkbox"/>	
d) Has Creutzfeldt-Jakob disease ever been diagnosed or suspected in yourself or a first-degree relative?	<input type="checkbox"/>	<input type="checkbox"/>	
e) In the last 12 months have you had a blood transfusion (red cells, platelets, plasma)? If yes, when? _____ Why? _____ In which country? _____	<input type="checkbox"/>	<input type="checkbox"/>	
10. a) In the last 30 days have you travelled outside Switzerland? Where? _____ From when to when? _____	<input type="checkbox"/>	<input type="checkbox"/>	
b) Did you have any symptoms (e.g. a temperature) while there or since coming back? Please specify _____	<input type="checkbox"/>	<input type="checkbox"/>	
c) Risk of malaria: In the last 12 months have you been outside Europe? Where? _____ When did you get back? _____	<input type="checkbox"/>	<input type="checkbox"/>	
11. a) Were you born or raised outside Europe or have you lived there for more than 6 months? In which country? _____ When did you arrive (back) in Europe? _____	<input type="checkbox"/>	<input type="checkbox"/>	
b) Was your mother born or raised outside Europe or has she lived there for more than 6 months? In which country? _____	<input type="checkbox"/>	<input type="checkbox"/>	



GRID / RELATED-ID: \_\_\_\_\_

	Yes	No	Visa
12. a) Have you ever had: <input type="checkbox"/> Tuberculosis, <input type="checkbox"/> Borreliosis, <input type="checkbox"/> Osteomyelitis, <input type="checkbox"/> Toxoplasmosis, <input type="checkbox"/> Malaria, <input type="checkbox"/> Zika? When? _____	<input type="checkbox"/>	<input type="checkbox"/>	
b) Have you ever had: <input type="checkbox"/> Babesiosis, <input type="checkbox"/> Brucellosis, <input type="checkbox"/> Chagas disease, <input type="checkbox"/> Ebola, <input type="checkbox"/> Viral haemorrhagic fever, <input type="checkbox"/> Q fever, <input type="checkbox"/> Leishmaniasis?	<input type="checkbox"/>	<input type="checkbox"/>	
c) In the last 4 weeks have you been in contact with any infectious disease? Which disease? _____	<input type="checkbox"/>	<input type="checkbox"/>	
d) In the last 4 weeks have you had a tick bite?	<input type="checkbox"/>	<input type="checkbox"/>	
13. In the last 4 months have you had: <input type="checkbox"/> a tattoo, <input type="checkbox"/> a gastroscopy or colonoscopy, <input type="checkbox"/> acupuncture, <input type="checkbox"/> electrolysis, <input type="checkbox"/> permanent make-up, <input type="checkbox"/> piercing, <input type="checkbox"/> microblading, <input type="checkbox"/> contact with third-party blood via needle stick injury or splash (eye, mouth etc.)? When? _____	<input type="checkbox"/>	<input type="checkbox"/>	
14. Have you ever had jaundice or a positive hepatitis test? Please specify Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C Other jaundice: _____ When? <input type="checkbox"/> At birth Other date: _____	<input type="checkbox"/>	<input type="checkbox"/>	
15. In the last 12 months has your sex partner or housemate had jaundice?	<input type="checkbox"/>	<input type="checkbox"/>	
16. In the last 12 months have you lived for at least 6 months in countries with a high AIDS rate <b>and</b> during that time were you exposed to the risk of HIV infection? (e.g. sexual contact, medical intervention, tattoo, piercing)	<input type="checkbox"/>	<input type="checkbox"/>	
17. Do one or more of the following risk scenarios apply to you? <input type="checkbox"/> New sex partner in the last 4 months How many _____ <input type="checkbox"/> Remunerated sex (paid or paid-for) in the last 12 months More than once? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Injection drug use in the last 10 years <input type="checkbox"/> Positive test for HIV (AIDS), Syphilis or Hepatitis _____	<input type="checkbox"/>	<input type="checkbox"/>	
18. In the last 12 months have you had sex with any persons) <input type="checkbox"/> to whom the risk scenarios in Question 17 applied? <input type="checkbox"/> who, within the last 12 months, has received a blood transfusion or some other exposure to HIV in a country where there is a high risk for AIDS?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Questions for women only</b>			
19. Have you given birth in the last 12 months, are you currently breastfeeding or are you currently pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	
20. How many pregnancies have you had (including miscarriages)?			

**Confirmation to be completed and signed by the donor:**

The personal data collected are covered by the professional duty of confidentiality. Swiss Transfusion SRC is subject to the Swiss Federal Act on Data Protection (FADP).

I hereby confirm that my personal details are correct and that I have been truthful in completing the questionnaire.

First name: \_\_\_\_\_ Surname: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
Date: \_\_\_\_\_ Signature: \_\_\_\_\_

**For internal use:**

Observations: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Questionnaire and signature checked complete Date: \_\_\_\_\_ Visa: \_\_\_\_\_

Donor suitability Yes  No  Reason: \_\_\_\_\_ Date: \_\_\_\_\_ Visa: \_\_\_\_\_