

1. QUESTIONNAIRE FOR DONORS OF BLOOD AND BLOOD COMPONENTS

Every time before donating blood or blood components, the donor must complete (update, supplement) this questionnaire. Should you have any questions or uncertainties, please contact the doctor of the Donor Department.

Donor's first name, surname _____

| | Yes | No |
|---|--------------------------|--------------------------|
| 1. Are you feeling good? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you experienced any of the following unexpectedly, without any clear reason, over the past two years: | | |
| • reduced weight? | <input type="checkbox"/> | <input type="checkbox"/> |
| • fever? | <input type="checkbox"/> | <input type="checkbox"/> |
| • laxity? | <input type="checkbox"/> | <input type="checkbox"/> |
| • skin, mucous membrane, lip rash? | <input type="checkbox"/> | <input type="checkbox"/> |
| • enlarged lymph nodes? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you been taking any medicine, have you been vaccinated or have you paid a visit to a dentist during the last month? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you read about and are you aware of AIDS, hepatitis and safe sex, and that the partner may get hepatitis even if he/she has never had jaundice? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you had during the past 12 months any sexual intercourse with the partner, who: | | |
| • has been infected with the Human Immunodeficiency Virus or hepatitis viruses? | <input type="checkbox"/> | <input type="checkbox"/> |
| • has taken injective drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| • receives payment (especially in money or drugs) for sexual intercourse? | <input type="checkbox"/> | <input type="checkbox"/> |
| • has haemophilia? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever taken any narcotic drugs, in particular injective drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had any sexual intercourse for money or drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Question for men: | | |
| • have you ever had any sexual relations with other men? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Question for women: | | |
| • do you think that your sexual partner could have any sexual relations with other men as well? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Over the past 12 months, have you: | | |
| • undergone any medical check-up or an operation? | <input type="checkbox"/> | <input type="checkbox"/> |
| • had your ears pierced, had a tattoo done or have you undergone any acupuncture treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| • had any blood transfusion? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Question for women: | | |
| • are you (have you been over the past 12 months) pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you have any relatives who have Creutzfeldt-Jakob (CJD) disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you been treated with any preparations made from human or animal organs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you stayed in the United Kingdom or France for the period of 6 months or longer since the year 1980? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you been held in custody or in any penal institution over the past 12 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you had any contact with persons infected with the Human Immunodeficiency Virus or hepatitis viruses (in family, at work or among friends)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Where were you born? _____ | | |
| 18. Have you lived or have you ever gone abroad? Where and how long? _____ | | |
| 19. Have you ever had: | | |
| • jaundice, malaria, tuberculosis, rheumatic fever? | <input type="checkbox"/> | <input type="checkbox"/> |
| • heart and vascular diseases, heightened blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| • allergy, asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| • neural diseases, have you ever had convulsions or consciousness disorders? | <input type="checkbox"/> | <input type="checkbox"/> |
| • chronic diseases (diabetes, malicious diseases, ulcer)? | <input type="checkbox"/> | <input type="checkbox"/> |
| • blood diseases? | | |
| • sexually transmitted diseases? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Do you have an invalidity category? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Do you have a risky job? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Have you ever refused to donate blood, or have you ever been rejected as a blood donor? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. What would you like to donate: | | |
| • blood? | <input type="checkbox"/> | <input type="checkbox"/> |
| • plasma? | <input type="checkbox"/> | <input type="checkbox"/> |
| • thrombocytes? | <input type="checkbox"/> | <input type="checkbox"/> |

Hereby I confirm that I have read and understood the presented educational material and that I have had an opportunity to ask questions and have received appropriate answers to all of the questions asked; and on the basis of the presented information, I agree to continue the process of donating blood or its components. I ensure that all the information provided above is correct to the best of my knowledge.

Signature, date