

Full-Length Blood Donor History Questionnaire (DHQ) v4.0

| Are you | Yes | No |
|---|--------------------------|--------------------------|
| 1. Feeling healthy and well today? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Currently taking an antibiotic? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Currently taking any other medication for an infection? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Pregnant now? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you | | |
| 5. Taken any medications on the Medication Deferral List in the time frames indicated? (Review the Medication Deferral List.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Read the blood donor educational materials today? | <input type="checkbox"/> | <input type="checkbox"/> |
| In the past 48 hours, have you | | |
| 7. Taken aspirin or anything that has aspirin in it? | <input type="checkbox"/> | <input type="checkbox"/> |
| In the past 8 weeks, have you | | |
| 8. Donated blood, platelets, or plasma? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Had any vaccinations or other shots? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Had contact with someone who was vaccinated for smallpox in the past 8 weeks? | <input type="checkbox"/> | <input type="checkbox"/> |
| In the past 3 months, have you | | |
| 11. Taken any medication by mouth (oral) to prevent HIV infection? (i.e., PrEP or PEP) | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Had sexual contact with a new partner? (refer to the examples of “new partner” in the Blood Donor Educational Material) | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Had sexual contact with more than one partner? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Had sexual contact with anyone who has ever had a positive test for HIV infection? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Received money, drugs, or other payment for sex? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Had sexual contact with anyone who has, in the past 3 months, received money, drugs, or other payment for sex? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Used needles to inject drugs, steroids, or anything not prescribed by your doctor? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Had sexual contact with anyone who has used needles in the past 3 months to inject drugs, steroids, or anything not prescribed by their doctor? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Had syphilis or gonorrhea or been treated for syphilis or gonorrhea? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Had sexual contact with a person who has hepatitis? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Lived with a person who has hepatitis? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Had an accidental needle-stick? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Come into contact with someone else’s blood? | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Had a tattoo? | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Had ear or body piercing? | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Had a blood transfusion? | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Had a transplant such as organ, tissue, or bone marrow? | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Had a graft such as bone or skin? | <input type="checkbox"/> | <input type="checkbox"/> |
| In the past 16 weeks, have you | | |
| 29. Donated a double unit of red blood cells using an apheresis machine? | <input type="checkbox"/> | <input type="checkbox"/> |

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| | Yes | No |
|---|--------------------------|--------------------------|
| In the past 12 months, have you | | |
| 30. Been in juvenile detention, lockup, jail, or prison for 72 hours or more consecutively? | <input type="checkbox"/> | <input type="checkbox"/> |
| In the past 2 years, have you | | |
| 31. Received any medication by injection to prevent HIV infection? (i.e. long-acting antiviral PrEP or PEP) | <input type="checkbox"/> | <input type="checkbox"/> |
| In the past 3 years, have you | | |
| 32. Been outside the United States or Canada? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you EVER | | |
| 33. Had a positive test for HIV infection? | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. Taken any medication to treat HIV infection? | <input type="checkbox"/> | <input type="checkbox"/> |
| 35. Been pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| 36. Had malaria? | <input type="checkbox"/> | <input type="checkbox"/> |
| 37. Received a dura mater (or brain covering) graft or xenotransplantation product? | <input type="checkbox"/> | <input type="checkbox"/> |
| 38. Had any type of cancer, including leukemia? | <input type="checkbox"/> | <input type="checkbox"/> |
| 39. Had any problems with your heart or lungs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 40. Had a bleeding condition or blood disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 41. Had a positive test result for <i>Babesia</i> ? | <input type="checkbox"/> | <input type="checkbox"/> |

| Use this area for additional questions | Yes | No |
|---|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> |
| | <input type="checkbox"/> | <input type="checkbox"/> |