

## Full-Length Donor History Questionnaire (DHQ)

	Yes	No
<b>Are you</b>		
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. Have you taken any medications on the Medication Deferral List in the time frames indicated? (Review the Medication Deferral List.)	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you read the educational materials today?	<input type="checkbox"/>	<input type="checkbox"/>
<b>In the past 48 hours,</b>		
6. Have you taken aspirin or anything that has aspirin in it?	<input type="checkbox"/>	<input type="checkbox"/>
<b>In the past 8 weeks, have you</b>		
7. Donated blood, platelets or plasma?	<input type="checkbox"/>	<input type="checkbox"/>
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"/>
<b>In the past 3 months, have you</b>		
10. Had a blood transfusion?	<input type="checkbox"/>	<input type="checkbox"/>
11. Had a transplant such as organ, tissue, or bone marrow?	<input type="checkbox"/>	<input type="checkbox"/>
12. Had a graft such as bone or skin?	<input type="checkbox"/>	<input type="checkbox"/>
13. Come into contact with someone else's blood?	<input type="checkbox"/>	<input type="checkbox"/>
14. Had an accidental needle-stick?	<input type="checkbox"/>	<input type="checkbox"/>
15. Had sexual contact with anyone who has ever had HIV/AIDS or has ever had a positive test for the HIV/AIDS virus?	<input type="checkbox"/>	<input type="checkbox"/>
16. Had sexual contact with a prostitute or anyone else who has ever taken money or drugs or other payment for sex?	<input type="checkbox"/>	<input type="checkbox"/>
17. 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"/>
18. Male donors: Had sexual contact with another male?	<input type="checkbox"/>	<input type="checkbox"/>
19. Female donors: Had sexual contact with a male who had sexual contact with another male in the past 3 months?	<input type="checkbox"/>	<input type="checkbox"/>
20. Had a tattoo?	<input type="checkbox"/>	<input type="checkbox"/>
21. Had ear or body piercing?	<input type="checkbox"/>	<input type="checkbox"/>
22. Had or been treated for syphilis or gonorrhea?	<input type="checkbox"/>	<input type="checkbox"/>
23. Used needles to take drugs, steroids, or anything <u>not</u> prescribed by your doctor?	<input type="checkbox"/>	<input type="checkbox"/>
24. Received money, drugs, or other payment for sex?	<input type="checkbox"/>	<input type="checkbox"/>
<b>In the past 16 weeks,</b>		
25. Have you donated a double unit of red cells using an apheresis machine?	<input type="checkbox"/>	<input type="checkbox"/>

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<b>In the past 12 months, have you</b>		
26. Had sexual contact with a person who has hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>
27. Lived with a person who has hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>
28. Been in juvenile detention, lockup, jail, or prison for 72 hours or more consecutively?	<input type="checkbox"/>	<input type="checkbox"/>
<b>In the past three years, have you</b>		
29. Been outside the United States or Canada?	<input type="checkbox"/>	<input type="checkbox"/>
<b>From 1980 through 1996,</b>		
30. Did you spend time that adds up to 3 months or more in the United Kingdom countries of England, Northern Ireland, Scotland, Wales, the Isle of Man, the Channel Islands, Gibraltar, or the Falkland Islands?	<input type="checkbox"/>	<input type="checkbox"/>
<b>From 1980 through 2001, did you</b>		
31. Spend time that adds up to 5 years or more in France or Ireland? Time spent in Ireland does not include time spent in Northern Ireland which is part of the United Kingdom.	<input type="checkbox"/>	<input type="checkbox"/>
<b>From 1980 to the present, did you</b>		
32. Receive a blood transfusion in France, Ireland, England, Northern Ireland, Scotland, Wales, the Isle of Man, the Channel Islands, Gibraltar, or the Falkland Islands?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Have you EVER</b>		
33. Female donors: Been pregnant or are you pregnant now?	<input type="checkbox"/>	<input type="checkbox"/>
34. Had a positive test for the HIV/AIDS virus?	<input type="checkbox"/>	<input type="checkbox"/>
35. Had malaria?	<input type="checkbox"/>	<input type="checkbox"/>
36. Received a dura mater (or brain covering) graft or xenotransplantation product?	<input type="checkbox"/>	<input type="checkbox"/>
37. Had any type of cancer, including leukemia?	<input type="checkbox"/>	<input type="checkbox"/>
38. Had any problems with your heart or lungs?	<input type="checkbox"/>	<input type="checkbox"/>
39. Had a bleeding condition or a blood disease?	<input type="checkbox"/>	<input type="checkbox"/>
40. Had a positive test result for <i>Babesia</i> ?	<input type="checkbox"/>	<input type="checkbox"/>

<b>Use this area for additional questions</b>	Yes	No