

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"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>