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| Donor (label) |

Dear Sir or Madam,

This medical questionnaire aims to screen you as a potential donor and to protect the patient who will receive your stem cells or lymphocytes. Your full sincerity in answering all questions is very important. Your answers are confidential.

Please read each question carefully and answer to the best of your ability.

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| --- | --- | --- |
| Have you read and understood the information, and were all your questions answered? | YES | NO |
| Are you in good health? | YES | NO |
| Do you smoke?   * If so, quantity per day: ……………………………………………………………….. | YES | NO |
| Do you drink alcohol?   * If so, quantity per day: ……………………………....................................... | YES | NO |

The following questions pertain more specifically to your health.

**Overall state of health**

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| --- | --- | --- |
| Have you visited a general practitioner or a specialist in recent months?   * If so, why? ……………………………………………………………………… | YES | NO |
| Have you been admitted to hospital in the last 6 months for an examination, operation, endoscopy (internal examination) or other treatment?   * If so, why and when? ……………………………………………………...... | YES | NO |
| Have you ever had a serious or malignant disease (including leukaemia) or a malignant tumour?   * If so, which one, when and describe the treatment you received:   ……………………………………………….......................................................... | YES | NO |
| Have you ever been found to have an immunological or haematological disorder?   * If so, which? ………………………………………………………………………… | YES | NO |
| Have you ever undergone brain surgery (craniotomy)? | YES | NO |
| Are you currently taking medication, including vitamins, herbal preparations or drugs undergoing clinical trials?   * If so, please write down the medication, dose and reason for taking:   1/ …………………………………………………………………………………  2/ …………………………………………………………………………………...  3/ …………………………………………………………………........................  4/ …………………………………………………………………………………...  5/ …………………………………………………………………………………...  6/ …………………………………………………….……………………………..  7/ ……………………………………………………...………….........................  8/ …………………………………………………….…………………………….. | YES | NO |
| Have you been taking corticoids for 90 days or longer? | YES | NO |
| Have you taken the medicine Neotigason in the past two years? | YES | NO |
| Are you taking immunosuppressants? | YES | NO |
| Do you have 1 of the following symptoms? |  |  |
| * unexplained weight loss | YES | NO |
| * unexplained night sweating | YES | NO |
| * unexplained persistent diarrhoea | YES | NO |
| * unexplained persistent cough or breathlessness | YES | NO |
| * unexplained high temperature (> 38°C) | YES | NO |
| * continuously swollen lymph nodes | YES | NO |
| Do you have spontaneous bruises or nosebleeds? | YES | NO |
| Do you bleed for a long time after a tooth extraction or operation? | YES | NO |
| Do you have family members with a tendency to bleeding or thrombosis? | YES | NO |
| Are you allergic to latex, medication, food or anything else?   * If so, please circle whichever applies. | YES | NO |
| Have you ever suffered from skin complaints such as eczema or psoriasis?   * If so, please circle whichever applies. | YES | NO |
| Have you ever had problems with:   * your stomach? * your intestines? * If so, please circle whichever applies. | YES | NO |
| Do you have diabetes:   * If so, how is it treated? …………………………………………………… | YES | NO |
| Have you undergone neurosurgery in the past? | YES | NO |
| In the past 12 months, have you been treated in an emergency unit, admitted to hospital or undergone a surgical operation?   * If so, please explain: ………………………………………………………………….. | YES | NO |
| Have you ever had problems with general or local anaesthetic?   * If so, please explain: …………………………………………………………………….. | YES | NO |
| Do some of your blood relatives have problems with anaesthesia?   * If so, please explain: …………………………………………………………………….. | YES | NO |

**Cardio-vascular and kidney disease**

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| Have you ever had a stroke, heart attack, heart disease or heart surgery?   * If so, which, and describe the treatment that you received:   …………………………………………………………………….............................. | YES | NO |
| Do you feel pain, pressure or chest tightness during exertion?   * If so, please circle whichever applies. | YES | NO |
| Do you have palpitations? | YES | NO |
| Are you short of breath at rest / during exertion?   * If so, please circle whichever applies. | YES | NO |
| Have you ever suffered from poor blood circulation in your legs? | YES | NO |
| Do you suffer from high blood pressure? | YES | NO |
| Do you have kidney disease? | YES | NO |
| Have you undergone chronic (renal) dialysis? | YES | NO |
| Have you ever suffered from urinary tract infections? | YES | NO |

**Airways and lungs**

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| --- | --- | --- |
| Have you ever experienced breathing problems, including asthma, hay fever, sleep apnoea or breathlessness?   * If so, which ones and please describe the treatment that you received: …………………………………………………………………………………………. | YES | NO |
| Have you or anyone in your entourage ever had tuberculosis?   * If so, when? ……………………………………………………………………… | YES | NO |
| Have you ever had a pulmonary embolism? | YES | NO |

**Central nervous system**

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| --- | --- | --- |
| Do you have epilepsy? | YES | NO |
| Do you have a degenerative disease of the nervous system (such as progressive dementia, Alzheimer's disease, etc.) or another neurological condition (such as multiple sclerosis, Parkinson's disease, etc.)?   * If so, which? …………………………………………………………………………. | YES | NO |
| Have you ever had a brain haemorrhage or stroke?   * If so, when? ……………………………………………………………………... | YES | NO |

**Muscles and joints**

|  |  |  |
| --- | --- | --- |
| Do you have a chronic systemic autoimmune disease (such as chronic rheumatoid arthritis or lupus erythematosus)?   * If so, please circle whichever applies. | YES | NO |
| Have you ever had neck, back, hip or muscle problems?   * If so, which and describe the treatment you received.   1/……………………………………………………………………………………  2/……………………………………………………………………………………  3/…………………………………………………………………………………… | YES | NO |
| Have you ever suffered from stiff or weak joints? | YES | NO |
| Have you ever suffered bone fractures? | YES | NO |
| Have you ever suffered from osteoporosis? | YES | NO |

**Questions about the risk of transmission of infection**

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| --- | --- | --- |
| Have you ever had an implant of tissue or other donor material of human origin (e.g. cornea, eardrum, dura mater (meninges) or tissue of animal origin (xenotransplant)?   * If so, please explain: ………………………………………………………………………. | YES | NO |
| Have you ever had an organ or cell transplant (bone marrow, skin, heart, kidney or liver)?   * If so, please explain: ………………………………………………………………………. | YES | NO |
| Have you ever donated an organ, tissue or cells?   * If so, please explain: ………………………………………………………………………. | YES | NO |
| In the past 6 months, have you been given blood, plasma or other blood products?   * If so, which and when? ………………………………………………………….. | YES | NO |
| Have you ever been refused for blood donation?   * If so, for what reason? …………………………………………………………….. | YES | NO |
| Have you ever had or do you have a blood coagulation problem such as haemophilia, have you ever received coagulating factors of human origin?   * If so, which and when? ………………………………………………………….. | YES | NO |
| Have you ever had sexual contact with someone who has haemophilia? | YES | NO |
| Have you ever been exposed to one of the following substances: cyanide, lead, mercury or gold?   * If so, please circle whichever applies. | YES | NO |
| In the past year: have you had tattoos, acupuncture, ear piercing, body piercing, or an internal examination? (circle whichever applies)   * If so, when?................................................................................................. | YES | NO |
| Was that procedure carried out in an officially approved business (licensed)? | YES | NO |
| In the past 12 months, have you had a needle injury, or have you been in contact with someone else's blood via a wound or damaged skin or via the mucous membranes (e.g. eye, mouth)?   * If so, please explain: …….………………………………………………………………… | YES | NO |
| In the past year, have you been injured on a used needle or a sharp object contaminated with blood?   * If so, when: ……………………………………………………………………… | YES | NO |
| Have you taken drugs in the past year? | YES | NO |
| Have you ever had sexual contact in exchange for money, drugs or another form of payment? | YES | NO |
| **Male donors**: have you ever had sexual contact with another man? | YES | NO  N/A |
| **Female donors** Have you ever had sexual contact with a man who has ever had sexual contact with another man? | YES | NO  N/A |
| Have you ever had sexual contact with someone born or living in Africa or with someone who has stayed or is living in South America? | YES | NO |
| In the past 4 weeks, have you been inoculated (vaccinated) with live vaccine (polio, herpes zoster, measles)?   * If so, which and when? ................................................................................. | YES | NO |
| Have you ever had jaundice (hepatitis)?   * If so, when? ……………………………………………………………………... | YES | NO |
| In the past 6 months, have you come into contact with someone who has jaundice or another infectious disease?   * If so, when? …………………………………………………………………….. | YES | NO |
| Have you been bitten by a tick in the last 4 months? | YES | NO |
| In the past 6 months, have you been to a region where malaria precautions are recommended?   * If so, where? ………………………………………………………………………….. | YES | NO |
| Did you take medication to prevent malaria?   * If so, which medication? …………………………………………………………….. | YES | NO |
| Have you ever had malaria? | YES | NO |
| Did you stay for a (cumulative) period of more than six months in the United Kingdom between 1980 and 1996? | YES | NO |
| Have you been given blood products in France or the United Kingdom since 1980?   * If so, in which country and when? ……………………………….. | YES | NO |
| In the past 5 weeks, have you spent time in a country other than Belgium?   * If so, in which country? ........................................................................................... | YES | NO |
| Have you spent time outside Europe in the past 3 years?   * If so, in which country and when? …………………………………………………… | YES | NO |
| Have you ever been in Central or South America? | YES | NO |
| Have you recently come into contact with someone who has spent time in an area with a risk of Ebola or Zika?   * If so, when: ……………………………………………………………………… | YES | NO |
| Do you think you had sexual contacts which have put you at risk of becoming infected with the HIV virus? | YES | NO |
| Do you have, or is there a suspicion that you may have HIV, viral hepatitis B or C or Human T-cell Lymphotropic Virus (HTLV)?   * If so, please circle whichever applies. | YES | NO |
| Have you ever tested positive for syphilis or another sexually transmitted disease or have you been treated for it? | YES | NO |
| Have you ever been treated with growth hormones (before 1985) or with pituitary hormones of human origin?  If so, when and which ones? ……………………………………………………………. | YES | NO |
| Are you suffering from a general infection (caused by bacteria, viruses, fungus or parasites)? | YES | NO |
| Have you ever had Chagas disease and/or had a positive test for Trypanosoma cruzi? | YES | NO |
| Have you ever been infected by West Nile Virus? | YES | NO |

**Hypersensitivity**

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| --- | --- | --- |
| Are you hypersensitive to medication, iodine, X-ray contrast products or other substances?   * If so, please circle whichever applies. | YES | NO |

**Family medical history**

|  |  |  |
| --- | --- | --- |
| Do genetic diseases run in your family?   * If so, which: ………………………………………………………………………….. | YES | NO |
| Have you or anyone in your family had Creutzfeld-Jacob disease (mad cow disease) or a variant of it, Gertsmann-Scheinker or fatal familial insomnia?   * If so, please circle whichever applies. | YES | NO |

**Female donors** (for male donors: not applicable )

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| --- | --- | --- |
| Do you have children?   * If so, how many? ………………………………………………………………………. | YES | NO |
| Have you been pregnant in the past 9 months? | YES | NO |
| Are you breast-feeding? | YES | NO |
| Is it possible that you are pregnant now? | YES | NO |
| Are you planning a pregnancy in the next 6 months? | YES | NO |
| Are you using contraception? | YES | NO |

**General**

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| --- | --- | --- |
| Are there things relating to your health that have not been covered by this questionnaire and which you feel are important?   * If so, please explain: ………………………………………………………………………. | YES | NO |

I declare that I have answered the above questionnaire truthfully.

***Donor's surname and first name Doctor's surname and first name***

*National register number/Identity card number:*

*Signature Signature*

*Place: Place:*

*Date: Date:*