

Surname: **Name:** **Title:** **Date of birth:**

Please fill in all the information responsibly and completely. **Circle the correct answer!**
Please familiarize yourself with the "Information for Blood Donors".

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| 1. Have you familiarized yourself with the instruction on risky behaviour in terms of donating blood and do you understand it? | Yes | No |
| 2. Do you belong to any group with risky behaviour? (see "INSTRUCTIONS" and "INFORMATION for donors") | Yes | No |

CURRENT HEALTH STATUS

- | | | |
|---|-----|----|
| 3. Do you feel healthy? | Yes | No |
| 4. Do you regularly take medication (list all, including e.g., Acylpyrine, hormonal contraception)? | Yes | No |
| Which one: | | |
| 5. Have you taken any medication in the last 4 weeks (do not list regularly used medications)? | Yes | No |
| Which one: | | |
| 6. Are you being treated or monitored for any disease (including infectious diseases)? | Yes | No |
| 7. Do you sweat excessively at night, do you notice increased body temperature, swollen nodes? | Yes | No |
| 8. Have you lost weight lately without any apparent reason? | Yes | No |
| 9. Have you had any illness (cold, diarrhoea, etc.) in the last 4 weeks? | Yes | No |
| 10. Have you had teeth pulled or minor surgery in the last 7 days? | Yes | No |
| 11. Have you been bitten by a tick in the last 4 weeks? | Yes | No |

CHANGES IN HEALTH STATUS

In the past 6 months, have you experienced:

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| 12. Transplantation, surgery, hospital treatment, intravenous drug administration, endoscopic examination (orthoscopy, gastroscopy, colonoscopy, etc.), injection needle injury, contact with blood (injury) or mucous membrane? | Yes | No |
| What: When: | | |
| 13. Have you received a blood transfusion? | Yes | No |
| 14. Have you had a tattoo, acupuncture, ear piercing, piercing, permanent make-up done? | Yes | No |
| (date of the procedure, describe location, shape, approximate size in cm): | | |
| 15. Have you been vaccinated? | Yes | No |
| Against what: | | |
| 16. Do you work in a risky (infectious, health-damaging) environment? | Yes | No |
| What type? (infection, radiation, chemical risks, etc.): | | |
| 17. Have you been treated for a sexually transmitted disease? | Yes | No |
| 18. Have you been in a correctional facility (prison)? | Yes | No |
| 19. In the past 12 months , have you been in close contact (family, sexual contact) with a patient with an infectious jaundice, AIDS, another infectious disease or with an intravenous drug user? | Yes | No |
| Please specify: | | |
| 20. Have you lived abroad? | Yes | No |
| Where? (also short-term, tourist stay): | | |
| 21. For women: Have you been pregnant in the last year or are you pregnant? | Yes | No |

BLOOD COLLECTIONS IN THE PAST

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|---|-----|----|
| 22. Are you donating blood or blood components for the first time? (if Yes, do not fill in questions 23 and 24) | Yes | No |
| 23. Did you have a health complication after the last collection (e.g., fainting, collapse, larger hematoma, etc.)? | Yes | No |
| 24. Do you also go to donate to another medical facility? | Yes | No |
| 25. Have you ever been rejected as a blood donor? | Yes | No |
| Reason: | | |

PREVIOUS DISEASES - ANANAMNESIS (from birth to the present day)

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| 26. Infectious jaundice, HIV infection (AIDS), HTLV I/II virus infection, venereal disease (syphilis, gonorrhoea), tuberculosis, other communicable diseases-inf. mononucleosis, tick-borne encephalitis, brucellosis, tularaemia, toxoplasmosis, listeriosis, borreliosis, babesiosis, leishmaniasis (Kala-Azar), Chagas disease, Q fever, typhoid, paratyphoid, malaria, etc. | Yes | No |
| 27. Heart disease, vascular disease, high or low blood pressure | Yes | No |
| 28. Blood diseases (anaemia, bleeding, polycythaemia, thalassaemia, etc.) | Yes | No |
| 29. Diseases of the digestive tract (ulcer disease, inflammation of the pancreas, intestines, etc.) | Yes | No |
| 30. Diseases of glands with internal secretion (diabetes, metabolic disorders, thyroid gland, etc.) | Yes | No |
| 31. Kidney diseases (inflammation, stones, colic, etc.) | Yes | No |
| 32. Diseases of respiratory organs (asthma, emphysema, chronic bronchitis, etc.) | Yes | No |

- 33. Bone and joint diseases (arthritis, rheumatic fever, osteomyelitis, etc.)..... Yes No
- 34. Tumour diseases Yes No
- 35. Diseases of the nervous system, eye diseases, mental illnesses (convulsive conditions, epilepsy, multiple sclerosis, glaucoma, depression, psychosis, etc.)..... Yes No
- 36. Operations and all major injuries; transplantation; blood transfusion. When, where – specify country: Yes No
- 37. Have you had a dura mater, cornea or eardrum implanted? Yes No
- 38. Allergies, immune disorders, skin diseases? What:..... Yes No
- 39. Have you or your family been diagnosed with Creutzfeldt-Jakob disease or its variant (vCJD)?..... Yes No
- 40. Have you ever taken the following medicines: isotretinoin (e.g., Aknenormin), etretinate (e.g., Tegison), Aciretin (e.g., Neotigason), finasteride (e.g., Adafin, Finard, Penester), dutasteride (e.g., Avodart, Dustar, Dufalan) etc.? Yes No
- 41. Have you ever been treated with growth hormone or pituitary extract? Yes No
- 42. Have you ever been treated for alcoholism or drug addiction? Yes No
- 43. Have you- ever had a tattoo, acupuncture, ear piercing, piercing, permanent make-up done in the past? (indicate the date of the procedure, describe the location, shape, approximate size in cm): Yes No
- 44. Have you ever used drugs (even intravenously), or injectable drugs not prescribed by a physician, anabolic steroids, etc.)? Yes No
- 45. Were you born or did you live abroad? Where? Yes No
- 46. In the period 1980-1996, did you spend a total of more than 6 months in Great Britain or France?..... Yes No
- 47. Do you have a job or hobby with increased physical load or attention demands? (professional driver, pilot, work at heights, mountain climbing, diving) Yes No

I confirm that I have not concealed any important facts and that all the information I have provided is true to the best of my knowledge and conscience (concealing facts that may endanger the health or life of the transfusion recipient and is punishable by law).

DATE:

DONOR SIGNATURE:

I have read the "Information for Blood Donors " and I understand its content. **In the sense of the wording of the "Information for Blood Donors" I consider myself a suitable donor whose blood will not endanger the recipient's health.** I have been informed about the course of the blood collection and the risks associated with it, and I agree with the collection. I have been informed that I have the right to ask questions about the blood collection and the right to withdraw from the blood collection at any time. I confirm that I have received a satisfactory answer to each question asked. I have been informed about the possibility of discreet self-exclusion. I agree to having my blood examined with all necessary tests, including an AIDS test, and with the storage of blood samples for possible additional examination of blood-borne infections and blood group antigens, including molecular-genetic methods. I agree that in case of unsatisfactory results, it will be used in healthcare for purposes other than transfusion. I was informed that I will be informed in case of unsatisfactory laboratory tests. I declare that I am not coming to donate blood for the reason of AIDS testing. I understand that I should rest for at least 30 minutes after the blood collection and only then actively participate in road traffic. I agree that my personal data and data on my state of health will be recorded in compliance with mandatory confidentiality according to the applicable law and that the data will be used in compliance with the principles of medical confidentiality within the transfusion service (e.g., reference laboratories for infectious diseases, register of excluded blood donors, register of blood donors with a rare blood group, etc.). I agree that medicinal products made from my blood (or plasma) are used in accordance with medical, ethical, and humanitarian principles to treat the sick within the framework of the applicable legislation only if they meet the requirements for their safety and quality. In the event of a surplus of medicinal products produced in the Czech Republic, I agree to their export for the purpose of treating patients in other countries. By signing, I confirm that I give my informed consent to the blood collection and laboratory examination.

DATE:

DONOR SIGNATURE:

EVALUATION OF THE QUESTIONNAIRE BY THE PERSON RESPONSIBLE FOR RELEASE OF THE DONOR TO BLOOD COLLECTION:

SUITABLE: <input type="checkbox"/>	NOT SUITABLE: <input type="checkbox"/>	Not suitable for:
Date:	Signature of responsible person:	