BLÓÐBANKINN

EBB-41141-011

BLOOD DONOR HEALTH QUESTIONNAIRE

FIRST TIME DONORS OR TWO YEARS EXCEEDING THE PREVIOUS DONATION

DONOR ID

RECEPTION | DONATION

Use capital letters

Name ..... ID number .....

Permanent address ..... Present address .....

Telephone number: Home ..... Work ..... Mobile .....

Email ..... Occupation .....

Any reaction during/after the previous blood donation? .....

Blood donation elsewhere than in the Icelandic Blood Bank, date and place: .....

Please inform The Blood Bank, if you experience any **illness** shortly after donating.
All information is treated **confidentially**. You have the **right to withdraw** from donating at any time without giving a reason.

I have read the Blood Bank booklet, "Infection prevention and blood donation – information to the donor" today. ☐

	Yes	No
1. Are you in good health?	☐	☐
2. Are you currently taking any medication?	☐	☐
3. Have you recently taken a pain reliever, anti-inflammatory medication, herbal/natural supplements or over-the-counter medication?	☐	☐
4. Have you during the past month:		
a. been in contact with any person having an infectious disease?	☐	☐
b. had influenza / a cold / a cold sore?	☐	☐
c. had a dental appointment?	☐	☐
5. Have you during the past 12 months:		
a. been ill/had surgery/ been under medical observation?	☐	☐
b. had a vaccination/immunization?	☐	☐
c. lost weight/had lymphadenitis/diarrhea/cough/fever?	☐	☐
d. had acupuncture / electrolysis / tattooing / body or skin piercing?	☐	☐
6. Are you born outside of Iceland?	☐	☐
7. Have you travelled or lived outside of Iceland?	☐	☐
8. Have you been told of a family history of Creutzfeld – Jakob Disease?	☐	☐
9. Have you ever been told not to give blood? If yes, state the reason.	☐	☐
10. Female donors: Have you been pregnant during the past 12 months or since your last donation/blood test?	☐	☐

Weight: ..... Height: .....

I had a meal/snack at ..... o'clock

11. Have you ever had:	Yes	No
a. heart or blood vessel disease/ Rheumatic fever?	☐	☐
b. chest pain / pressure feeling?	☐	☐
c. lung disease?	☐	☐
d. Tuberculosis?	☐	☐
e. Rheumatic arthritis?	☐	☐
f. anemia/blood disease?	☐	☐
g. high blood pressure/low blood pressure?	☐	☐
h. jaundice/liver disease?	☐	☐
i. gastric/intestinal disease?	☐	☐
j. kidney disease?	☐	☐
k. endocrine disease (e.g. thyroid disease)?	☐	☐
l. Diabetes?	☐	☐
m. allergy?	☐	☐
n. sexually transmitted disease?	☐	☐
o. nervous system disease?	☐	☐
p. loss of consciousness (fainted)/convulsions?	☐	☐
q. cancer/cell dysplasia?	☐	☐
12. Have you been in an accident?	☐	☐
13. Have you had a blood transfusion?	☐	☐
14. Have you had:		
a. treatment with growth hormone or other human pituitary hormone?	☐	☐
b. tissue grafting (e.g. corneal graft, dura mater graft)?	☐	☐
c. treatment with the medication isotretinoin (e.g. Decutan, Roaccutan)/ etretinate (e.g. Tegison)/acitretin (e.g. Neotigason)/finasteride (e.g. Finol, Propecia, Proscar)/ dutasteride (e.g. Avodart, Duodart)?	☐	☐
15. Female donors: Have you had a conization?	☐	☐

I have read and understood the educational materials provided by the Blood Bank to blood donors, have had opportunity to ask questions and have received satisfactory answers.
I consent to blood donation/blood test today and to the Blood Bank storage of this health questionnaire as well as computer recording of blood test results.
I vouch for having answered the health questionnaire according to the best of my knowledge and that I do not belong to any mentioned risk group.

Date: ..... Blood donor signature: .....

Skin inspection: ..... Nurse: .....

Strikamerki: 5690939123397

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