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Questionnaire

Hand in the questionnaire before the clinical examination. Remember to bring a reliable picture ID (passport or driver's license).

All questions must be answered. If you do not have the necessary information to answer the questions, please try to obtain them.

1. Introductory questions:

Donor No: _____ (To be added by Cryos)

Name: _____

Date of birth: _____

Are you employed at one of Cryos' departments? yes _____ no _____

Have you been convicted of a crime or been to prison? yes _____ no _____

2. Education and profession:

Education in progress: _____

Highest completed education: _____

Current occupation: _____

3. Ethnic origin:

Father race: _____
Caucasian, African, Hispanic, Asian, Middle Eastern, or a combination

ethnicity: _____
e.g. Danish, French, or a combination (state Jewish origin here, if any)

Mother race: _____
Caucasian, African, Hispanic, Asian, Middle Eastern, or a combination

ethnicity: _____
e.g. Danish, French, or a combination (state Jewish origin here, if any)

4. Questions about your health:

Have you ever had a blood transfusion?	yes _____	no _____
Do you take or have you taken medicine daily?	yes _____	no _____
If yes, state which kind? (e.g. asthma/anti-epileptic medicine)	_____	
Have you ever had an operation?	yes _____	no _____
If yes - what kind of operation?	_____	
Do you have or have you had any allergy/allergies?	yes _____	no _____
If yes - to what and is/was treatment needed?	_____	
Are you being or have you ever been treated with psychoactive drugs?	yes _____	no _____
Are you currently or have you been treated with growth hormones?	yes _____	no _____
Do you or have you had asthma/chronic atopic dermatitis?	yes _____	no _____
Have you had cancer?	yes _____	no _____
Do you have or have you had a heart disease?	yes _____	no _____
Do you have or have you had a kidney disease?	yes _____	no _____
Do you have diabetes?	yes _____	no _____
Have you had jaundice/enlarged liver?	yes _____	no _____
Do you have or have you had a skin disease?	yes _____	no _____
Do you have or have you had high blood pressure?	yes _____	no _____
Did you have seizures as a child?	yes _____	no _____
Do you have or have you had, epilepsy or a seizure?	yes _____	no _____
Do you have or have you had mental diseases?	yes _____	no _____
Do you have a hearing impairment?	yes _____	no _____
Do your have an impaired vision?	yes _____	no _____
Do you have any congenital malformations?	yes _____	no _____
Do you have or have you had any other long-term diseases?	yes _____	no _____

5. Questions about infectious diseases and lifestyle:

Do you have or have you had chlamydia?	yes _____	no _____
Do you have or have you had genital warts/condyloma?	yes _____	no _____
Do you have or have you had herpes?	yes _____	no _____
Do you have or have you had gonorrhea?	yes _____	no _____
Do you have or have you had syphilis?	yes _____	no _____
Have you had sexual relations with another man?	yes _____	no _____
Have you had a sexual relation with a prostitute or have you engaged in sex for money or drugs?	yes _____	no _____
Do you use, or have you ever used, non-prescription medicine for injection?	yes _____	no _____
Are you/have you been treated with haemophilia medicine?	yes _____	no _____
Have you had a sexual relation with a person mentioned in one of the 4 categories above, within the last 6 months	yes _____	no _____
Have you been pierced, had a tattoo, scarification and/or acupuncture performed by a non-healthcare professional within the last 12 months in which sterile procedures were not used?	yes _____	no _____
Have you had sexual intercourse without using a condom with anyone other than a steady partner within the last 6 months?	yes _____	no _____
Do you use or have you used non-prescribed narcotic drugs?	yes _____	no _____
Have you been exposed to known or suspected HIV, hepatitis B and/or hepatitis C infected blood through percutaneous inoculation within the last 6 months, e.g. a needlestick incident?	yes _____	no _____
Have you had sexual relations with a person who you knew or suspected was HIV or hepatitis B or C positive?	yes _____	no _____
How many units of alcohol do you drink on average per week?	_____ units	
Have you tested positive or reactive for West Nile Virus infection using a donor screening test in the preceding 120 days?	yes _____	no _____
Have you received a transfusion of blood or blood components in the United Kingdom or France between 1980 and the present?	yes _____	no _____

Are you a current or former U.S. military member, civilian military employee, or dependent of a military member or civilian employee who resided at U.S. military bases in Northern Europe (Germany, United Kingdom., Belgium, and the Netherlands) for 6 months or more from 1980 through 1990, or elsewhere in Europe (Greece, Turkey, Spain, Portugal, and Italy) for 6 months or more from 1980 through 1996? yes _____ no _____

Have you lived cumulatively for 5 years or more in Europe from 1980 until the present?
Europe includes: Albania, Austria, Belgium, Bosnia-Herzegovina, Bulgaria, Croatia, Czech Republic, Denmark, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Liechtenstein, Luxembourg, Macedonia, Netherlands, Norway, Poland, Portugal, Romania, Slovak Republic, Slovenia, Spain, Sweden, Switzerland, United Kingdom (England, Northern Ireland, Scotland, Wales, the Isle of Man, the Channel Islands, Gibraltar, and the Falkland Islands), and Yugoslavia. yes _____ no _____

Were you or any of your sexual partners born, or have you or any of your sexual partners lived in Cameroon, Central African Republic, Chad, Congo, Equatorial Guinea, Gabon, Niger, and/or Nigeria after 1977? yes _____ no _____

Have you received a blood transfusion or any medical treatment that involved blood in the countries listed in the preceding question between 1980 and the present? yes _____ no _____

Are you or any close contacts a recipient of a xenotransplantation product? Note: Xenotransplantation involves the surgical removal of an organ or tissue from one species and transplanting it into a member of a different species: for example, the use of a baboon heart in a human being. yes _____ no _____

Have you been bitten by an animal suspected of rabies in the last six months? yes _____ no _____

Have you had significant, potentially toxic exposure to lead, mercury, and/or gold? yes _____ no _____

Have you had more than one sexual partner within the last six months? yes _____ no _____

Have you been an inmate of correctional facilities for 72 consecutive hours or longer within the preceding 12 months? yes _____ no _____

Within the preceding 12 months, have you been a heterosexual partner of HIV-positive individuals or of individuals who use narcotic drugs, have been treated with blood or products derived from blood, engaged in high risk behavior for HIV infection, etc.? yes _____ no _____

6. Questions about the health of your closest family:

Paternal grandfather: age (or age at death): _____ If deceased, cause of death: _____

Health (well? illnesses?):

Paternal grandmother: age (or age at death): _____ If deceased, cause of death: _____

Health (well? illnesses?):

Dad: age (or age at death): _____ If deceased, cause of death: _____

Health (well? illnesses?):

Maternal grandfather: age (or age at death): _____ If deceased, cause of death: _____

Health (well? illnesses?):

Maternal grandmother: age (or age at death): _____ If deceased, cause of death: _____

Health (well? illnesses?):

Mother: age (or age at death): _____ If deceased, cause of death: _____

Health (well? illnesses?):

Siblings: age: _____ Gender: _____

Health (well? illnesses?):

Children: age: _____ Gender: _____

Health (well? (any illnesses?):

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7. Questions about your family's health:

Has or does anybody in your family suffer from one or more of the below illnesses or malformations? Family includes siblings, nephews, nieces, father, paternal grandfather, paternal grandmother, uncles, aunts, mother, maternal grandfather, maternal grandmother, maternal uncles, maternal aunts, cousins and their children.

Down's syndrome (mongolism)	yes _____	no _____
Rheumatic diseases (Morbus Bechterew)	yes _____	no _____
Spina bifida	yes _____	no _____
Cleft lip and/or palate	yes _____	no _____
Club foot	yes _____	no _____
Congenital heart defect	yes _____	no _____
Heart disease	yes _____	no _____
Cystic fibrosis (hereditary lung disease)	yes _____	no _____
Gastrointestinal disease	yes _____	no _____
Kidney disease	yes _____	no _____
Diabetes (insulin-dependent)	yes _____	no _____
Diabetes (non-insulin-dependent)	yes _____	no _____
Cataracts (before the age of 40)	yes _____	no _____
Hearing impairment (deafness) before the age of 5	yes _____	no _____
Reduced muscular strength or changed muscular coordination	yes _____	no _____
Schizophrenia	yes _____	no _____
Manic-depressive / bipolar disease	yes _____	no _____
Autism/ Asperger's syndrome	yes _____	no _____
Disease with tremor	yes _____	no _____
Senility before the age of 60	yes _____	no _____
One or more incidents of premature death (e.g. blood clot, brain haemorrhage, cancer)	yes _____	no _____

By signing below, I confirm that all the information I have provided is correct. I also confirm that I am aware of the employee's duty of confidentiality and have received sufficient information about being a donor and have had the chance to ask questions

Date: _____ Donor candidate’s signature: _____

By signing below, the responsible person affirms that all questions were answered and any answers requiring clarification have been addressed and noted

Date: _____ Responsible Person Signature: _____