Produits sanguins
Cellules souches
Tissus humains
HÉMA-QUÉBEC

Héma-Québec
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HEALTH SCREENING QUESTIONNAIRE

❒ **CT** ❒ **Work-up**

Donor ID EdgeCell #: _____ Date: _____ (dd-mm-yyyy)

_____ _____ _____
First name Last Name Initial

_____ _____ _____ _____
Street address City Province Postal code

_____ _____ _____ _____
Home phone Work phone Date of birth (dd-mm-yyyy) Gender (M/F)

BLOOD DONOR STATUS

1. Have you ever attended a blood donor clinic in Canada? Yes ☐ No ☐

   *If yes, specify the location:*_____

2. Have you ever given blood under a different name? Yes ☐ No ☐ N/A ☐

   *If yes, specify the name:*_____

MEDICAL HISTORY

3. Have you ever had any serious illness or infection? Yes ☐ No ☐

   *If yes, please describe:*_____

4. In the last 12 months, have you had any medical investigations or procedures? Yes ☐ No ☐

   If yes, please describe:_____

5. Have you ever had surgery? Yes ☐ No ☐

   If yes, please list:

Type of surgery	Date (dd-mm-yyyy)	Type of anesthetic

Donor ID #: _____ Date: _____ (dd-mm-yyyy)

a) Are you fully recovered from these surgeries? Yes ☐ No ☐ N/A ☐

b) Did you have any complications with these surgeries? Yes ☐ No ☐ N/A ☐

If yes, please describe: _____

6. To your knowledge, do you or any of your blood relatives have any genetic disorders? Yes ☐ No ☐

If yes, explain : _____

7. Do you have a blood relative with a history of leukemia or lymphoma? Yes ☐ No ☐

If yes, how is this person related to you and what type of leukemia or lymphoma did this person have?

_____

_____

_____

8. Have you ever been diagnosed or treated for depression, bipolar disorder, schizophrenia, or other mental illness? Yes ☐ No ☐

If yes, did you receive treatment and/or require hospitalization?

_____

9. Have you ever had :

a) Liver problems? Yes ☐ No ☐

b) Epilepsy, coma, stroke, convulsions or fainting? Yes ☐ No ☐

c) Heart or blood pressure problems or heart surgery? Yes ☐ No ☐

d) Cancer, including blood cancer such as leukemia or lymphoma? Yes ☐ No ☐

e) Diabetes, ulcerative colitis or Crohn's disease? Yes ☐ No ☐

f) Kidney, lung or blood problems? Yes ☐ No ☐

g) Chagas' disease, babesiosis or leishmaniasis? Yes ☐ No ☐

h) Ankylosing spondylitis or rheumatoid arthritis? Yes ☐ No ☐

i) Neurological disease (ex. Prion related diseases such as Creutzfeldt-Jakob disease or other transmissible spongiform encephalopathies), Alzheimer, Parkinson, multiple sclerosis, amyotrophic lateral sclerosis? Yes ☐ No ☐

If yes, please describe*:* _____

10. Have you ever had a back or spinal injury? Yes ☐ No ☐

If yes, please describe: _____

Donor ID #: _____ Date: _____ (dd-mm-yyyy)

CURRENT HEALTH STATUS

11. Do you have chronic back problems? Yes ☐ No ☐

If yes, please describe:

_____

12. In the last month, have you taken any medication other than birth control pills or vitamins? Yes ☐ No ☐

If yes, what did you take and why?

_____

13. Do you have any allergies to medication, food, latex or other? Yes ☐ No ☐

If yes, please list allergies and describe reactions:

_____

14. a) In the last 3 months, have you had a vaccination? Yes ☐ No ☐

b) Are you planning on receiving a vaccination in the next 3 months? Yes ☐ No ☐

If yes, please explain: _____

15. In the last 6 months, have you had hepatitis? Yes ☐ No ☐

If yes, please describe: _____

16. Is there anything else about your health that has been of concern to you? Yes ☐ No ☐

If yes, please describe: _____

17. Donor Height : _____ cm or ft./in

Donor Weight : _____ kg of lbs.

18. **FEMALES ONLY**:

a) Have you ever been pregnant? Yes ☐ No ☐

If yes, have you been pregnant in the past 6 months? Yes ☐ No ☐

Number of pregnancies (including miscarriages and abortions): # _____

b) Are you pregnant now or are you planning a pregnancy in the next 6 months? Yes ☐ No ☐

c) Are you currently breastfeeding? Yes ☐ No ☐

If yes, would you be prepared to express milk prior to anesthetic to be stored for use during the 24 hour period after anesthetic? Yes ☐ No ☐

Donor ID #: _____ Date: _____
(dd-mm-yyyy)

RISK SCREENING FOR INFECTIOUS DISEASE

19. In the past 12 months, have you had sexual or other close contact, such as living in the same household or sharing bathroom or kitchen facilities, with a person who has had hepatitis? Yes ☐ No ☐
20. In the past 5 years, have you engaged in sex in exchange for money or drugs? Yes ☐ No ☐
21. In the past 12 months, have you had sex with anyone who has engaged in sex in exchange of money or drugs within the past 5 years? Yes ☐ No ☐
22. In the past 12 months, have you had or been treated for syphilis or gonorrhea? Yes ☐ No ☐
23. In the past 5 years, have you taken illegal drugs or medications by injection (intravenous, intramuscular or subcutaneous) for non-medical reasons? Yes ☐ No ☐
24. In the past 12 months, have you had sex with anyone who has taken illegal drugs or medications by injection (intravenous, intramuscular or subcutaneous) for non-medical reasons within the past 5 years? Yes ☐ No ☐
25. In the past 12 months, have you been in a youth correctional facility, jail or prison for more than 72 consecutive hours? Yes ☐ No ☐
26. In the past 6 months, have you had a tattoo, ear piercing, skin piercing, acupuncture, electrolysis, injury from a needle contaminated with blood, or come in contact with someone else's blood? Yes ☐ No ☐

    If yes, please describe: _____

27. **MALES ONLY**: In the past 12 months, have you had sex with a man? Yes ☐ No ☐
28. **FEMALES ONLY**: In the last 12 months, have you had sex with a man who has had sex with a man in the past 12 months? Yes ☐ No ☐
29. In the past 12 months, have you had sex with anyone known or suspected to have HIV, hepatitis B or hepatitis C? Yes ☐ No ☐
30. Have you ever had a positive test for HIV? Yes ☐ No ☐
31. Have you ever had a positive test for hepatitis B, hepatitis C or Human T-cell lymphotrophic virus (HTLV I/II)? Yes ☐ No ☐
32. Have you ever taken human growth hormone? Yes ☐ No ☐
33. Have you or any of your blood relatives (parent, child, or sibling) been diagnosed with a prion-related disease such as Creutzfeldt-Jakob disease? Yes ☐ No ☐
34. Have you ever had malaria? Yes ☐ No ☐

    If yes, please describe: _____

35. Have you ever had infectious mononucleosis or the Epstein Barr virus? Yes ☐ No ☐

    If yes, please describe: _____

Donor ID #: _____ Date: _____
(dd-mm-yyyy)

36. Have you ever received:

a) A dura mater (brain covering) graft? Yes ☐ No ☐

b) An organ transplant? Yes ☐ No ☐

If yes, please describe: _____

37. In the last 12 months, have you been bitten by an animal and treated as if the animal had rabies? Yes ☐ No ☐

38. Have you ever received a transfusion of blood or blood products? Yes ☐ No ☐

If yes, approximate date: _____ *# of units :* _____
(month/year)

39. In the last 6 months, have you received a human tissue graft? Yes ☐ No ☐

If yes, please describe: _____

40. Have you spent 1 month or more in a continuous period in Latin America including Mexico? Yes ☐ No ☐

If yes, please describe: _____

41. Were you born in Latin America, including Mexico? Yes ☐ No ☐

42. Was your mother or maternal grandmother born in Latin America including Mexico? Yes ☐ No ☐

If yes, please explain: _____

43. Have you travelled or resided outside of Canada, continental United States or Europe in the last 21 days? Yes ☐ No ☐

If yes, specify where, when, & for how long?

_____

_____

_____

44. In the last 3 years, have you traveled or resided outside of Canada, other than the US? Yes ☐ No ☐

If yes, specify where, when, & for how long? Please indicate any anti-malarial medication used if applicable.

_____

_____

_____

45. From 1980 to 1996 inclusively, have you traveled or resided in United Kingdom (England, Northern Ireland, Scotland, Wales, the Isle of Man, or the Channel Islands) for a total of 3 months or more? Yes ☐ No ☐

46. From 1980 to 1996 inclusively, have you traveled or resided in France for a total of 3 months or more? Yes ☐ No ☐

47. From 1980 to 1996 inclusively, have you traveled or resided in Saudi Arabia for a total of 6 months or more? Yes ☐ No ☐

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48. Since 1980, have you traveled or resided in Western Europe for a total of 5 years or more? Yes ☐ No ☐

49. Since 1980, did you receive a blood transfusion in Western Europe? Yes ☐ No ☐

50. In the past 6 months, have you traveled to or resided in a risk area for the ZIKA virus? Yes ☐ No ☐

If yes, indicate the travel return date : _____

If yes, have you experienced one or more of the following symptoms within the 2 weeks following your return: fever, rash, joint and muscle pain, conjunctivitis (red eyes), headache? Yes ☐ No ☐

If you answered "yes", specify the type, start date and end date of the symptoms:

_____

51. In the past 6 months, have you been diagnosed with the ZIKA virus infection? Yes ☐ No ☐

If yes, date of diagnosis: _____

52. In the past 6 months, have you had sexual contact with a person who is known to have either of the following :

a) Was diagnosed with the ZIKA virus infection in the past 6 months?? Yes ☐ No ☐

b) Traveled to or resided in a risk area for the ZIKA virus in the past 6 months? Yes ☐ No ☐

53. In the last 120 days, have you been diagnosed or suspected to be infected by the West Nile Virus (WNV)? Yes ☐ No ☐

SECTION CORONAVIRIUS:

IN THE LAST 30 DAYS :

54. Have you travelled or resided in a country assigned by the CDC with a risk assessment level 2 or higher for COVID-19? Yes ☐ No ☐

If yes, specify country and travel dates: _____

_____

✓ Voir la liste de pays ayant été désignés zones à risque niveau 2 ou plus sur le site suivant :

COVID-19 Travel Recommendations by Destination | CDC

55. Had any symptoms of COVID-19 such as fever, cough, shortness of breath, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, or diarrhea? Yes ☐ No ☐

If so, specify date of complete recovery: _____

56. Been suspected of having or diagnosed with COVID-19 by a medical professional based on your symptoms? Yes ☐ No ☐

If so, specify dates of complete recovery: _____

57. Had a positive diagnostic test for COVID-19, even if you never developed symptoms? Yes ☐ No ☐

If so, when? _____

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(dd-mm-yyyy)

58. Cared for, lived with, or otherwise had close contact with anyone diagnosed with or suspected of having COVID-19 infection? Yes ☐ No ☐

If so, when was the last contact? _____

59. Have you been vaccinated against COVID? Yes ☐ No ☐

*If so, which vaccine did you receive (**manufacturer**) and when (**date**)?*

a) **1st Dose**: _____

b) **2nd Dose**: _____

EXPOSURE RISK ASSESSMENT:

60. Is there any other information regarding your work or social interactions that might increase your risk for getting COVID-19?

_____

_____

_____

_____

_____

61. In the upcoming 2 months, do you plan to travel Yes ☐ No ☐

If so, please indicate country and travel dates: _____

_____

_____

_____

_____

Donor ID #: _____ Date: _____
(dd-mm-yyyy)

ADDITIONAL COMMENTS

_____

_____

_____

_____

I have answered all questions truthfully and with honesty.

I have read and understand the *Guide for the Potential Donors*, and consent to the collection, use and disclosure of my personal information as described therein. I understand the information describing how HIV (AIDS virus) and Hepatitis B and C can be transmitted to a recipient and I will refrain from making a donation if there are any risks that I may transmit HIV or Hepatitis B and C. I understand that my blood will be tested for HIV and other infectious disease makers. I understand that any positive test results will be given to me and might be reported to Public Health, if need be.

I understand that information in this questionnaire will be released to stem cell registry responsible for the stem cell transplant of the recipient for which I will donate and that the potential recipient of my donation may be advised of any transmissible disease risks, if need be.

I understand that my samples may be stored indefinitely by the transplant center for further HLA typing, blood grouping and/or infectious disease testing related to the recipient's stem cell transplant.

Donor's Signature: _____ Date (dd-mm-yyyy): _____

Print name: _____

Phone interview performed by: _____ Date (dd-mm-yyyy): _____

If interview conducted in another language:

Interpreter Name:_____ Language: _____

Written Translation by: _____

Translator Signature:_____ Date (dd-mm-yyyy): _____

For office use only

Double vérification effectuée par : _____ Date (jj-mm-aaaa) : _____