

First name: .....

Family name .....

Date of birth: .....

Address: .....

City: .....

Passport:.....

Telephone: .....

Mobile phone: .....

Sex: M  F

Dades de l'extracció

Data d'extracció		
Codi colecta	Idioma	
Pes	TA	Hb
Pols	Tipus bossa	
Resp. Mèdic		
Resp. Infermeria		
Observacions		

Número de donació

**Personal Questionnaire**

	YES	NO		YES	NO
<b>Understanding of the donor information brochure</b>			<b>Medication</b>		
<ul style="list-style-type: none"> <li>Has the blood bank provided you with understandable information in writing about donating blood? (If not, clarify any doubts you may have by asking the staff who will attend to you.) ..... <input type="checkbox"/> <input type="checkbox"/></li> </ul>			<ul style="list-style-type: none"> <li>Are you taking, or have you recently taken, any medicinal product?..... <input type="checkbox"/> <input type="checkbox"/></li> <li>Have you ever taken Avidart® or Duagen® for a prostate problem?..... <input type="checkbox"/> <input type="checkbox"/></li> <li>Have you ever taken Neotigason® for skin problems? ..... <input type="checkbox"/> <input type="checkbox"/></li> </ul>		
<b>Basic conditions for making a donation</b>			<b>In the last 2 weeks</b>		
<ul style="list-style-type: none"> <li>Are you over 18 years of age and weigh 50 kilos or more? ..... <input type="checkbox"/> <input type="checkbox"/></li> <li>Are you in good health? ..... <input type="checkbox"/> <input type="checkbox"/></li> <li>If you are a woman, are you pregnant or have you been pregnant in the last 6 months? ..... <input type="checkbox"/> <input type="checkbox"/></li> </ul>			<ul style="list-style-type: none"> <li>Have you had fever accompanied by headache and general malaise? ..... <input type="checkbox"/> <input type="checkbox"/></li> <li>Have you visited a dentist?..... <input type="checkbox"/> <input type="checkbox"/></li> </ul>		
<b>Precautions for the next 12 hours</b>			<b>In the last month</b>		
<ul style="list-style-type: none"> <li>Do you have to perform any hazardous job or sporting activity (diving, climbing...) or drive a public transport vehicle? ..... <input type="checkbox"/> <input type="checkbox"/></li> </ul>			<ul style="list-style-type: none"> <li>Have you received a vaccination? ..... <input type="checkbox"/> <input type="checkbox"/></li> <li>Have you been in contact with a person who had a contagious infectious disease?.. <input type="checkbox"/> <input type="checkbox"/></li> </ul>		
<b>Parents and place of birth</b>			<b>In the last 6 months</b>		
<ul style="list-style-type: none"> <li>Is your mother a foreigner?..... <input type="checkbox"/> <input type="checkbox"/></li> <li>Were you born in a foreign country? ..... <input type="checkbox"/> <input type="checkbox"/></li> </ul>			<ul style="list-style-type: none"> <li>Have you consulted a doctor or been hospitalised? ..... <input type="checkbox"/> <input type="checkbox"/></li> <li>Have you undergone an endoscopy: colonoscopy, gastroscopy, rectoscopy or other examination? ..... <input type="checkbox"/> <input type="checkbox"/></li> <li>Have you undergone a surgical operation?.. <input type="checkbox"/> <input type="checkbox"/></li> <li>Have you received acupuncture treatment with material that is not single use? ..... <input type="checkbox"/> <input type="checkbox"/></li> <li>Have you had a tattoo? ..... <input type="checkbox"/> <input type="checkbox"/></li> </ul>		
<b>On a waiting list</b>					
<ul style="list-style-type: none"> <li>Are you on a waiting list for a medical consultation or examination?..... <input type="checkbox"/> <input type="checkbox"/></li> </ul>					

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	YES	NO		YES	NO
• Have you had contact with the blood from another person by accidental prick or splashing? .....	<input type="checkbox"/>	<input type="checkbox"/>	• Are you or have you been infected by the human lymphotropic virus (HTLV-I/II)? .....	<input type="checkbox"/>	<input type="checkbox"/>
• Do you or have you lived, or maintained intimate contact, with a person who has had hepatitis, jaundice or was a carrier of the hepatitis virus? .....	<input type="checkbox"/>	<input type="checkbox"/>	<b>Periods abroad</b>		
• Have you travelled (tourism, business, NGO, family visit...) to Africa, America, Asia or Oceania? .....	<input type="checkbox"/>	<input type="checkbox"/>	• Have you resided in a foreign country? .....	<input type="checkbox"/>	<input type="checkbox"/>
<b>At any time in your life:</b>			• Have you lived for more than one year -adding all periods of residence-in the United Kingdom (England, Wales, Scotland, Northern Ireland, Channel Islands, Isle of Man) during the period from 1980 to 1996? .....	<input type="checkbox"/>	<input type="checkbox"/>
• Have you been rejected as a blood donor? .....	<input type="checkbox"/>	<input type="checkbox"/>	<b>Risk situations</b>		
• Have you suffered any severe disease that required regular medical control? .....	<input type="checkbox"/>	<input type="checkbox"/>	• Are you a carrier of the Human Immunodeficiency Virus (HIV) or AIDS Virus, or do you believe that you could be? .....	<input type="checkbox"/>	<input type="checkbox"/>
• Have you had hepatitis, jaundice or liver problems? .....	<input type="checkbox"/>	<input type="checkbox"/>	• Are you a carrier of any hepatitis virus (B or C), or do you believe that you could be? .....	<input type="checkbox"/>	<input type="checkbox"/>
• Have you suffered any severe infectious disease such as malaria, Chagas disease, leishmaniasis, infectious mononucleosis or tuberculosis, among others? .....	<input type="checkbox"/>	<input type="checkbox"/>	• Have you injected drugs (heroin, muscle building or other hormones) at anytime in your life, even though it was only once and a long time ago? .....	<input type="checkbox"/>	<input type="checkbox"/>
• Have you had any severe disease of the lungs, brain, kidney, thyroid, digestive system or other locations? .....	<input type="checkbox"/>	<input type="checkbox"/>	• Have you ever accepted money, drugs or any other type of retribution in exchange for sexual relations? .....	<input type="checkbox"/>	<input type="checkbox"/>
• Have you had heart or blood pressure problems? .....	<input type="checkbox"/>	<input type="checkbox"/>	• In the last 6 months have you had sexual relations with:		
• Have you suffered repeated episodes of epileptic fits, convulsions or fainting spells? .....	<input type="checkbox"/>	<input type="checkbox"/>	various partners? .....	<input type="checkbox"/>	<input type="checkbox"/>
• Do you suffer diabetes treated with insulin? .....	<input type="checkbox"/>	<input type="checkbox"/>	a person who is a carrier of the AIDS virus (HIV)? .....	<input type="checkbox"/>	<input type="checkbox"/>
• Have you had any type of cancer? .....	<input type="checkbox"/>	<input type="checkbox"/>	a person who frequently changes partners? .....	<input type="checkbox"/>	<input type="checkbox"/>
• Have you suffered any severe allergic disease or response? .....	<input type="checkbox"/>	<input type="checkbox"/>	a person who may have injected intravenous drugs .....	<input type="checkbox"/>	<input type="checkbox"/>
• Have you had any bleeding problem or blood disease such as anaemia or an excess of red blood cells? .....	<input type="checkbox"/>	<input type="checkbox"/>	a person who exercises or has exercised prostitution? .....	<input type="checkbox"/>	<input type="checkbox"/>
• Have you received a transfusion of blood or coagulation factors? .....	<input type="checkbox"/>	<input type="checkbox"/>	a person resident or originating from areas of the world where the AIDS virus is very widespread (Sub-Saharan Africa or Thailand)? .....	<input type="checkbox"/>	<input type="checkbox"/>
• Have you received human growth hormone (before 1987)? .....	<input type="checkbox"/>	<input type="checkbox"/>	• Have you suffered from any sexually transmitted disease such as syphilis or gonorrhoea, among others? .....	<input type="checkbox"/>	<input type="checkbox"/>
• Have you received tissue from another person (dura mater, cornea, other...)? .....	<input type="checkbox"/>	<input type="checkbox"/>			
• Are you or have you been infected by the human lymphotropic virus (HTLV-I/II)? .....	<input type="checkbox"/>	<input type="checkbox"/>			

With my signature, I declare that I have read the informative document given to me, I have understood it, I have been able to ask any questions I considered necessary and the staff attending me has answered them correctly. I also declare that I have answered this questionnaire truthfully.

I hereby give my consent for BST to obtain my personal details, to use them as specified in the information provided as stipulated in Organic Law 15/1999 of December 13 for the Protection of Personal Data, and to extract my blood for use in transfusions and, in special cases, for others medical purposes.

Given name and family name of the donor:

Signature of the person responsible for the extraction:

Signature of the donor: