



Please read carefully and tick ✓ Yes or No. If you are uncertain of any answer leave the box blank.

Your COMPLETE HONESTY in answering all questions is essential for your safety and the safety of patients who receive your blood. ALL INFORMATION YOU PROVIDE IS CONFIDENTIAL

NEVER DONATE TO GET A TEST FOR HIV OR HEPATITIS IF YOU DO YOU RISK INFECTING OTHER PEOPLE

Are You:	Yes	No
1. Well and healthy at present?	<input type="checkbox"/>	<input type="checkbox"/>
2. Involved in a hazardous occupation or hobby?	<input type="checkbox"/>	<input type="checkbox"/>

In the past 48 hours have you:	Yes	No
3. Taken an anti-inflammatory?	<input type="checkbox"/>	<input type="checkbox"/>

In the past 5 days have you:	Yes	No
4. Taken aspirin or any tablet with aspirin in it?	<input type="checkbox"/>	<input type="checkbox"/>

In the past 4 weeks have you:	Yes	No
5. Had sex with anyone who has EVER had Zika Virus Infection - with or without protection?	<input type="checkbox"/>	<input type="checkbox"/>
6. Been in contact with anyone with an infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>
7. Taken any tablets or medicines other than the pill or HRT for the menopause?	<input type="checkbox"/>	<input type="checkbox"/>
8. Had treatment with Proscar, Propecia, Roaccutane, Isotrex, Retin-A or Zorac?	<input type="checkbox"/>	<input type="checkbox"/>
9. Had treatment from a dentist?	<input type="checkbox"/>	<input type="checkbox"/>

In the past 8 weeks have you:	Yes	No
10. Had a vaccination?	<input type="checkbox"/>	<input type="checkbox"/>

In the past 3 months have you:	Yes	No
11. Had any illness or received any treatment from a doctor, nurse or other health care professional?	<input type="checkbox"/>	<input type="checkbox"/>

In the past 4 months have you:	Yes	No
12. Had acupuncture?	<input type="checkbox"/>	<input type="checkbox"/>
13. Had ear, face or body piercing?	<input type="checkbox"/>	<input type="checkbox"/>
14. Had a tattoo or cosmetic treatment that involved piercing the skin?	<input type="checkbox"/>	<input type="checkbox"/>
15. Suffered a needlestick-injury, human bite or a blood splash into your eyes, nose or mouth or onto broken skin?	<input type="checkbox"/>	<input type="checkbox"/>
16. Had an endoscopy (scope)?	<input type="checkbox"/>	<input type="checkbox"/>
17. Been in close contact with a person with hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>
18. Had or been treated for a sexually transmitted infection?	<input type="checkbox"/>	<input type="checkbox"/>

In the past 5 years have you:	Yes	No
19. Taken medication to prevent HIV infection (pre/post exposure prophylaxis, PrEP/PEP)?	<input type="checkbox"/>	<input type="checkbox"/>

Have you EVER:	Yes	No
20. Had a blood transfusion - red cells, platelets or plasma?	<input type="checkbox"/>	<input type="checkbox"/>
21. Had or been treated for syphilis or gonorrhoea?	<input type="checkbox"/>	<input type="checkbox"/>
22. Been diagnosed with or treated for Haemochromatosis?	<input type="checkbox"/>	<input type="checkbox"/>

Since 01 January 1980 have you:	Yes	No
23. Had any operation, eye surgery, laser eye treatment or root canal treatment in the UK? <i>UK includes Northern Ireland, England, Scotland, Wales, the Channel Islands and the Isle of Man.</i>	<input type="checkbox"/>	<input type="checkbox"/>

Since your last donation have you:	Yes	No
24. Had any serious illness or medical condition?	<input type="checkbox"/>	<input type="checkbox"/>
25. Been treated by a Dermatologist or skin specialist?	<input type="checkbox"/>	<input type="checkbox"/>
26. Had an operation or any surgery?	<input type="checkbox"/>	<input type="checkbox"/>
27. Had jaundice or hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>
28. Been told that any of your relatives had Creutzfeldt-Jakob Disease (CJD)?	<input type="checkbox"/>	<input type="checkbox"/>
29. Taken care of or handled monkeys or their body fluids?	<input type="checkbox"/>	<input type="checkbox"/>

After your last donation did you:	Yes	No
30. Faint or have any problems?	<input type="checkbox"/>	<input type="checkbox"/>

Travel:	Yes	No
31. In the past 12 months OR since your last donation (if less than 12 months ago) have you been outside of Ireland or the UK for any reason e.g. business or holidays?	<input type="checkbox"/>	<input type="checkbox"/>
32. Have you EVER had malaria or an unexplained fever or an illness which you could have picked up while travelling?	<input type="checkbox"/>	<input type="checkbox"/>
33. Have you EVER lived in a malarial area for 6 months or more?	<input type="checkbox"/>	<input type="checkbox"/>
34. Have you EVER lived in or visited Mexico, Central or South America for 4 weeks or more?	<input type="checkbox"/>	<input type="checkbox"/>

For Females only: Have you	Yes	No
35. Been pregnant in the past 12 months or are you pregnant at present?	<input type="checkbox"/>	<input type="checkbox"/>
36. Received a donated egg or embryo since 01 January 1980?	<input type="checkbox"/>	<input type="checkbox"/>

37. For all Donors:	Yes	No
• Are you donating JUST to be tested for HIV or hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>
• Do you or your partner have HIV or HTLV?	<input type="checkbox"/>	<input type="checkbox"/>
• Do you or your partner or close household contacts have hepatitis B or hepatitis C?	<input type="checkbox"/>	<input type="checkbox"/>
• Have you EVER injected or have you been injected with non-prescribed drugs - EVEN ONCE OR A LONG TIME AGO? This includes body building drugs & injectable tanning agents.	<input type="checkbox"/>	<input type="checkbox"/>
• Have you EVER been given money or drugs for sex?	<input type="checkbox"/>	<input type="checkbox"/>

38. For Males only: In the past 12 months	Yes	No
Have you had oral or anal sex with another male, even if it was 'safer sex' using a condom or pre-exposure prophylaxis (PrEP)?	<input type="checkbox"/>	<input type="checkbox"/>

39. For Females only: In the past 12 months	Yes	No
Have you had sex with a male who has EVER had oral or anal sex with another male, even if it was 'safer sex' using a condom or pre-exposure prophylaxis (PrEP)?	<input type="checkbox"/>	<input type="checkbox"/>

40. In the past 12 months, have you had sex with:	Yes	No
• Anyone who has HIV, hepatitis B or C, or HTLV?	<input type="checkbox"/>	<input type="checkbox"/>
• Anyone who has syphilis or any other sexually transmitted infection?	<input type="checkbox"/>	<input type="checkbox"/>
• Anyone who has EVER been given money or drugs for sex?	<input type="checkbox"/>	<input type="checkbox"/>
• Anyone who has EVER had sex in parts of the world where HIV is very common? This includes Africa and South East Asia.	<input type="checkbox"/>	<input type="checkbox"/>
• Anyone who has EVER injected drugs?	<input type="checkbox"/>	<input type="checkbox"/>

All the above apply even if a condom or other form of protection was used.

41. In the past 12 months have you:	Yes	No
• Been imprisoned?	<input type="checkbox"/>	<input type="checkbox"/>
• Snorted cocaine or any other drug?	<input type="checkbox"/>	<input type="checkbox"/>