



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. Having any treatment from a doctor, dentist, nurse or any other health care professional?	<input type="checkbox"/>	<input type="checkbox"/>
3. Involved in a hazardous occupation or hobby?	<input type="checkbox"/>	<input type="checkbox"/>

**Have You:**

	Yes	No
4. Spent 12 months or more in total in the UK* in the years 1980 - 1996?	<input type="checkbox"/>	<input type="checkbox"/>
5. Had any operation, eye surgery, laser eye treatment or root canal treatment in the UK* since 01 January 1980? <small>*UK includes Northern Ireland, England, Scotland, Wales, The Channel Islands &amp; The Isle of Man</small>	<input type="checkbox"/>	<input type="checkbox"/>

**In the past 48 hours have you:**

	Yes	No
6. Taken an anti-inflammatory?	<input type="checkbox"/>	<input type="checkbox"/>

**In the past 5 days have you:**

	Yes	No
7. Taken aspirin or any tablet with aspirin in it?	<input type="checkbox"/>	<input type="checkbox"/>

**In the past 4 weeks have you:**

	Yes	No
8. Had sex with anyone who has EVER had Zika Virus infection - with or without protection?	<input type="checkbox"/>	<input type="checkbox"/>
9. Been in contact with an infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>
10. Taken any tablets or medication other than HRT or the pill?	<input type="checkbox"/>	<input type="checkbox"/>
11. Had treatment with Proscar, Propecia, Roaccutane, Isotrex, Retin-A or Zorac?	<input type="checkbox"/>	<input type="checkbox"/>
12. Had treatment from a dentist?	<input type="checkbox"/>	<input type="checkbox"/>

**In the past 8 weeks have you:**

	Yes	No
13. Had a vaccination?	<input type="checkbox"/>	<input type="checkbox"/>

**In the past 4 months have you:**

	Yes	No
14. Had acupuncture?	<input type="checkbox"/>	<input type="checkbox"/>
15. Had ear, face or body piercing?	<input type="checkbox"/>	<input type="checkbox"/>
16. Had a tattoo or cosmetic treatment that involved piercing the skin?	<input type="checkbox"/>	<input type="checkbox"/>
17. Suffered a needlestick-injury, human bite or a blood splash into your eyes, nose or mouth?	<input type="checkbox"/>	<input type="checkbox"/>
18. Had an endoscopy (scope)?	<input type="checkbox"/>	<input type="checkbox"/>
19. Been in close contact with a person with hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>

**In the past 12 months have you:**

	Yes	No
20. Seen a doctor for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
21. Had any medical tests or treatments?	<input type="checkbox"/>	<input type="checkbox"/>
22. Had an operation or any surgery?	<input type="checkbox"/>	<input type="checkbox"/>

**23. Have you EVER had any of the following:**

	Yes	No		Yes	No
Allergy/Asthma?	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Fits?	<input type="checkbox"/>	<input type="checkbox"/>
Cancer?	<input type="checkbox"/>	<input type="checkbox"/>	Fainted?	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	Heart Condition?	<input type="checkbox"/>	<input type="checkbox"/>
Dizzy Spells?	<input type="checkbox"/>	<input type="checkbox"/>	Operation/Surgery?	<input type="checkbox"/>	<input type="checkbox"/>

**Have you EVER:**

	Yes	No
24. Had any serious illness?	<input type="checkbox"/>	<input type="checkbox"/>
25. Had jaundice or hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>
26. Received a blood transfusion?	<input type="checkbox"/>	<input type="checkbox"/>
27. Had a sexually transmitted infection?	<input type="checkbox"/>	<input type="checkbox"/>
28. Had or been treated for syphilis or gonorrhoea?	<input type="checkbox"/>	<input type="checkbox"/>
29. Had an organ, tissue, or corneal transplant?	<input type="checkbox"/>	<input type="checkbox"/>
30. Been told that any of your relatives had Creutzfeldt-Jakob Disease (CJD)?	<input type="checkbox"/>	<input type="checkbox"/>
31. Been treated with Human Pituitary Growth Hormone or other Human Pituitary Extract?	<input type="checkbox"/>	<input type="checkbox"/>
32. Been treated with Tigason or Neotigason?	<input type="checkbox"/>	<input type="checkbox"/>
33. Taken care of or handled monkeys or their body fluids?	<input type="checkbox"/>	<input type="checkbox"/>
34. Been diagnosed with or treated for Haemochromatosis?	<input type="checkbox"/>	<input type="checkbox"/>
35. Had any problems during or after giving blood or blood samples?	<input type="checkbox"/>	<input type="checkbox"/>

**Travel History:**

	Yes	No
36. Were you born outside of Ireland?	<input type="checkbox"/>	<input type="checkbox"/>
37. Did you live outside of Ireland before you were 5 years old?	<input type="checkbox"/>	<input type="checkbox"/>
38. Have you been outside of Ireland or the UK in the past 12 months for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
39. Have you EVER lived in a malarial area?	<input type="checkbox"/>	<input type="checkbox"/>
40. Have you EVER had Malaria, Chagas' Disease or Babesiosis?	<input type="checkbox"/>	<input type="checkbox"/>
41. Have you EVER had an unexplained fever?	<input type="checkbox"/>	<input type="checkbox"/>
42. Have you EVER lived in or visited Mexico, Central or South America for four weeks or more?	<input type="checkbox"/>	<input type="checkbox"/>
43. Was your mother born in Mexico, Central or South America?	<input type="checkbox"/>	<input type="checkbox"/>

**For Females only: Have you**

	Yes	No
44. EVER been pregnant or are you pregnant at present?	<input type="checkbox"/>	<input type="checkbox"/>
45. Had Anti-D in Ireland between 1 May 1977 & 31 July 1979 or 1 March 1991 & 18 February 1994?	<input type="checkbox"/>	<input type="checkbox"/>
46. EVER had treatment for infertility?	<input type="checkbox"/>	<input type="checkbox"/>

**47. 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 - <b>EVEN ONCE OR A LONG TIME AGO?</b> 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"/>

**48. 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"/>

**49. 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"/>

**50. 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? <b>All the above apply even if a condom or other form of protection was used.</b>	<input type="checkbox"/>	<input type="checkbox"/>

**51. 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"/>

**52. In the past 5 years have you:**

	Yes	No
Taken medication to prevent HIV infection (pre/post exposure prophylaxis, PrEP/PEP)?	<input type="checkbox"/>	<input type="checkbox"/>

Sample Only