Donor Health History questionnaire
(to be completed at or prior to donor's medical)

ANTHONY NOLAN
Saving lives through stem cells

Donor ID: an_gridformatted **Date:** 15/05/2025

Donor Name: fullname

MEDICAL HISTORY			
1	**What is your current living situation?** ☐ I live alone ☐ I live with family ☐ I live with a partner ☐ I live with housemates or friends ☐ Other: _____		
2	**Please tell us about your current work or study situation (if any).** *You can include your job title, employer, course name, or let us know if you're not currently working or studying.* …… ……		
3	Do you have any allergies? If so, please provide details of them below including how they are managed, the severity and type of reaction:…… …. …… …… ……	Yes ☐ **Inform AN if relevant**	No ☐
4	Have you received any immunisations or vaccinations in the past **eight weeks**? Do you have any planned before your donation? If yes, please specify what they were and when:……	Yes ☐ **Check vaccination type (e.g. live). Inform AN, if live defer**	No ☐
5	Have you **ever** been pregnant, including any miscarriages or terminations? If yes, how many times?..... How many live births?.....	Yes ☐	No ☐
6	Date of beginning of last menstrual period……		☐
7	Have any of your close relatives (parent, sibling, child) been diagnosed with cancer (in particular blood cancers) or any other blood disorder? If yes, please provide details …… ……	Yes ☐ **Inform AN**	No ☐
8	Have you received a transfusion of blood, platelets or other blood product **since 1980**? If yes, please provide when, where and the reason for the transfusion:…… ……	Yes ☐ **Inform AN**	No ☐
9	Are you a blood donor? If yes, when was the last time you donated blood?……	Yes ☐	No ☐
10	Have you **ever** had a bleeding problem, such as haemophilia or other clotting factor deficiencies and received blood products or clotting factor concentrates?	Yes ☐ **Defer**	No ☐

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	If yes, please provide details …….		
11	Have you **ever** been diagnosed with Creutzfeldt-Jakob-Disease (CJD), or do you have a degenerative neurological disease? If yes, please provide details …….	Yes ☐ **Defer**	No ☐
12	Has anyone in your family had CJD, or have you been told that your family has an increased risk for CJD? If yes, please provide details …….	Yes ☐ **Inform AN**	No ☐
13	Have you had brain surgery or an operation for a tumour or cyst on the spine **prior** to August 1992? If yes, please provide details …….	Yes ☐ **Inform AN**	No ☐
14	Have you **ever** received a corneal transplant, or had any other operations on your eyes? If yes, please provide details …….	Yes ☐ **Obtain details re scleral/ other ocular tissue grafts**	No ☐
15	**Have you ever received a xenograft transplant (a transplant of tissue or organs from a non-human?** If yes, please provide details:	Yes ☐ **Defer**	No ☐
16	**Have you ever** been treated with human pituitary extracts such as growth hormones prior to 1985? If yes, please provide details ……	Yes ☐ **Inform AN**	No ☐
17	Have you **ever** had yellow jaundice, liver disease or hepatitis (except for jaundice as a young baby)? If yes, please provide details …….	Yes ☐ **Inform AN**	No ☐
18	Have you ever had any physiotherapy or other pain management? If yes, are you fully recovered? Please provide details. ……	Yes ☐	No ☐
19	Have you ever suffered from a head injury? **If no, please skip to Q19 (next question)**. If yes, please provide details, including when it occurred and the type of injury: …… …… Was this diagnosed as concussion by a health care professional? If so, who by and/or where did this diagnosis take place ? Have you suffered from more than 3 concussions in your lifetime? If yes, were there more than 6? …….	Yes ☐ Yes ☐ Yes ☐	No ☐ No ☐ No ☐

	Did you lose consciousness for more than 5 minutes? If yes, was it more than 1 hour?..... Post injury have you suffered from any of the following symptoms that lasted more than 72 hours: **short term memory loss, blurred vision, light or noise sensitivity, nausea or vomiting, dizziness or balance problems, difficulty thinking, poor concentration, seizure, personality changes, severe headache?** If yes, please provide more details…… …… ……	Yes ☐	No ☐
	MENTAL HEALTH **Please answer the following questions honestly.** A 'Yes' response won't necessarily mean you can't donate—it simply helps us understand your situation better so we can support you throughout the donation process.		
20	Are you or have you ever been in any type of therapy? This can include psychotherapy, cognitive behavioural therapy, counselling therapy, etc. If so, what type and when? (exact date needs to be removed) …… …… ……	Yes ☐	No ☐
21	In the past six months, have you seen a medical professional regarding your mental health? If yes, was it for a crisis appointment, a routine check-in, or something else? Please feel free to share any details you're comfortable providing: …… Following that appointment, did you start any new medication or have any changes made to your existing medication? ……	Yes ☐	No ☐
22	Do you, or have you ever suffered from a mental health condition or disorder in relation to:		
a	Anxiety (including panic disorder, obsessive compulsive disorder- OCD and post-traumatic stress disorder- PTSD)?	Yes ☐	No ☐
b	Eating (including anorexia and bulimia nervosa)?	Yes ☐	No ☐
c	Mood (including depression and bipolar disorder)?	Yes ☐	No ☐
d	Personality (including borderline personality disorder)?	Yes ☐	No ☐
e	Alcohol or substance abuse? If yes, please share any details you're comfortable providing:	Yes ☐	No ☐
f	Schizophrenia and other Psychotic Disorders (including schizoaffective and delusional disorder)	Yes ☐	No ☐

23	**Do you experience health-related anxiety or worries about your health?** If yes, please feel free to share any details you're comfortable with:…… ….. ……	Yes ☐ Yes ☐	No ☐ No ☐
24	**Have you ever had a traumatic or distressing experience related to your health or medical care?** If so, please provide any information you feel is relevant:……. …….. ……..	Yes ☐	No ☐
25	**Do you have a fear or phobia of needles?** If yes, please tell us more so we can support you appropriately:…… …… …….. **Do you have any concerns or worries about the needles that will be used during the donation process?** If yes, please feel free to share: ……. ……	Yes ☐ Yes ☐	No ☐ No ☐
26	**Have you experienced any events or situations in your life that caused emotional stress, which you feel might impact your donation in any way?** If yes, please tell us more so we can support you appropriately:…… …… …… …… …… …… We would strongly encourage you to read through this link and take the time to carefully consider the information it covers. It's important for you to understand all aspects before moving forward with the donation process.	Yes ☐	No ☐

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TRAVEL HISTORY

27 Have you travelled outside the UK or Ireland **in the last 12 months**? Yes ☐ No ☐

If yes, please list all destinations along with the month and year of travel:……
……
……
……
……
……
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……

NOTES FOR ASSESSING CLINICIAN

For endemic areas and high-risk season for each country visited refer to geographical disease risk index (www.transfusionguidelines.org).
If testing is required but results cannot be obtained in time donor can proceed at AN's discretion.

Malaria

All visitors to endemic areas within the last 12 months should be tested, regardless of prophylaxis.

Status		Action
Visitor	<4 months since return	Request MAT **and NAT**
	4-12 months since return	Request MAT
	>12 months since return	Accept, No test
Resident Lived in a malaria area > 6 continuous months at any point in their life	<4 months since last exposure	**Request MAT and NAT**
	>4 months since last exposure	Request MAT
UFI Unexplained febrile illness	<4 months since last exposure	**Request MAT and NAT**
	>4 months since last exposure	Request MAT
History of Malaria	**<4 months** since recovery	**Request MAT and NAT**
	>4 months since recovery	**Request MAT**

West Nile Virus

Accept without testing:
- Visitors to endemic areas outside of high-risk season
- Visitors to endemic areas during high risk season who returned to the UK over 28 days ago and had neither symptoms nor evidence of WNV infection while abroad or since return

WNV NAT should be tested in the following instances:
- Visitors to endemic areas during high risk season (See Geographical Disease Risk Index) who have returned to the UK in last 28 days
- Visitors to endemic areas during high risk season (See Geographical Disease Risk Index) who have returned to the UK within last six months and had symptoms suggestive of WNV while abroad or within 28 days of return

Tropical Viruses – Dengue Virus, Chikungunya, Zika Virus

Accept without testing:
- Visitors to endemic areas who have returned to the UK over 28 days ago and had neither symptoms nor evidence suggestive of Chikungunya, Dengue or Zika virus infection while abroad or since return

	NAT <u>should</u> be tested in the following instances: *- Visitors to endemic areas who have returned to the UK in last 28 days* *- Visitors to endemic areas who have returned to the UK within last six months and had symptoms or evidence of Dengue, Chikungunya or Zika virus infection while abroad or within 28 days of return* **<u>T. Cruzi (American Trypanosomiasis / Chagas' Disease</u> See** Qs 34-36		
28	Do you have plans to travel outside the UK and Ireland **between now and your donation date**? **If yes, please specify the destination(s) and the dates of travel:**	Yes ☐ **Consult Geographical Disease Risk Index**	No ☐
29	Have you **ever** been diagnosed with West Nile Virus? If yes, when	Yes ☐ **Test WNV NAT if within last four months. Inform AN**	No ☐

	Zika Virus Q30 - Please notify Anthony Nolan if donor answers yes to this question. Additional testing not required.		
30	Have you had sexual contact with a male partner who had travelled to or lived in an area affected by the Zika virus within 3 months prior to the encounter? (*If you are unsure about regions affected by Zika Virus please discuss with the doctor / nurse during your medical assessment)* If yes, was the sexual contact within the last 28 days?	Yes ☐ Yes ☐	No ☐ No ☐
31	Have you **ever** had malaria, or suffered an unexplained fever during or after visiting a malaria risk area? If yes, please provide details of when and where. ……	Yes ☐ **Test malaria anti-bodies. Inform AN**	No ☐
32	Have you lived in a malaria risk area for six or more continuous months at any time of your life? If yes, please provide details of when and where. …….	Yes ☐ **Test malaria anti-bodies. Inform AN**	No ☐
33	Were you born in Africa, or have you ever lived there? If yes, please specify the location(s).	Yes ☐ **Inform AN**	No ☐
	T. Cruzi (American Trypanosomiasis / Chagas' Disease) Qs 34-35 - all donors answering yes to any of these questions must have T. cruzi tested. Donors answering "yes" to both 36a and 36b should have T. cruzi tested.		
34	Have you **ever** been diagnosed with South American Trypanosomiasis (Chagas) disease? If yes, please provide details …….	Yes ☐	No ☐

35	Were you or your mother born in South America or Central America (including Mexico, excluding Cuba)? If yes, please provide details …….	Yes ☐	No ☐
36 a	Have you ever travelled to rural areas in South or Central America, even for a short period of time? If yes, please provide details of when and where……	Yes ☐	No ☐
b	If yes have you ever stayed in a mud-lined hut, an adobe house, or a dwelling with a thatched roof during your visit to South or Central America? If yes, please provide details ……. …… ……	Yes ☐	No ☐

37 a	Have you ever been diagnosed with Viral Haemorrhagic Fever (VHF), including Crimean-Congo Fever, Ebola, Lassa Fever, Marburg fever? If yes, please provide details …….	Yes ☐ **Defer**	No ☐
b	Have you ever travelled to a VHF endemic area? e.g. Guinea, Liberia, Sierra Leone, Nigeria, etc. If yes, please provide details of when and where …….	Yes ☐ **Defer if in area during active outbreak, if not defer for six months post return**	No ☐
c	Have you ever had a sexual partner diagnosed with VHF at any time before your last sexual contact? If yes, please provide details …….	Yes ☐ **Defer if partner diagnosed before last contact**	No ☐

SEXUAL HEALTH

38	Have you had sex (oral, vaginal or anal) with a new partner, or more than one partner, in the last 14 days?	Yes ☐	No ☐
39	In the past **three months** have you had sex (oral, vaginal or anal) with:		
a	A **new partner,** or **multiple partners**? If yes: Can you provide a date/timeframe within the past 3 months…… Did you have anal sex? Did you use a condom?	Yes ☐ Yes ☐ Yes ☐ **Inform AN**	No ☐ No ☐ No ☐

b	an individual who is HIV positive or who has ever had syphilis, hepatitis B or C or yellow jaundice? If yes, can you provide a date/timeframe within the past 3 months……	Yes ☐ **Inform AN**	No ☐
c	anyone who has ever injected drugs? If yes, can you provide a date/timeframe within the past 3 months……	Yes ☐ **Inform AN**	No ☐
d	an individual who has ever been given or taken money in exchange for drugs or sex? If yes, can you provide a date/timeframe within the past 3 months……	Yes ☐ **Inform AN**	No ☐
40	Have you had chem sex or used drugs during sex (excluding erectile dysfunction drugs or cannabis) within the last **three months**? If yes, can you provide a date/timeframe within the past 3 months……	Yes ☐ **Inform AN**	No ☐
41	Have you given or taken money in exchange for drugs or sex within the last **three months**? If yes, can you provide a date/timeframe within the past 3 months…… Please provide details of the …… ……	Yes ☐ **Inform AN, consider deferral**	No ☐
427	Have you ever taken **PrEP** (Pre-Exposure Prophylaxis, anti-HIV medication)? If so was it in the **last 3 months**?	Yes ☐ Yes ☐ **Defer**	No ☐ No ☐
43	Have you **ever** tested positive for HIV or do you think you may be HIV positive? If yes, please can you provide more details? ……	Yes ☐ **Defer**	No ☐
44	Have you **ever** had hepatitis B or C, have you **ever** tested positive for hepatitis B or C, or do you think you may have hepatitis now? If yes, please can you provide more details? ……	Yes ☐ **Defer**	No ☐
45	Have you **ever** tested positive for HTLV (Human T-lymphotropic virus)? If yes, when ……	Yes ☐ **Inform AN**	No ☐
46	Within the last **four months** have you had an injury which could have put you at risk of hepatitis or HIV – for example a needle stick injury, coming into contact with someone else's blood through an open wound, non-intact skin, or mucous membrane (e.g. into your eye or mouth) If yes, please provide details …… …… …… ……	Yes ☐ **Inform AN**	No ☐
47	**In the past 12 months** have you had a confirmed positive test result or been treated for syphilis or gonorrhoea?	Yes ☐ **Inform AN**	No ☐

	If yes, which one and when …….. ……		
MISCELLANEOUS			
48	**Have you ever** injected or been injected with illegal or non-prescription drugs including bodybuilding drugs? If yes, please provide details …… …… …… ……	Yes ☐ **Inform AN, consider deferral for 12 months**	No ☐
49	In the past **three months** have you undergone acupuncture in a **non-UK establishment or by an unqualified practitioner?** If yes, please provide details …… …… …… ……	Yes ☐ **Obtain professional reg certificate if possible. Inform AN.**	No ☐
50	In the past **three months** have you had a tattoo (or tattoo removal), any piercing to your ears, face or body or undergone any cosmetic treatment that involved piercing the skin **in a non-licensed establishment**? If yes, please provide details …… …… …… ……	Yes ☐ **Inform AN**	No ☐
51	In the past **four months** have you been detained in a prison for more than 72 continuous hours? If yes, please provide details …… …… …… ……	Yes ☐ **Inform AN**	No ☐
52	Have you **ever** been bitten by a non-human primate? e.g. ape, lemur If yes, please provide details …… …… …… ……	Yes ☐ **Defer**	No ☐
53	Have you been bitten by a bat in the last two years? If yes, please provide details …… …… …… ……	Yes ☐ **Defer for two years from date of bite**	No ☐
54	Have you ever been exposed to rabies? If yes, please provide details …… …… …… …… If yes, were you cleared by a Doctor/Physician? ……	Yes ☐ **Defer for two years from exposure date, if medically cleared.**	No ☐

55	**Have you ever** taken or been exposed to or ingested cyanide, lead or mercury? **Have you ever** ingested gold? If yes, please provide details …… …… …… ……	Yes ☐ Yes ☐ **Inform AN**	No ☐ No ☐

Please provide next of kin details here:	
Name	
Relationship to you	
Contact number	

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DONOR STATEMENT OF UNDERSTANDING

I have had the opportunity to ask questions about the information requested on this questionnaire "Donor Health History".

I understand that the requested information is important if I am at risk for infection due to HIV, Hepatitis B or C, or any other communicable disease agents or diseases, my donated cells may transmit these diseases to the recipient of the cells.

I will contact my Donor Provision coordinator if at any time during the donation process:

- **I decide I want to withdraw consent and not go ahead**
- **I have any new sexual partners**
- **I develop a cough, fever or have difficulty breathing**
- **I develop any kind of infection, e.g. tooth**
- **I start a course of antibiotics or have any symptoms that necessitates a GP appointment**
- **I have to go to A&E and/or hospital**
- **There are any changes to my general health**

I have truthfully answered all the questions on this questionnaire.

If I consent to my donation of blood stem cells being used to treat a patient, I authorise the release of information on the questionnaire to the overseas Registry (which may be outside the European Union) and its agents and representatives and other medical facilities known as transplants centres.

If I consent to my donation of blood stem cells being used for research or the development of cell and gene therapy treatments, I also authorise the release of information on the questionnaire to the organisation undertaking that research or development. I understand that any information identifying me will remain confidential and only my unique donor identification number will be used on any information passed to that organisation.

I understand that my name and contact details will remain confidential and instead my unique donor identification number will be used on any information that is shared in the circumstances described above. I also understand that the potential recipient of my donation may be advised of any communicable risk.

I understand that authorising this release of information is voluntary and that I can refuse to sign this document.

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ANTHONY NOLAN
Saving lives through stem cells

Donor ID: an_gridformatted **Date:** 15/05/2025

Donor Name: fullname

Donor Details	
Name	fullname
GRID/donor ID	an_gridformatted
Signature	

Reviewed by	
Name	
Signature	
Job Title	
Date	

If the donation date has been postponed since the original medical, please complete the following:

☐ I confirm there have been no changes to the above information provided, and I have advised the Collection Centre/AN of all health changes (if any) since my original medical

Donor name	
Signature*	
Date	

* If you are completing online and unable to insert a signature, please just initial this box.