**MEDICAL Questionnaire** (part of DECLARATION I.)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Last Name:** | | | First Name: | | | *ID*  *GRID*  *(assigned by CSCR)* |
| Date of birth: | | | Personal number/Health insurance ID: | | |
| Height: cm | Weight: kg | | | Blood group (if known): | |
| Permanent address: Postcode: | | | | | | |
| Contact address: Postcode: | | | | | | |
| Mobile: | | Email: | | | Other contact: | |

**Please fill in the questionnaire truthfully and correctly. Circle the correct answer.**

**Please note that false or incorrect answers may hinder finding suitable donor or it could endanger either yours or patient’s health condition.**

**Should any question arise please consult our staff before blood sample drawing.**

|  |  |  |  |
| --- | --- | --- | --- |
| 1 | Are you feeling healthy and well? | Yes | No |
| 2 | Have you ever donated blood or other components – plasma, platelets? | Yes | No |
| 3 | Have you ever been told that you should not give blood? Why: | Yes | No |
| 4 | Have you ever had any problems during blood drawing (faintness, nausea)? | Yes | No |
| 5 | Have you ever had a serious illness?  When: Describe: | Yes | No |
| 6 | Have you ever had a serious injury?  When: Describe: | Yes | No |
| 7 | Have you ever had a surgery?  When: Describe: | Yes | No |
| 8 | Are youtreated or followed for any diseases? Describe: | Yes | No |
| 9 | Are you taking any prescribed medicine? (except oral contraceptives)  Describe: | Yes | No |
| 10 | **Have you ever had any of the following diseases:** | | |
| ● | Hepatitis B or hepatitis C | Yes | No |
| ● | Tuberculosis | Yes | No |
| ● | Sexually transmitted diseases (syphilis, gonorrhea, other......................................................................................) | Yes | No |
| ● | Other infectious diseases (lyme disease, leishmaniasis, malaria, tularemia, other.................................................) | Yes | No |
| ● | Blood disorders (anemia, abnormal bleeding, blood coagulation disorders -eg. Factor V Leiden, thalassemia, other.................) | Yes | No |
| ● | Vascular or heart disease (heart rhythm disorders, thrombosis, chest pain, other.................................................) | Yes | No |
| ● | High or low blood pressure | Yes | No |
| ● | Pulmonary diseases (asthma, bronchitis, emphysema, other..................................................................................) | Yes | No |
| ● | Gastrointestinal diseases (ulcers, intestine/pancreatic inflammation, liver diseases, gallstones, .........................) | Yes | No |
| ● | Kidney/urinary tract diseases (inflammations, stones, cysts, other........................................................................) | Yes | No |
| ● | Any neurological diseases or eye diseases (migraine, spasms, epilepsy, multiple sclerosis, meningitis**,** encephalitis, glaucoma, retinitis , other......................................................................................................................) | Yes | No |
| ● | Psychological disorders (depression, other..............................................................................................................) | Yes | No |
| ● | Disorders of endocrine glands (diabetes, metabolic, thyroid disorders, other.......................................................) | Yes | No |
| ● | Allergies, skin diseases (hay-fever, anaphylactic reaction, psoriasis, vitiligo, eczema, other.....................) | Yes | No |
| ● | Autoimmune diseases (rheumatoid arthritis, Crohn disease, celiac disease, vasculitis, Lupus, other.....................) | Yes | No |
| ● | Cancer (including blood cancer) | Yes | No |
| 11 | Has any member of your family suffered from any form of Creutzfeldt-Jakob Disease? (CJD) | Yes | No |
| 12 | Have you ever taken any drugs including marijuana? | Yes | No |
| 13 | Have you been in close contact (sexual contact; common household) with person suffering from hepatitis, HIV or drug addict? | Yes | No |
| 14 | Are you exposed to radiation or chemicals at your work? | Yes | No |
| 15 | **For women:** Have you ever been pregnant?  Number of pregnancies: Number of children born: | Yes | No |

**DECLARATION I**

**Informed consent with the registration in the Czech Stem Cells Registry**

**The Medical Questionnaire is an integral part of the Declaration I**

**I confirm with my signature that:**

**I was informed about following facts:**

* Donation is voluntary, unpaid and anonymous
* By joining the registry the donor agrees with the donation for any patient all over the world
* Initial HLA typing is performed by molecular genetic methods on DNA extracted from your sample (blood, saliva, buccal swab)
* Pseudonymised donor’s data are provided to the Czech transplant centers, to World Marrow Donor Association database and to international registries all over the world for search of suitable donor for particular patient. Several blood drawings are necessary during the process of the search and graft donation conditioning: for HLA antigens typing, infectious disease markers testing and further tests needed to check donor’s health condition
* Bone marrow harvest is performed under general anaesthesia (eligibility of this type of donation will be assessed by responsible physician during the medical check before the collection)
* Peripheral Blood Stem Cells (PBSC) collection is an out-patient procedure. Prior to the collection, G-CSF injections (naturally-occurring hormone which increases the number of stem cells your body produces) are administered for four days (eligibility of this type of donation will be assessed by responsible physician during the medical check before the collection)
* There are some risks connected with the blood drawing and Bone marrow or PBSC collection.
* Impediments to donation are: behaviour which increases risk of transmitting serious diseases by blood – e.g. close long-term contact with HIV positive person or person with hepatitis; risk sexual behaviour – promiscuity, sexual intercourse between men, sexual intercourse carried out for money or drugs; intravenous drug use; stay in prison; employment in hazardous environment
* I have the right to change my mind about being a donor at any time
* I should keep the Registry updated about any changes of my contact information, health condition or my willingness to be a donor
* My personal data will be used and processed for purpose of hematopoietic stem cell donation in accordance with Regulation No 2016/679 of the European Parliament and of the Council from 27 April 2016 on the protection of individuals with regard to the processing of personal data and on the free movement of such data GDPR) - For details, see <http://gdpr.ikem.cz>
* Personal data are stored for 30 years at least in accordance with law 285/2002 Coll. - Transplant law and 296/2008 Coll. - Law on human tissues and cells

**I agree with**

* Being included in the Czech Stem Cells Registry database under the above mentioned conditions
* Use of my anonymised data collected for scientific purposes related to the donation of hematopoietic stem cells
* Storage of my blood samples /DNA samples and its use for further testing related to stem cells donation (samples may be tested in laboratories outside Czech Republic or EU)

**I declare that:**

* I filled out The Medical Questionnaire truthfully to the best of my knowledge and belief
* I had the opportunity to ask about anything concerning the hematopoietic stem cells donation I was interested in and I received an explanation which I had understood.

|  |  |
| --- | --- |
| Donor’s name: | Donor’s signature: |
| Donor’s identity verified by ID card/passport: | Signature: |
| Place: | Date: |