

UT Health Multispecialty and Research Hospital Donor Center
8311 Ewing Halsell Drive, San Antonio, TX 78229
Donor Questionnaire and Acknowledgement
DONOR 5-F1 (version 2.0)

Attach Donor Identification Number	Donor's name: *Will autopopulate from e-Delphyn*	
ENGLISH 01/25/2024	YES	NO
1. Are you feeling healthy and well today?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you currently taking an antibiotic?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you currently taking any other medication for an infection?	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you pregnant now?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you taken any medications on the Medication Deferral List in the time frames indicated?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you read the blood donor educational materials today?	<input type="checkbox"/>	<input type="checkbox"/>
7. In the past 48 hours, have you taken aspirin or anything that has aspirin in it?	<input type="checkbox"/>	<input type="checkbox"/>
8. In the past 8 weeks, have you donated blood, platelets, or plasma?	<input type="checkbox"/>	<input type="checkbox"/>
9. In the past 8 weeks, have you had any vaccinations or other shots?	<input type="checkbox"/>	<input type="checkbox"/>
10. In the past 8 weeks, have you had contact with someone who was vaccinated for smallpox in the past 8 weeks?	<input type="checkbox"/>	<input type="checkbox"/>
11. In the past 3 months, taken any medication by mouth (oral) to prevent HIV infection? (i.e., PrEP or PEP)?	<input type="checkbox"/>	<input type="checkbox"/>
12. In the past 3 months, have you had sexual contact with a new partner? (refer to the examples of "new partner" in the Blood Donor Educational Material)	<input type="checkbox"/>	<input type="checkbox"/>
13. In the past 3 months, have you had sexual contact with more than one partner?	<input type="checkbox"/>	<input type="checkbox"/>
14. In the past 3 months, have you had sexual contact with anyone who has ever had a positive test for HIV infection?	<input type="checkbox"/>	<input type="checkbox"/>
15. In the past 3 months, have you received money, drugs, or other payment for sex?	<input type="checkbox"/>	<input type="checkbox"/>
16. In the past 3 months, have you had sexual contact with anyone who has, in the past 3 months, received money, drugs, or other payment for sex?	<input type="checkbox"/>	<input type="checkbox"/>
17. In the past 3 months, have you used needles to inject drugs, steroids, or anything not prescribed by your doctor?	<input type="checkbox"/>	<input type="checkbox"/>
18. In the past 3 months, have you had sexual contact with anyone who has used needles in the past 3 months to inject drugs, steroids, or anything not prescribed by their doctor?	<input type="checkbox"/>	<input type="checkbox"/>
19. In the past 3 months, have you had syphilis or gonorrhea or been treated for syphilis or gonorrhea?	<input type="checkbox"/>	<input type="checkbox"/>
20. In the past 3 months, have you had sexual contact with a person who has hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>
21. In the past 3 months, have you lived with a person who has hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>
22. In the past 3 months, have you had an accidental needle-stick?	<input type="checkbox"/>	<input type="checkbox"/>
23. In the past 3 months, have you come into contact with someone else's blood?	<input type="checkbox"/>	<input type="checkbox"/>
24. In the past 3 months, have you had a tattoo?	<input type="checkbox"/>	<input type="checkbox"/>
25. In the past 3 months, have you had ear or body piercing?	<input type="checkbox"/>	<input type="checkbox"/>
26. In the past 3 months, have you had a blood transfusion?	<input type="checkbox"/>	<input type="checkbox"/>
27. In the past 3 months, have you had a transplant such as organ, tissue, or bone marrow?	<input type="checkbox"/>	<input type="checkbox"/>
28. In the past 3 months, have you had a graft such as bone or skin?	<input type="checkbox"/>	<input type="checkbox"/>
29. In the past 16 weeks, have you donated a double unit of red blood cells using an apheresis machine?	<input type="checkbox"/>	<input type="checkbox"/>
30. In the past 12 months, have you been in juvenile detention, lockup, jail, or prison for 72 hours or more consecutively?	<input type="checkbox"/>	<input type="checkbox"/>
31. In the past 2 years, have you received any medication by injection to prevent HIV infection? (i.e. long-acting antiviral PrEP or PEP)	<input type="checkbox"/>	<input type="checkbox"/>
32. In the past 3 years, have you been outside the United States or Canada?	<input type="checkbox"/>	<input type="checkbox"/>
33. Have you EVER had a positive test for HIV infection?	<input type="checkbox"/>	<input type="checkbox"/>
34. Have you EVER taken any medication to treat HIV infection?	<input type="checkbox"/>	<input type="checkbox"/>
35. Have you EVER, been pregnant? This includes pregnancies that did not go to term or result in live birth; for example: miscarriage	<input type="checkbox"/>	<input type="checkbox"/>
36. Have you EVER had malaria?	<input type="checkbox"/>	<input type="checkbox"/>
37. Have you EVER received a dura mater (or brain covering) graft or xenotransplantation product?	<input type="checkbox"/>	<input type="checkbox"/>

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38. Have you EVER had any type of cancer, including leukemia?	<input type="checkbox"/>	<input type="checkbox"/>
39. Have you EVER had any problems with your heart or lungs?	<input type="checkbox"/>	<input type="checkbox"/>
40. Have you EVER had a bleeding condition or blood disease?	<input type="checkbox"/>	<input type="checkbox"/>
41. Have you EVER had a positive test result for Babesia?	<input type="checkbox"/>	<input type="checkbox"/>
42. Have you had any illnesses or hospital visits in the last 90 days?	<input type="checkbox"/>	<input type="checkbox"/>
43. Are you currently on any type of Testosterone Replacement Therapy such as injections, gel, pellets, or other form?	<input type="checkbox"/>	<input type="checkbox"/>

Donor Consent:
I have read the educational materials provided by MSRH Donor Center today, including information about Human Immunodeficiency Virus (HIV), the causative agent of Acquired Immune Deficiency Syndrome (AIDS). I understand that persons at risk for HIV and AIDS must not donate blood.

I understand that it is illegal under Texas Law to donate blood knowing that I have tested positive for HIV or have been diagnosed with having AIDS.

I agree not to donate if the donation could result in a potential risk to a recipient as described in the educational material.

I affirm that the medical history I have provided is complete and accurate.

I understand that my blood will be tested for relevant transfusion transmitted infections, including but not limited to HIV, Hepatitis B, Hepatitis C. Other tests may be performed, and some of these may be investigational (research tests). There may be circumstances where infectious disease testing may not be performed. Testing data may also be used for quality purposes

I understand if any relevant transmitted diseases are positive, my blood will not be used for transfusion, and I will be placed on a donor deferral lists, meaning that I may not be eligible to donate blood in the future.

I understand that I will be notified by the method of communication indicated by me in this questionnaire of any positive transmitted diseases, any deferral bases, and the period of any deferrals.

I understand that state law requires reporting of some infectious diseases to the state and local health authorities

I understand that if a computer assisted interview is completed, the questions that I have answered including those that required further information are printed on this form.

I understand there may be some risks in donating blood, which may include but are not limited to bruising, pain, nerve damage, fainting, or injury from fainting.

I have been given the opportunity to ask any questions and to refuse the phlebotomy procedure.

I give permission for MSRH Donor Center to collect blood or blood components from me and to regulate their use.

Donor Signature: _____

Date _____

Screener Signature: _____

Date _____