Donor Health Questionnaire

Case # _____

Donor Last Name	Donor First Name	Donor Middle Name

Cause of Death	Sex	Height	Weight

Date of Birth	Date of Death	BMI

Has the donor had any of the following? Please explain any yes answers on back of form.

_____ Blood or life-saving measures in past 48 Hours
_____ Ever refused as a blood donor
_____ HIV/Aids
_____ Hepatits A, B, C or Liver Disease
_____ Tuberculosis
_____ Family Physician _____
_____ Urgent Care _____
_____ Prescription Medications _____
_____ Non Prescription Dietary Supplements
_____ Tattoos, how many and where
_____ New tattoo, piercing or touchup
_____ Recent Fever or Cough
_____ Recent Diarrhea
_____ Recent Swolen Lymph Nodes
_____ Recent Weight Loss
_____ Recent Rash
_____ Recent Sores in mouth or skin
_____ Recent Night sweats
_____ Recent Severe Headache
_____ Recent rapid deline in mental ability
_____ Recent Seizures
_____ Recent Tremors
_____ Recent Difficulty Walking
_____ Jail or Prison in last 12 month
_____ Autoimmune disease-Lupus, rheumatoid Arthritis
_____ Hysterectomy or other Gyn Surgery

_____ Exposed to uncommon diseases such as Rabies, Chigas, Zika, Ebola, Malaria, Dengue,etc
_____ Viral/Bacterial/Fungal infection
_____ Sepsis or Septic Shock
_____ Exposed to someone elses blood
_____ Sexually transmitted infection
Close Contact with person who tested positive for HIV/Hepatitis/Tuberculosis in past 5 years
_____ Injectable Drugs
_____ Brain or Neurological Disease
_____ Travel or live outside of North America
_____ Blood Transfusion outside of US
_____ Surgery
_____ Cancer _____
_____ Radiation or Chemotherapy
_____ Smoke
_____ COPD or Emphysema
_____ Alcohol
_____ Diabetes
_____ Kidney Problems
_____ High Blood Pressure or Cholesterol
_____ Heart Disease, attack or infection
_____ Circulation Problems
_____ Eye problems or surgery
_____ Other

DONORCURE
YOUR ANGEL'S GIFT FOR LIFE

Name of Person Providing Information

DonorCure Representative

Relationship to Deceased

Date

Phone number

Version 3 01/08/2020

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