Blood Donor Questionnaire & Consent Form

Name and address of blood bank:

License no: Blood unit no:

Please answer the following questions correctly. This will help to protect you and the patient who receives your blood.

Name:  □ Male  □ Female

Date of Birth: Age  Father's/Husband's Name:

Occupation Organization:

Address for communication:

Telephone: Mobile No.:

Would you like us to call you on your mobile:  □ Yes  □ No

Fax No. (if any): Email (if any):

Have you donated previously  □ Yes  □ No

Your blood group: Time of last meal:

Did you have any discomfort during/after donation? □ Yes □ No
❖ Do you feel well today?:  
☐ Yes  ☐ No

❖ Did you have something to eat in the last 4 hours?  
☐ Yes  ☐ No

❖ Did you sleep well last night?:  
☐ Yes  ☐ No

❖ Have you any reason to believe that you may be infected:  
By Hepatitis, Malaria, HIV/AIDS, and/or venereal disease?  
☐ Yes  ☐ No

❖ In the last 6 months have you had any history of the following:

☐ Unexplained weight loss
☐ Repeated Diarrhea
☐ Swollen glands
☐ Continuous low-grade fever

❖ In the last 6 months have you had any:-  

☐ Tattooing  
☐ Ear Piercing  
☐ Dental Extraction

❖ Do you suffer from or have suffered from any of the following diseases?

☐ Heart Disease  ☐ Lung disease  ☐ Kidney Disease
☐ Cancer/Malignant Disease  ☐ Epilepsy
☐ Diabetes  ☐ Tuberculosis  ☐ Malaria
☐ Abnormal bleeding tendency  ☐ Jaundice
☐ Allergic Disease  ☐ Fainting spells  ☐ Hepatitis B/C
☐ Sexually Trans. Diseases  ☐ Typhoid (last 1 yr.)

❖ Are you taking or have taken any of these in the past 72 hours?

☐ Antibiotics  ☐ Aspirin  ☐ Alcohol
☐ Steroids  ☐ Vaccinations
☐ Dog Bite/Rabies vaccine (1 yr.)

❖ Is there any history of surgery or blood transfusion in the past 6 months?

☐ Major Surgery  ☐ Minor Surgery  ☐ Blood Transfusion
For women donors,
Are you pregnant □ Yes □ No
Have you had an abortion in the last 3 months □ Yes □ No
Do you have a child less than one year old? □ Yes □ No
Is the child still breast-feeding? □ Yes □ No
Are you having your periods today? □ Yes □ No

Would you like to be informed about any abnormal test result at the address furnished by you? □ Yes □ No

Have you read and understood all the information presented and answered all the questions truthfully, as any incorrect statement or concealment may affect your health or may harm the recipient. □ Yes □ No

I understand that
(a) blood donation is a totally voluntary act and no inducement or remuneration has been offered
(b) Donation of blood/components is a medical procedure and that by donating voluntarily, I accept the risk associated with this procedure.
(c) my blood will be tested for Hepatitis B, Hepatitis C, Malarial Parasite, HIV/AIDs and venereal diseases in addition to any other screening tests required to ensure blood safety

I prohibit any information provided by me or about my donation to be disclosed to any individual or government agency without my prior permission.

Date: ___________ Time: ___________
Donor’s signature: __________________________________________

**General Physical Examination:**
Weight ___________________ Pulse ___________________
Hb ___________________ BP ___________________
Temperature ___________________

Accept □ Defer □ Reason ___________________

Signature of Medical Officer:

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*Five minutes of your time + 350 ml. of your blood = One life saved.*