

FULL-LENGTH DONOR HISTORY QUESTIONNAIRE

Prescreen #:

Subject #:

RECEIVED
Human Subjects Division

DEC 05 2012

UW

DATE:		STAFF:	
AGE:	SEX:	HEIGHT:	WEIGHT:

	Yes	No
1. Do you live with the transplant recipient?	<input type="checkbox"/>	<input type="checkbox"/>
2. What is your relationship to transplant recipient?		

Are you:

3. Feeling healthy and well today?	<input type="checkbox"/>	<input type="checkbox"/>
4. Currently taking an antibiotic or have you taken antibiotics in the past 12 weeks?	<input type="checkbox"/>	<input type="checkbox"/>
5. Currently taking any other medication for an infection?	<input type="checkbox"/>	<input type="checkbox"/>

In the past 48 hours:

6. Have you taken Aspirin or anything that has Aspirin in it? <i>- not an exclusion factor</i>	<input type="checkbox"/>	<input type="checkbox"/>
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In the past two weeks:

7. Have you taken Steroids (including exogenous glucocorticoids)?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you taken Probiotics?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you taken Immunomodulators (including calcineurin inhibitors)?	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you taken Biologics?	<input type="checkbox"/>	<input type="checkbox"/>
11. Taken any systemic antineoplastic agents (chemotherapy)?	<input type="checkbox"/>	<input type="checkbox"/>
12. <i>If subject has known food allergies:</i> Have you ingested (subject food allergen(s)) _____ in the past two weeks?	<input type="checkbox"/>	<input type="checkbox"/>
Note washout period(s), if necessary:		

In the past 6 weeks:

13. Female donors: Have you been pregnant or are you pregnant now? <i>- not an exclusion factor</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	I am male		

In the past 8 weeks:

14. Have you had any vaccinations or other shots?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had contact with someone who had a smallpox vaccination?	<input type="checkbox"/>	<input type="checkbox"/>

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<i>In the past 12 months have you:</i>		
15. Had a transplant such as organ, tissue, or bone marrow?	<input type="checkbox"/>	<input type="checkbox"/>
16. Had a graft such as bone or skin?	<input type="checkbox"/>	<input type="checkbox"/>
17. Come into contact with someone else's blood?	<input type="checkbox"/>	<input type="checkbox"/>
18. Had an accidental needle-stick?	<input type="checkbox"/>	<input type="checkbox"/>
19. Had sexual contact with anyone who has HIV/AIDS or has had a positive test for the HIV/AIDS virus?	<input type="checkbox"/>	<input type="checkbox"/>
20. Had sexual contact with a prostitute or anyone else who takes money or drugs or other payment for sex?	<input type="checkbox"/>	<input type="checkbox"/>
21. Had sexual contact with anyone who has ever used needles to take drugs or steroids, or anything <u>not</u> prescribed by their doctor?	<input type="checkbox"/>	<input type="checkbox"/>
22. Had sexual contact with anyone who has hemophilia or has used clotting factor concentrates?	<input type="checkbox"/>	<input type="checkbox"/>
23. Female donors: Had sexual contact with a male who has ever had sexual contact with another male?	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> I am male	
24. Had sexual contact with a person who has hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>
25. Lived with a person who had hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>
26. <i>Non-intimate donors:</i> Had a tattoo?	<input type="checkbox"/>	<input type="checkbox"/>
27. <i>Non-intimate donors:</i> Had ear or body piercing?	<input type="checkbox"/>	<input type="checkbox"/>
28. Had or been treated for syphilis or gonorrhea?	<input type="checkbox"/>	<input type="checkbox"/>
29. <i>Non-intimate donors:</i> Been in juvenile detention, lockup, jail, or prison for more than 72 hours?	<input type="checkbox"/>	<input type="checkbox"/>

<i>In the past three years have you:</i>		
30. <i>Non-intimate donors:</i> Been outside the United States or Canada to countries where diarrheal illnesses are endemic or risk of traveler's diarrhea is high	<input type="checkbox"/>	<input type="checkbox"/>
Location/Date of travel(s): _____		

<i>From 1980 through 1996:</i>		
31. Did you spend time that adds up to 3 months or more in the United Kingdom?	<input type="checkbox"/>	<input type="checkbox"/>
32. Were you a member of the U.S. military, a civilian military employee, or a dependent of a member of the U.S. military?	<input type="checkbox"/>	<input type="checkbox"/>

<i>From 1980 to the present, did you:</i>		
33. Spend time that adds up to 5 years or more in Europe?	<input type="checkbox"/>	<input type="checkbox"/>

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From 1977 to the present, have you:			
34. Received money, drugs, or other payment for sex?		<input type="checkbox"/>	<input type="checkbox"/>
35. Male donors: Had sexual contact with another male, even once?	<input type="checkbox"/> I am female	<input type="checkbox"/>	<input type="checkbox"/>

Have you EVER:			
36. Had a positive test for the HIV/AIDS virus?		<input type="checkbox"/>	<input type="checkbox"/>
37. Used needles to take drugs, steroids, or anything <u>not</u> prescribed by your doctor?		<input type="checkbox"/>	<input type="checkbox"/>
38. Used clotting factor concentrates?		<input type="checkbox"/>	<input type="checkbox"/>
39. Had hepatitis?		<input type="checkbox"/>	<input type="checkbox"/>
40. Had malaria?		<input type="checkbox"/>	<input type="checkbox"/>
41. Had Chagas' disease?		<input type="checkbox"/>	<input type="checkbox"/>
42. Had babesiosis?		<input type="checkbox"/>	<input type="checkbox"/>
43. Received a dura mater (or brain covering) graft?		<input type="checkbox"/>	<input type="checkbox"/>
44. Had sexual contact with anyone who was born in or lived in Africa?		<input type="checkbox"/>	<input type="checkbox"/>
45. Had a relative with Creutzfeldt-Jakob disease?		<input type="checkbox"/>	<input type="checkbox"/>
46. Had inflammatory bowel disease?		<input type="checkbox"/>	<input type="checkbox"/>
47. Had irritable bowel syndrome, idiopathic chronic constipation, or chronic diarrhea? <i>Specify</i> _____		<input type="checkbox"/>	<input type="checkbox"/>
48. Had a gastrointestinal malignancy or colon polyps?		<input type="checkbox"/>	<input type="checkbox"/>

<i>Relative Exclusion Criteria at researchers' discretion</i>			
49. Have you ever had the infection <i>Clostridium difficile</i> ("C. Diff")?		<input type="checkbox"/>	<input type="checkbox"/>
50. Do you have a history of major gastrointestinal surgery? (e.g. gastric by-pass) <i>Specify</i> _____		<input type="checkbox"/>	<input type="checkbox"/>
51. Have you been diagnosed with an autoimmune disease? (e.g. multiple sclerosis, connective tissue disease) <i>Specify</i> _____		<input type="checkbox"/>	<input type="checkbox"/>
52. Have you been diagnosed with atopic diseases? (e.g. asthma, eczema, eosino-hilic disorder of the gastrointestinal tract) <i>Specify</i> _____		<input type="checkbox"/>	<input type="checkbox"/>
53. Have you been diagnosed with a chronic pain syndrome? (e.g. chronic fatigue syndrome, fibromyalgia) <i>Specify</i> _____		<input type="checkbox"/>	<input type="checkbox"/>
54. Do you have diabetes and/or hypertension? <i>Specify</i> _____		<input type="checkbox"/>	<input type="checkbox"/>
55. Had any type of cancer, including leukemia? <i>Specify</i> _____		<input type="checkbox"/>	<input type="checkbox"/>
56. Had any problems with your heart or lungs? <i>Specify</i> _____		<input type="checkbox"/>	<input type="checkbox"/>
57. Had a bleeding condition or a blood disease? <i>Specify</i> _____		<input type="checkbox"/>	<input type="checkbox"/>