



Temporary copy is not valid for the blood donation.

(Copia provvisoria non valida ai fini della donazione del sangue).

Last name.....	First name.....
Gender M/F	Palce of birth.....on.....
Resident in.....	Street.....
Identification document.....	nr..... CF.....
Tel.....	Cell..... Email.....

	Yes	No
Do you feel weel today?		
Do you suffer or have you suffered from allergies, autoimmune diseases, diseases of the respiratory tract, gastrointestinal, osteoarticular illnesses, malignant tumours, turbeculosis, diabetes, convulsions and/or fainting, epilepsy, fevers or flu symptoms, cardiovascular illnesses, hypertension, infectious diseases, jaundice and/or Hepatitis, kidney disease, haematological, rheumatic, tropical, dermatological diseases.	Yes	No
Have you ever been pregnant or had an abortions? When?.....	Yes	No
Are you menstruating?	Yes	No
Are you pregnant?	Yes	No
Are you taking medication or under a doctor's cure?	Yes	No
Are you recently (in the past 5 days) taken aspirin or other analgesics?	Yes	No
Have you exeperienced any unjustified weight loss?	Yes	No
Have you had any fevers from unknown causes?	Yes	No
Have you noticed any swelling of the lymph nodes?	Yes	No
Are you alcoholic?	Yes	No
Have you recently been vaccinated? Which?..... When?.....	Yes	No
Have you read and understood the information on AIDS, viral Hepatitis and other contagious diseases?	Yes	No
Have you ever taken narcotisc?	Yes	No
Have you ever had sexual relations at risk for the transmission of infectious diseases?	Yes	No
Have you ever tested positive for Hepatitis B and/or C and/or for AIDS?	Yes	No
Have you ever had sexual relations with a partner who tested positive for Hepatitis B and/or C and/or for AIDS?	Yes	No
Do you have a family history of Creutzfeldt-Jakob disease, fatal familial insomnia, dementia or spongiform encephalitis?	Yes	No
Have you received growth hormones or pituitary extract?	Yes	No
If foreign, how long have you lived in Italy?.....		
Have you had any transfusions of blood or blood components or have you been administered any blood derivatives?	Yes	No
Have you recently travelled and stayed abroad? When?.....Where?.....For how long?.....	Yes	No
Have you ever been instructed not to donate blood?	Yes	No
Have you ever had an organ, tissue or cell transplant? When?.....	Yes	No

From 1980 to 1996, did you stay for more than 6 cumulative months in the United Kingdom?	Yes	No
THE LAST 4 MONTHS		
Have you had any surgery? Which?..... When?.....	Yes	No
Have you had any endoscopic examinations?	Yes	No
Have you had any procedures performer requiring the use of a venous catheter?	Yes	No
Have you had any orthodontic treatments?	Yes	No
Have you had any tattoos?	Yes	No
Have you had any ear piercings or piercings anywhere else on your body?	Yes	No
Have you had any subjected to acupuncture?	Yes	No
Have you had any transfusions of blood or blood components or have you been administered any blood derivates?	Yes	No
Have you been accidentally injured with a needle or other object contaminated with blood?	Yes	No
Have you been accidentally exposed to contamination of the mucous membranes with blood?	Yes	No
Have had direct contact with patients with liver disease?	Yes	No
Do you have any dangerous activities or hobbies?	Yes	No
How many hours have you been fasting?.....	Yes	No
Have you ever had sexual risk behaviour of infectious diseases?	Yes	No

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