

MUSCULOSKELETAL TRANSPLANT FOUNDATION

TITLE: Medical History and Behavioral Risk Assessment Questionnaire

Document: Form -617	Revision: 5	Page: 3 of 8
--------------------------------------	------------------------------	-------------------------------

		MTF Donor Number
b. Did the potential donor have close contact with someone with SARS or suspected to have SARS?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, explain (include when): _____ _____
8. In the past twelve months, was the potential donor bitten by or have close contact with an animal that could have carried the rabies virus (e.g., dogs, mice, rats, bats, squirrels, raccoons, etc.)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, please describe: _____ _____
9. Has the potential donor ever received blood transfusions or blood products?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, explain (include when): _____ _____
10. Was the potential donor ever refused as a blood donor or told not to donate?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, explain (include when and reason): _____ _____
11. Did the potential donor ever receive a human or animal organ or tissue transplant (e.g., bone, cornea, skin, heart, kidney, dura mater, Epicel™)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, explain (include what kind and when): _____ _____
a. Ever have intimate contact with a person who received an organ or tissue transplant from an animal?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, explain (include what kind and when): _____ _____
12. Did the potential donor have any of the following:		(For yes responses, provide details such as body site, when, by whom, and how many)
a. Tattoo?	<input type="checkbox"/> No	<input type="checkbox"/> Yes _____
b. Body piercing?	<input type="checkbox"/> No	<input type="checkbox"/> Yes _____
c. Acupuncture?	<input type="checkbox"/> No	<input type="checkbox"/> Yes _____
d. Accidental needle stick?	<input type="checkbox"/> No	<input type="checkbox"/> Yes _____
e. For tattoo(s), describe location and content.		Tattoo(s) description(s): _____ _____
f. For a yes response to a, b, and/or c above that occurred in the preceding 12 months: were shared and/or contaminated needles, ink, or instrumentation known to have been used?	<input type="checkbox"/> No	<input type="checkbox"/> Yes _____
13. In the preceding 12 months, was the potential donor vaccinated or immunized for any reason?	<input type="checkbox"/> No	<input type="checkbox"/> Yes _____
a. Any in the preceding 8 weeks?	<input type="checkbox"/> No	<input type="checkbox"/> Yes (document what and when) _____ _____
b. Was the potential donor vaccinated for Hepatitis B?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
14. Was the potential donor vaccinated for smallpox?	<input type="checkbox"/> No	<input type="checkbox"/> Yes (Document when, status of vaccination site, and any known complications from the vaccination) _____ _____
a. Did the potential donor have close physical contact with a recipient of the smallpox vaccine?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, explain _____
15. Was the potential donor ever given human pituitary-derived growth hormone?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, explain including when _____ _____

Interviewer's initials _____

Date _____

Original - MTF

RM -708



MEDICAL SOCIAL HX

MUSCULOSKELETAL TRANSPLANT FOUNDATION

TITLE: Medical History and Behavioral Risk Assessment Questionnaire

Document: Form -617	Revision: 5	Page: 4 of 8
--------------------------------	------------------------	-------------------------

		MTF Donor Number
16. Did the potential donor have any history of: a. Heart disease? b. High blood pressure? c. Chest pain? d. Varicose veins and/or vein stripping?	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No	<input type="checkbox"/> Yes _____ <input type="checkbox"/> Yes _____ <input type="checkbox"/> Yes _____ <input type="checkbox"/> Yes, explain _____
17. Did the potential donor: a. Have any type of liver disease or hepatitis? b. Have any history of jaundice? c. Ever have a positive test for hepatitis? d. Live with and/or have close contact with a person(s) diagnosed with viral hepatitis in the preceding 12 months?	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No	(Please explain any yes response) <input type="checkbox"/> Yes _____ <input type="checkbox"/> Yes _____ <input type="checkbox"/> Yes _____ <input type="checkbox"/> Yes _____
18. Did the potential donor have any kidney related disease(s) and/or kidney dialysis treatments?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, explain (For dialysis treatments, include when/how long): _____ _____
19. Did the potential donor have a history of: a. Digestive or intestinal problems? b. Bloody stools? c. Recent weight loss?	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No	<input type="checkbox"/> Yes _____ <input type="checkbox"/> Yes _____ <input type="checkbox"/> Yes, explain including how much and reason _____ _____
20. Did the potential donor: a. Have a history of diabetes? b. If yes, did he/she require medication?	<input type="checkbox"/> No <input type="checkbox"/> No	<input type="checkbox"/> Yes _____ <input type="checkbox"/> Yes (include name of medication and length of treatment if any) _____
21. Did the potential donor have any history of: a. Lung disease? b. Tuberculosis (TB)? c. Treatment for TB? d. A positive skin test for TB?	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No	<input type="checkbox"/> Yes _____ <input type="checkbox"/> Yes _____ <input type="checkbox"/> Yes (include what and when) _____ _____ <input type="checkbox"/> Yes (explain including if there was follow-up, what, and when) _____ _____
22. Has the potential donor: a. Ever had cancer? b. Ever received radiation therapy or drugs for cancer? c. Ever had skin cancer?	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No	<input type="checkbox"/> Yes (explain including type and when) _____ _____ <input type="checkbox"/> Yes _____ <input type="checkbox"/> Yes (explain including when, type, and treatment) _____ _____

Interviewer's initials _____

Date _____

Original - MTF

RM -708



MEDICAL SOCIAL HX

MUSCULOSKELETAL TRANSPLANT FOUNDATION

TITLE: Medical History and Behavioral Risk Assessment Questionnaire

Document: Form -617	Revision: 5	Page: 5 of 8
--------------------------------	------------------------	-------------------------

	MTF Donor Number
--	-------------------------

23. Did the potential donor have a history of any of the following autoimmune diseases: a. Systemic lupus erythematosus (SLE)? b. Polyarteritis nodosa? c. Sarcoidosis? d. Other (List): _____	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No	<input type="checkbox"/> Yes _____ <input type="checkbox"/> Yes _____ <input type="checkbox"/> Yes _____ <input type="checkbox"/> Yes _____
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24. Did the potential donor suffer from any type of neurologic or brain disease such as: a. Alzheimer's? b. Encephalitis? c. Degenerative neurological disease? d. Multiple Sclerosis (MS)? e. ALS (Lou Gehrig's Disease)? f. History of brain tumor? g. Seizures? h. Periods of confusion or recent memory loss? i. Unsteady walking? j. Sudden unexplained anxiety or personality changes? k. Visual changes? l. Hallucinations? m. Has the potential donor or any of the donor's blood relatives had Creutzfeldt-Jakob Disease (CJD)? n. Or been told they were at risk for CJD?	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No	<input type="checkbox"/> Yes _____ <input type="checkbox"/> Yes _____ <input type="checkbox"/> Yes _____ <input type="checkbox"/> Yes _____ <input type="checkbox"/> Yes _____ <input type="checkbox"/> Yes _____ <input type="checkbox"/> Yes _____ <input type="checkbox"/> Yes _____ <input type="checkbox"/> Yes _____ <input type="checkbox"/> Yes _____ <input type="checkbox"/> Yes _____ <input type="checkbox"/> Yes _____ <input type="checkbox"/> Yes, explain _____ <input type="checkbox"/> Yes, explain _____
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25. Did the potential donor have any medical diagnosis of: a. Rheumatoid arthritis? b. Other arthritis? c. Osteoporosis? d. Osteomyelitis? e. Broken bones? f. Was the potential donor physically active (i.e., exercise regularly, take walks, participate in sports)	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No	(If yes, please explain including when as well as any treatment and/or medications) <input type="checkbox"/> Yes _____ <input type="checkbox"/> Yes _____ <input type="checkbox"/> Yes _____ <input type="checkbox"/> Yes _____ <input type="checkbox"/> Yes _____ <input type="checkbox"/> Yes _____ <input type="checkbox"/> Yes _____
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26. Did the potential donor have a history of skin infections such as leprosy, eczema, dermatitis, psoriasis, or inflammatory skin diseases?	<input type="checkbox"/> No	<input type="checkbox"/> Yes _____ _____
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CURRENT CRITERIA FOR ASSESSING RISK BEHAVIOR for HIV (Human Immunodeficiency Virus) and **VIRAL HEPATITIS**

27. In the preceding twelve months has the potential donor had or been treated for any sexually transmitted disease such as syphilis, gonorrhea, genital herpes or venereal warts?	<input type="checkbox"/> No	<input type="checkbox"/> Yes (Please explain including what, when, and any treatment) _____ _____
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Original - MTF

RM -708



MEDICAL SOCIAL HX

MUSCULOSKELETAL TRANSPLANT FOUNDATION

TITLE: Medical History and Behavioral Risk Assessment Questionnaire

Document: Form -617	Revision: 5	Page: 6 of 8
--------------------------------------	------------------------------	-------------------------------

	MTF Donor Number
--	-------------------------

<p>28. Was the potential donor born in or live in Cameroon, Central African Republic, Chad, Congo, Equatorial Guinea, Gabon, Niger, or Nigeria after 1977?</p> <p>a. Did the potential donor:</p> <p style="padding-left: 20px;">a.1 Have sexual contact with anyone who was born or lived in Cameroon, Central African Republic, Chad, Congo, Equatorial Guinea, Gabon, Niger, or Nigeria after 1977?</p> <p style="padding-left: 20px;">a.2 Receive a blood transfusion or any medical treatment that involved blood in Cameroon, Central African Republic, Chad, Congo, Equatorial Guinea, Gabon, Niger, or Nigeria after 1977?</p>	<p align="center"><input type="checkbox"/> No</p> <p align="center"><input type="checkbox"/> No</p> <p align="center"><input type="checkbox"/> No</p>	<p>(Please explain yes responses including what country and when)</p> <p><input type="checkbox"/> Yes _____</p> <p>_____</p> <p><input type="checkbox"/> Yes _____</p> <p>_____</p> <p><input type="checkbox"/> Yes (Explain including what country, when, and treatment received) _____</p> <p>_____</p>
<p>29. Has the potential donor recently exhibited or experienced:</p> <p>a. Unexplained weakness, fatigue, or flu-like symptoms such as persistent cough, cold, shortness of breath, swollen lymph nodes for greater than one month?</p> <p>b. Nausea, vomiting, persistent diarrhea?</p> <p>c. Night sweats or fever >100.5° F. for greater than 10 days?</p> <p>d. Blue or purple spots on the skin or mucous membranes?</p> <p>e. Significant weight loss or opportunistic (unusual) infections?</p> <p>f. Unexplained persistent white spots or unusual blemishes in the mouth?</p>	<p align="center"><input type="checkbox"/> No</p> <p align="center"><input type="checkbox"/> No</p> <p align="center"><input type="checkbox"/> No</p> <p align="center"><input type="checkbox"/> No</p> <p align="center"><input type="checkbox"/> No</p> <p align="center"><input type="checkbox"/> No</p>	<p><input type="checkbox"/> Yes _____</p> <p><input type="checkbox"/> Yes _____</p> <p><input type="checkbox"/> Yes _____</p> <p><input type="checkbox"/> Yes _____</p> <p><input type="checkbox"/> Yes _____</p> <p><input type="checkbox"/> Yes _____</p>
<p>30. Has the potential donor ever had a positive test for HIV?</p>	<p align="center"><input type="checkbox"/> No</p>	<p><input type="checkbox"/> Yes _____</p>
<p>31A. <u>Male Donors</u>: Has the potential donor had sexual relations with another male in the preceding 5 years?</p> <p>31B. <u>Female Donors</u>: Has the potential donor had sexual relations with a male(s) who has had sex with another male(s) in the preceding 5 years?</p>	<p align="center"><input type="checkbox"/> No</p> <p align="center"><input type="checkbox"/> No</p>	<p><input type="checkbox"/> Yes _____</p> <p><input type="checkbox"/> Female</p> <p><input type="checkbox"/> Yes _____</p> <p><input type="checkbox"/> Male</p>
<p>32. Has the potential donor used a needle to inject drugs into the vein, muscle, or under the skin for a non-medical reason in the preceding 5 years?</p> <p>a. Or had sexual relations with such an individual in the preceding 12 months?</p>	<p align="center"><input type="checkbox"/> No</p> <p align="center"><input type="checkbox"/> No</p>	<p><input type="checkbox"/> Yes _____</p> <p><input type="checkbox"/> Yes _____</p>
<p>33. Has the potential donor received human-derived clotting factor concentrates for hemophilia or related clotting disorders in the preceding 5 years?</p> <p>a. Or had sexual relations with such an individual in the preceding 12 months?</p>	<p align="center"><input type="checkbox"/> No</p> <p align="center"><input type="checkbox"/> No</p>	<p><input type="checkbox"/> Yes _____</p> <p><input type="checkbox"/> Yes _____</p>
<p>34. Has the potential donor engaged in sex in exchange for money or drugs in the preceding 5 years?</p> <p>a. Or had sexual relations with such an individual in the preceding 12 months?</p>	<p align="center"><input type="checkbox"/> No</p> <p align="center"><input type="checkbox"/> No</p>	<p><input type="checkbox"/> Yes _____</p> <p><input type="checkbox"/> Yes _____</p>

Interviewer's initials _____

Date _____

Original - MTF

RM -708



MEDICAL SOCIAL HX

MUSCULOSKELETAL TRANSPLANT FOUNDATION

TITLE: Medical History and Behavioral Risk Assessment Questionnaire

Document: Form -617	Revision: 5	Page: 7 of 8
--------------------------------------	------------------------------	-------------------------------

	MTF Donor Number
--	-------------------------

35. Was the potential donor exposed to known or suspected viral hepatitis or HIV-infected blood through accidental needle stick or through contact with an open wound, non-intact skin, or mucous membrane in the preceding 12 months?	<input type="checkbox"/> No	<input type="checkbox"/> Yes _____
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36. Has the potential donor had sex in the preceding 12 months with any person known or suspected to have viral hepatitis or HIV infection?	<input type="checkbox"/> No	<input type="checkbox"/> Yes _____
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37. Has the potential donor ever: a. Been an inmate (confined to juvenile detention, lockup, jail, or prison) for more than 72 consecutive hours? b. Been released from any of these facilities in the preceding 12 months?	<input type="checkbox"/> No	(If yes, please explain including when, how long, why) <input type="checkbox"/> Yes _____ <input type="checkbox"/> Yes _____
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PEDIATRIC DONORS

38A. Was the potential donor 18 months of age or less?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
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38B. If less than 5 years of age, was the child breast-fed within the preceding 12 months?	<input type="checkbox"/> No	<input type="checkbox"/> Yes _____
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NOTE: If the answer to either question 38A or 38B is yes, a separate Medical History and Behavioral Risk Assessment questionnaire must be completed for the birth mother to determine if a pediatric donor was born to a mother with or at risk for HIV or viral hepatitis infection - this includes a potential donor one month (28 days) of age or less (See TM -6 for additional information)

EYE DONORS

39. Did the potential donor have a history of diseases, infections, or surgeries involving the eyes?	<input type="checkbox"/> No	<input type="checkbox"/> Yes _____
a. Glaucoma?	<input type="checkbox"/> No	<input type="checkbox"/> Yes _____
b. Cataracts?	<input type="checkbox"/> No	<input type="checkbox"/> Yes _____
c. Corneal disease?	<input type="checkbox"/> No	<input type="checkbox"/> Yes _____
d. Laser surgery?	<input type="checkbox"/> No	<input type="checkbox"/> Yes _____
e. Radial keratotomy?	<input type="checkbox"/> No	<input type="checkbox"/> Yes _____
f. Did the potential donor have an eye physician?	<input type="checkbox"/> No	<input type="checkbox"/> Yes _____

ALL DONORS

40. Having answered many questions about medical diseases and behavioral risk factors, do you now have any concerns that it might not be safe to proceed with organ or tissue donation?	<input type="checkbox"/> No	<input type="checkbox"/> Yes _____
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41. Are there other individuals that may provide additional information regarding any of these questions? If yes , please provide contact information.	<input type="checkbox"/> No	<input type="checkbox"/> Yes Name: _____ Telephone: _____ Relationship: _____
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Interviewer's initials _____

Date _____

Original - MTF

RM -708



MEDICAL SOCIAL HX

