

MILK BANK PRELIMINARY SCREENING QUESTIONS

Date: ___ / ___ / ___

Info Recorder: _____ (Initials)

1. How old is your baby? _____ DOB: _____
2. Was your baby a premie? _____ If so, what was gestational age at birth? _____
3. How many ounces do you have stored that you want to donate? _____
4. In what type of freezer is your milk stored?

top	bottom
stand alone	deep freeze
5. In what type of bags are you storing your milk? _____
5. Have you had a major illness in the last year? Comments: _____

Yes No

6a. Have you had blood products or a transfusion in the last year or received blood in the UK during 1999-2000? _____

6b. Have you ever been told you cannot donate blood? (*Unable to donate milk; unless the reason was low body weight, pregnancy or breastfeeding, or low iron*) _____

7. Have you or your sexual partner had any body piercing in the last 12 months? _____

8. Have your or your sexual partner gotten a tattoo or had permanent make-up applied in the last 12 months? _____

If yes, was it done at a regulated site?	
Were single use needles and dyes used?	
Name of facility:	
Address:	
Phone Number:	

9. Have you or your partner had an accidental stick with a contaminated needle with the last 12 months? _____

10. During the time you were pumping milk, or now if still pumping, were you taking ANY medications? _____

Tylenol _____ Thyroid replacement _____

Ibuprofen _____ Insulin _____

PNV _____ Birth Control Pills; If yes, name and dose: _____

Allergy Meds _____ Antidepressant _____

Antibiotics _____

11. Do you take any medication to increase your milk supply? _____

12. Do you drink caffeinated beverages? _____

coffee	
tea	
soda	

13. Do you drink herbal teas? _____

If yes, what kind? _____ How often? _____ Amount? _____

14. Do you smoke, use a nicotine patch, nicotine gum or chew tobacco? _____

15. Would you consider yourself or your partner at high risk for exposure to HIV, HTLV, or Hepatitis? _____

16. Have you or your partner ever injected drugs, other than prescription drugs? _____

17. Have you ever lived outside the US? (If from 1980-1996 spent more than 3 months in the UK, disqualified) Where? _____ How long? _____

	YES	NO
18. Since 1980 spent time that adds up to a total of 5 years on Europe? (If yes, disqualified)		
19. Between 1980 and 1996 were you a member of US military, a civilian employee or a dependent of a member of the military?		

If yes, did you spend a total of six months or more associated with a military base in the following countries:

From 1980-1990 in Belgium, the Netherlands, UK or Germany		
From 1980-1996 in Spain, Portugal, Turkey, Italy or Greece		
20. Born in, lived in, traveled in or did you have intimate contact with someone who was born in, lived in or traveled in any African country since 1977?		

If yes, where?

21. Have you or your sexual partner been incarcerated for more than 72 consecutive hours in the last 12 months?		
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22. Have you ever received human pituitary-derived growth hormone, a dura mater graft or bovine insulin?		
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23. Do you have a family history of Creutzfeldt-Jakob disease?		
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24. Have you ever had a chronic infection such as HIV, malaria or active TB?		
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25. Do you have a history of hepatitis, leukemia or lymphoma?		
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26. Have you been treated for cancer in the last 5 years?		
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27. Are you on a special diet?		
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28. Have you recently been vaccinated against any illnesses?		
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29. How often do you eat:	Tuna _____	Mackerel _____
	Swordfish _____	Tilefish _____

30. How often do you drink alcohol?		
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If she is ready for further screening: **ASK the following**

What is your name?

Full Address: _____

Phone Number _____

Your Date of Birth _____

Do we have permission to leave you messages on your home, work or cell phone? (circle one) YES NO

Would you like some Medela storage bags? (circle one) YES NO

***NOTE: WE DO NOT SHIP A COOLER OR ACCEPT MILK UNTIL THE FILE IS COMPLETE**

Preferred Mailing: (circle one) E-mail Reg. Mail

E-mail address: _____

Assigned Donor # _____

Send Freezer Bags (circle one) Yes No

Lab Work (circle one) Yes No

Other NOTES: