Female Donor Eligibility Screening Form

Full Name

Date of Birth

Contact Number

Address

Are you currently pregnant?

Yes No

Date of Last Menstrual Period

Are you currently breastfeeding?

Yes No

Have you ever been diagnosed with any of the following? (check all that apply)

Anemia

Hypertension

Diabetes

Other

Have you donated blood in the past 3 months?

Yes No

Are you currently taking any medication?

Yes No

If yes, please specify

Do you feel well and healthy today?

Yes No

Comments / Additional Information