Attachment 2

OMB#0925-XXXX Exp:xx-xxxx

Donor Iron Status Survey (Cohort version)

This research sponsored by the National Heart, Lung, and Blood Institute of the National Institutes of Health (NIH) will help us better understand iron status in blood donors and contribute valuable information for improving the health of blood donors. This survey will ask you questions about your donation history, smoking history, diet, vitamins and supplements that you take and if you are female, a few questions on your reproductive history. Your answers to all questions will be kept confidential and only be used for the purpose of this research.

Your participation in this survey is voluntary. If you choose not to participate, it will not affect your ability to donate blood again in the future. You will not lose any benefits.

Name: .....

First Name Middle Name Last Name

Today's Date: ____ ____ - ____ ____ - ____ ____
Month Day Year

Blood Center ID: .....

Whole Blood Number (WBN): .....

AFFIX LABEL WITH ID HERE

Sponsored by
National Heart Lung and Blood Institute
National Institutes of Health (NIH)

SECTION A
Your blood donation history:

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1. Is this the first time you have EVER donated blood?

- ☐ Yes **{SKIP TO SECTION B, QUESTION 7}**
- ☐ No

2. Including your most recent donation, how many times in your life have you donated blood?

- ☐ 1 to 2 times
- ☐ 2 to 5 times
- ☐ 5 to 10 times
- ☐ 10 to 20 times
- ☐ More than 20 times
- ☐ Don't Know

3. Other than today, when was the last time you donated blood?

|__|__| |__|__|
M M Y Y

☐ Don't Know

{IF YOUR LAST DONATION WAS MORE THAN 2 YEARS AGO SKIP TO SECTION B, QUESTION 7}

4. Please tell us the total number of blood donations you have made in the last 2 years.

|__|__|
NUMBER OF DONATIONS

☐ Don't Know

5. Were any of these donations made through a DIFFERENT blood center?

- ☐ Yes
- ☐ No
- ☐ Don't Know

6. Were any of these apheresis donations? (Apheresis: Donors give only select blood components such as platelets, plasma, red cells, or a combination of these)

- ☐ Yes
- ☐ No

How many of these where apheresis donations?
|__|__|
NUMBER OFAPHERESIS DONATIONS
☐ Don't Know

SECTION B
Your smoking history:

7. Have you smoked at least 100 cigarettes in your entire life?

- ☐ Yes
- ☐ No
- ☐ Don't know

8. Did you smoke ANY cigarettes during the last 90 DAYS (3 months)?

- ☐ Yes
- ☐ No **{SKIP TO SECTION C QUESTION 11}**
- ☐ Don't know

9. Thinking about the last 30 DAYS (1 month), on how many of these days did you smoke?

|___|___|
NUMBER OF DAYS

☐ Don't know

10. In the LAST 30 DAYS, on the days that you DID smoke, about how many cigarettes did you usually smoke per day?

|___|___|
NUMBER OF CIGARETTES

☐ Don't know

SECTION C
Your Diet:

AFFIX LABEL WITH ID HERE

11. Over the LAST 12 MONTHS, about how many times per week did you eat the following foods?

[When thinking about the foods you eat, remember to include soups, stews, sandwiches, lunch meats, casseroles and salads that are made with these food items.]

Foods	How many times?							
	Never	Less than once/ week	Once/ week	Twice/ week	3-4 times/ week	5-6 times/ week	Once every day	2 or more times/day
Liver (any kind)	☐	☐	☐	☐	☐	☐	☐	☐
Beef (including ground Beef)	☐	☐	☐	☐	☐	☐	☐	☐
Lamb, Pork, Chicken, Turkey	☐	☐	☐	☐	☐	☐	☐	☐
Clams	☐	☐	☐	☐	☐	☐	☐	☐
Oysters, Mussels, Shrimp, Sardines	☐	☐	☐	☐	☐	☐	☐	☐
Other Fish	☐	☐	☐	☐	☐	☐	☐	☐
Eggs	☐	☐	☐	☐	☐	☐	☐	☐
Dairy Products (Milk, Yoghurt, Cheese)	☐	☐	☐	☐	☐	☐	☐	☐

SECTION D
Your use of vitamin pills, supplements and aspirin:

12. Over the LAST 12 MONTHS, did you take any multivitamins such as One-A-Day, Theragran, or Centrum type multivitamins (as pills, liquids, or packets) on a regular basis (at least once a week)?

☐ ~~Yes~~
☐ No
☐ Don't know

How often did you take multivitamins?

☐ Everyday
☐ 4 to 6 days per week
☐ 1 to 3 days per week
☐ Don't know

Does your multivitamin contain iron?

☐ Yes
☐ No
☐ Don't Know

13. Over the LAST 12 MONTHS, did you take any iron supplements other than your multivitamins on a regular basis (at least once a week)?

☐ ~~Yes~~
☐ No
☐ Don't know

How often did you take iron supplements?

☐ Everyday
☐ 4 to 6 days per week
☐ 1 to 3 days per week
☐ Don't know

14. Do you currently take Aspirin or Aspirin containing pain relievers daily or nearly everyday?

☐ Yes
☐ No
☐ Don't Know

Why?

☐ For heart or cardiac health
☐ For pain relief
☐ For both

AFFIX LABEL WITH ID HERE

{MALE DONORS SKIP SECTION E AND GO TO END STATEMENT}

SECTION E
FOR FEMALE DONORS ONLY
Your reproductive history:

15. Which of these statements best describes your current menstrual status?

- ☐ I am still having periods and am NOT going through menopause
- ☐ I am still having periods, but am possibly going through menopause
- ☐ My periods have stopped completely because I have gone through menopause **{SKIP TO QUESTION 19}**
- ☐ I had an operation which stopped my periods **{SKIP TO QUESTION 19}**
- ☐ I am taking a medication that has stopped my periods completely **{SKIP TO QUESTION 19}**
- ☐ My periods have stopped because of other reasons **{SKIP TO QUESTION 19}**

16. What was the date when your last menstrual period started?

|___|___| |___|___|
M M Y Y
ENTER DATE OF LAST PERIOD

☐ I am having my period now

17. About how many periods did you have in the last year (12 Months)?

|___|___|
ENTER NUMBER OF PERIODS

18. How would you describe your menstrual flow or bleeding?

- ☐ **Spotting**, a drop or two of blood, not even requiring sanitary protection though you may prefer to use some.
- ☐ **Very light bleeding** (you would need to change the least absorbent tampon or pad one or two times per day, though you may prefer to change more frequently)
- ☐ **Light bleeding** (you would need to change a low or regular absorbency tampon or pad two or three times per day, though you may prefer to change more frequently)
- ☐ **Moderate bleeding** (you would need to change a regular absorbency tampon or pad every 3 to 4 hours, though you may prefer to change more frequently)
- ☐ **Heavy bleeding** (you would need to change a high absorbency tampon or pad every 3 to 4 hours, though you may prefer to change more frequently)
- ☐ **Very heavy bleeding or gushing** (protection hardly works at all; you would need to change the highest absorbency tampon or pad every hour or two)

AFFIX LABEL WITH ID HERE

The next few questions are about your pregnancy history. This information is very important to this study because it will help improve the health of all women. So please take whatever time you need to answer them as accurately and completely as possible.

19. Have you ever been pregnant? Please include live births, miscarriages, still births, tubal pregnancies and abortions.

- ☐ Yes
- ☐ No **{SKIP TO END STATEMENT}**
- ☐ Don't know

20. How many times have you been pregnant in your life? Again, be sure to include live births, miscarriages, still births, tubal pregnancies and abortions.

|___|___|
ENTER NUMBER OF PREGNANCIES

☐ Don't know

21. How many of your pregnancies resulted in a live birth? Please count the number of pregnancies, not number of live-born children. For example, if you had twins or other multiple births, count as a single pregnancy.

|___|___|
ENTER NUMBER OF PREGNANCIES RESULTING IN LIVE BIRTHS

☐ No live births **{SKIP TO END STATEMENT}**

22. When was your last baby born?

|___|___| |___|___|
M M Y Y

END STATEMENT

The survey is now complete. We appreciate you taking the time to complete this survey. Your responses have provided us with valuable information

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AFFIX LABEL WITH ID HERE

Donor Iron Status Survey (Deferred donor version)

This research sponsored by the National Heart, Lung, and Blood Institute of the National Institutes of Health (NIH) will help us better understand iron status in blood donors and contribute valuable information for improving the health of blood donors. This survey will ask you questions about your donation history, smoking history, diet, vitamins and supplements that you take and if you are female, a few questions on your reproductive history. Your answers to all questions will be kept confidential and only be used for the purpose of this research.

Your participation in this survey is voluntary. If you choose not to participate, it will not affect your ability to donate blood again in the future. You will not lose any benefits.

Name: .....

First Name Middle Name Last Name

Today's Date: ____ ____ - ____ ____ - ____ ____
Month Day Year

Blood Center ID: .....

Whole Blood Number (WBN): .....

AFFIX LABEL WITH ID HERE

Sponsored by
National Heart Lung and Blood Institute
National Institutes of Health (NIH)

SECTION A
Your blood donation history:

1. Is this the first time you have EVER tried to donate blood?

- ☐ Yes **{SKIP TO SECTION B, QUESTION 7}**
- ☐ No

2. How many times in your life have you donated blood?

- ☐ 1 to 2 times
- ☐ 2 to 5 times
- ☐ 5 to 10 times
- ☐ 10 to 20 times
- ☐ More than 20 times
- ☐ Don't Know

3. When was the last time you donated blood?

|__|__| |__|__|
M M Y Y

☐ Don't Know

{IF YOUR LAST DONATION WAS MORE THAN 2 YEARS AGO SKIP TO SECTION B, QUESTION 7}

4. Please tell us the total number of blood donations you have made in the last 2 years.

|__|__|
NUMBER OF DONATIONS

☐ Don't Know

5. Were any of these donations made through a DIFFERENT blood center?

- ☐ Yes
- ☐ No
- ☐ Don't Know

6. Were any of these apheresis donations? (Apheresis: Donors give only select blood components such as platelets, plasma, red cells, or a combination of these)

- ☐ Yes
- ☐ No

How many of these where apheresis donations?

|__|__|
NUMBER OFAPHERESIS DONATIONS
☐ Don't Know

SECTION B
Your smoking history:

7. Have you smoked at least 100 cigarettes in your entire life?

- ☐ Yes
- ☐ No
- ☐ Don't know

8. Did you smoke ANY cigarettes during the last 90 DAYS (3 months)?

- ☐ Yes
- ☐ No **{SKIP TO SECTION C QUESTION 11}**
- ☐ Don't know

9. Thinking about the last 30 DAYS (1 month), on how many of these days did you smoke?

|___|___|
NUMBER OF DAYS

☐ Don't know

10. In the LAST 30 DAYS, on the days that you DID smoke, about how many cigarettes did you usually smoke per day?

|___|___|
NUMBER OF CIGARETTES

☐ Don't know

AFFIX LABEL WITH ID HERE

SECTION C
Your Diet:

11. Over the LAST 12 MONTHS, about how often did you eat the following foods?

[When thinking about the foods you eat, remember to include soups, stews, sandwiches, lunch meats, casseroles and salads that are made with these food items.]

Foods	How many times?							
	Never	Less than once/ week	Once/ week	Twice/ week	3-4 times/ week	5-6 times/ week	Once every day	2 or more times/day
Liver (any kind)	☐	☐	☐	☐	☐	☐	☐	☐
Beef (including ground Beef)	☐	☐	☐	☐	☐	☐	☐	☐
Lamb, Pork, Chicken, Turkey	☐	☐	☐	☐	☐	☐	☐	☐
Clams	☐	☐	☐	☐	☐	☐	☐	☐
Oysters, Mussels, Shrimp, Sardines	☐	☐	☐	☐	☐	☐	☐	☐
Other Fish	☐	☐	☐	☐	☐	☐	☐	☐
Eggs	☐	☐	☐	☐	☐	☐	☐	☐
Dairy Products (Milk, Yoghurt, Cheese)	☐	☐	☐	☐	☐	☐	☐	☐

SECTION D
Your use of vitamin pills, supplements and aspirin:

12. Over the LAST 12 MONTHS, did you take any multivitamins such as One-A-Day, Theragran, or Centrum type multivitamins (as pills, liquids, or packets) on a regular basis (at least once a week)?

☐ ~~Yes~~
☐ No
☐ Don't know

How often did you take multivitamins?

☐ Everyday
☐ 4 to 6 days per week
☐ 1 to 3 days per week
☐ Don't know

Does your multivitamin contain iron?

☐ Yes
☐ No
☐ Don't Know

13. Over the LAST 12 MONTHS, did you take any iron supplements other than your multivitamins on a regular basis (at least once a week)?

☐ ~~Yes~~
☐ No
☐ Don't know

How often did you take iron supplements?

☐ Everyday
☐ 4 to 6 days per week
☐ 1 to 3 days per week
☐ Don't know

AFFIX LABEL WITH ID HERE

14. Do you currently take Aspirin or Aspirin containing pain relievers daily or nearly everyday?

- ☐ Yes → **Why?**
  - ☐ For heart or cardiac health
  - ☐ For pain relief
  - ☐ For both
- ☐ No
- ☐ Don't Know

{MALE DONORS SKIP SECTION E AND GO TO END STATEMENT}

SECTION E
FOR FEMALE DONORS ONLY
Your reproductive history:

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15. Which of these statements best describes your current menstrual status?

- ☐ I am still having periods and am NOT going through menopause
- ☐ I am still having periods, but am possibly going through menopause
- ☐ My periods have stopped completely because I have gone through menopause **{SKIP TO QUESTION 19}**
- ☐ I had an operation which stopped my periods **{SKIP TO QUESTION 19}**
- ☐ I am taking a medication that has stopped my periods completely **{SKIP TO QUESTION 19}**
- ☐ My periods have stopped because of other reasons **{SKIP TO QUESTION 19}**

16. What was the date when your last menstrual period started?

|___|___| |___|___|
M M Y Y
ENTER DATE OF LAST PERIOD

- ☐ I am having my period now

17. About how many periods did you have in the last year (12 Months)?

|___|___|
ENTER NUMBER OF PERIODS

18. How would you describe your menstrual flow or bleeding?

- ☐ **Spotting**, a drop or two of blood, not even requiring sanitary protection though you may prefer to use some.
- ☐ **Very light bleeding** (you would need to change the least absorbent tampon or pad one or two times per day, though you may prefer to change more frequently)
- ☐ **Light bleeding** (you would need to change a low or regular absorbency tampon or pad two or three times per day, though you may prefer to change more frequently)
- ☐ **Moderate bleeding** (you would need to change a regular absorbency tampon or pad every 3 to 4 hours, though you may prefer to change more frequently)
- ☐ **Heavy bleeding** (you would need to change a high absorbency tampon or pad every 3 to 4 hours, though you may prefer to change more frequently)
- ☐ **Very heavy bleeding or gushing** (protection hardly works at all; you would need to change the highest absorbency tampon or pad every hour or two)

The next few questions are about your pregnancy history. This information is very important to this study because it will help improve the health of all women. So please take whatever time you need to answer them as accurately and completely as possible.

AFFIX LABEL WITH ID HERE

19. Have you ever been pregnant? Please include live births, miscarriages, still births, tubal pregnancies and abortions.

- ☐ Yes
- ☐ No **{SKIP TO END STATEMENT}**
- ☐ Don't know

20. How many times have you been pregnant in your life? Again, be sure to include live births, miscarriages, still births, tubal pregnancies and abortions.

|___|___|
ENTER NUMBER OF PREGNANCIES

☐ Don't know

21. How many of your pregnancies resulted in a live birth? Please count the number of pregnancies, not number of live-born children. For example, if you had twins or other multiple births, count as a single pregnancy.

|___|___|
ENTER NUMBER OF PREGNANCIES RESULTING IN LIVE BIRTHS

☐ No live births **{SKIP TO END STATEMENT}**

22. When was your last baby born?

|___|___| |___|___|
M M Y Y

END STATEMENT

The survey is now complete. We appreciate you taking the time to complete this survey. Your responses have provided us with valuable information. THANK YOU!

AFFIX LABEL WITH ID HERE

Donor Iron Status Follow-up Survey

Thank you for your continued participation in the Donor Iron Status Survey sponsored by the National Heart, Lung, and Blood Institute of the National Institutes of Health (NIH).This follow-up survey will ask you questions about any changes in your smoking history, vitamins and supplements that you take and if you are female, a few questions on your reproductive history. Your answers to all questions will be kept confidential and only be used for the purpose of this research.

Your continued participation is extremely important and will help us better understand iron status in blood donors. Your participation in this survey is voluntary. If you choose not to participate, it will not affect your ability to donate blood again in the future. You will not lose any benefits.

Name: .....

First Name Middle Name Last Name

Today's Date: ____ ____ - ____ ____ - ____ ____
Month Day Year

Blood Center ID: .....

Whole Blood Number (WBN): .....

AFFIX LABEL WITH ID HERE

Sponsored by
National Heart Lung and Blood Institute
National Institutes of Health (NIH)

SECTION A
Your smoking history:

1. SINCE THE SUMMER OF 2007, WHEN YOU ENROLLED IN THIS STUDY, have you started smoking, stopped smoking, continued to smoke, or still do not smoke? PLEASE CHECK ONE BOX

- ☐ I started smoking →
- ☐ I stopped smoking
- ☐ I have continued to smoke →
- ☐ I still do not smoke

Thinking about the last 30 DAYS (1 month), on how many of these days did you smoke?

|___|___|
NUMBER OF DAYS

☐ Don't know

In the LAST 30 DAYS, on the days that you DID smoke, about how many cigarettes did you usually smoke per day?

|___|___|
NUMBER OF CIGARETTES

☐ Don't know

SECTION B
Your use of vitamin pills, supplements and aspirin:

2. ARE YOU CURRENTLY TAKING any multivitamins such as One-A-Day, Theragran, or Centrum type multivitamins (as pills, liquids, or packets) on a regular basis (at least once a week)?

☐ Yes
☐ No
☐ Don't know

When did you start?

|___|___| |___|___|
M M Y Y

How often do you take multivitamins?

☐ Everyday
☐ 4 to 6 days per week
☐ 1 to 3 days per week
☐ Don't know

Does your multivitamin contain iron?

☐ Yes
☐ No
☐ Don't Know

3. ARE YOU CURRENTLY TAKING any iron supplements other than your multivitamins on a regular basis (at least once a week)?

☐ Yes
☐ No
☐ Don't know

When did you start?

|___|___| |___|___|
M M Y Y

How often do you take iron supplements?

☐ Everyday
☐ 4 to 6 days per week
☐ 1 to 3 days per week
☐ Don't know

4. Do you currently take Aspirin or Aspirin containing pain relievers daily or nearly everyday?

☐ Yes
☐ No
☐ Don't Know

Why?

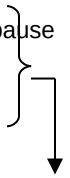
☐ For heart or cardiac health
☐ For pain relief
☐ For both

{MALE DONORS SKIP SECTION C AND GO TO END STATEMENT}

SECTION C
FOR FEMALE DONORS ONLY
Your reproductive history:

5. Which of these statements best describes your current menstrual status?

- ☐ I am still having periods and am NOT going through menopause
- ☐ I am still having periods, but am possibly going through menopause
- ☐ My periods have stopped completely because I have gone through menopause
- ☐ I had an operation which stopped my periods
- ☐ I am taking a medication that has stopped my periods completely
- ☐ My periods have stopped because of other reasons



When did you stop having your menstrual period?

|___|___| |___|___|
M M Y Y

ENTER DATE OF LAST PERIOD AND THEN PLEASE SKIP TO QUESTION 8

6. What was the date when your last menstrual period started?

|___|___| |___|___|
M M Y Y
ENTER DATE OF LAST PERIOD

☐ I am having my period now

7. How would you describe your MOST RECENT menstrual flow or bleeding?

- ☐ **Spotting**, a drop or two of blood, not even requiring sanitary protection though you may prefer to use some.
- ☐ **Very light bleeding** (you would need to change the least absorbent tampon or pad one or two times per day, though you may prefer to change more frequently)
- ☐ **Light bleeding** (you would need to change a low or regular absorbency tampon or pad two or three times per day, though you may prefer to change more frequently)
- ☐ **Moderate bleeding** (you would need to change a regular absorbency tampon or pad every 3 to 4 hours, though you may prefer to change more frequently)
- ☐ **Heavy bleeding** (you would need to change a high absorbency tampon or pad every 3 to 4 hours, though you may prefer to change more frequently)
- ☐ **Very heavy bleeding or gushing** (protection hardly works at all; you would need to change the highest absorbency tampon or pad every hour or two)

AFFIX LABEL WITH ID HERE

8. SINCE THE SUMMER OF 2007, WHEN YOU ENROLLED IN THIS STUDY, have you given birth to a baby?

☐ Yes

☐ No

When was this baby born?

|___|___| |___|___|
M M Y Y

END STATEMENT

The follow-up survey is now complete. We appreciate you taking the time to complete this survey. Your responses have provided us with valuable information. THANK YOU!

AFFIX LABEL WITH ID HERE