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HIV risk factor questionnaire (English Translation)

RECIPIENT EPIDEMIOLOGY AND DONOR EVALUATION STUDY-III (REDS-III)
HIV RISK FACTOR QUESTIONNAIRE

Date: __/__/____ (D D/ M M / Y Y Y Y)

Study identification number: __ - _____ - __

RETROVIRUS EPIDEMIOLOGY DONOR STUDY-III (REDS-III)

HIV RISK FACTOR QUESTIONNAIRE

Date: ___/___/___ (D D/ M M / Y Y Y Y)

Study identification number: ___ - _____ - ___

Instructions: Please answer each of the following questions about your health, lifestyle, and blood donation history. For each question, provide a response unless directed to skip to another question further down in the questionnaire. It will take approximately 20 minutes to complete these questions.

A. Your Background

1. When were you born?	___ ___ ___ (year)
2. What is your gender?	<input type="checkbox"/> Female <input type="checkbox"/> Male
3. What is your place of birth?	Province: _____ City: _____ County: _____
4. What is your ethnicity?	<input type="checkbox"/> Han <input type="checkbox"/> Hui <input type="checkbox"/> Uygur <input type="checkbox"/> Man <input type="checkbox"/> Dai <input type="checkbox"/> Zhuang <input type="checkbox"/> Other, specify _____
5. What is your current occupation?	<input type="checkbox"/> Worker <input type="checkbox"/> Farmer who works at hometown <input type="checkbox"/> Farmer or worker working out of town <input type="checkbox"/> Service or business <input type="checkbox"/> Education/research/government

<p>5a. Have you ever provided special services at entertainment business (including night clubs, private clubs, night bar, Karaoke clubs)?</p>	<input type="checkbox"/> Military/Police <input type="checkbox"/> Medicine/Health care <input type="checkbox"/> Student <input type="checkbox"/> Company employee <input type="checkbox"/> Self-employed <input type="checkbox"/> Other, specify _____ <input type="checkbox"/> Yes (please describe) _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown
<p>6. What is the highest level of education you have received?</p>	<input type="checkbox"/> Primary school or less <input type="checkbox"/> Junior high school <input type="checkbox"/> High School or vocational school <input type="checkbox"/> Associate degree <input type="checkbox"/> Bachelor's degree <input type="checkbox"/> Graduate level degree <input type="checkbox"/> Other, specify _____
<p>7. What is your marital status?</p>	<input type="checkbox"/> Never married <input type="checkbox"/> Married or co-habiting <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Other, specify _____

B. History of Blood Donation & Infection Risks

8. How many times have you donated blood?
 ___ time (s) → ANSWER QUESTION 8a-8c

Please list the most recent three blood donations indicating the year and type of blood donation for each. (If you have donated blood more than 3 times, please list the most recent three):

Donation	Year	Type of Donation
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8a. Most recent donation	___ _ _ _ _	<input type="checkbox"/> Whole blood donation <input type="checkbox"/> Apheresis donation
8b. Next most recent donation	___ _ _ _ _	<input type="checkbox"/> Whole blood donation <input type="checkbox"/> Apheresis donation
8c. Next most recent donation	___ _ _ _ _	<input type="checkbox"/> Whole blood donation <input type="checkbox"/> Apheresis donation

9. How much do you agree or disagree with each of the statements (9a-9c) below:

Statement	Do not agree at all	Disagree a little	Agree a little	Agree very much
9a. It's important that I received blood test results from blood donation.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9b. I think blood donation is a good, fast, anonymous way to get my blood test result.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9c. One of my reasons for donating blood is to find out if I have HIV and/or hepatitis infection.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. Have you ever been told that you are at risk for spreading diseases through your blood?	<input type="checkbox"/> Yes → ANSWER QUESTION 10a <input type="checkbox"/> No → Skip to Q11 <input type="checkbox"/> Unknown → Skip to Q11
10a. What kind of diseases? (Mark all that apply)	<input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C <input type="checkbox"/> Syphilis/Gonorrhea <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Other, specify _____ <input type="checkbox"/> Unknown
10b. When was the last time you were told so?	<input type="checkbox"/> Within 3 days up to 1 month <input type="checkbox"/> Within 1-3 months <input type="checkbox"/> Within 3-6 months <input type="checkbox"/> From 6 months to less than 1 year <input type="checkbox"/> 1 year ago

	<input type="checkbox"/> Unknown
11. Did you ever receive notification from blood center about your infection status?	<input type="checkbox"/> Yes→ANSWER QUESTION 11a-11c <input type="checkbox"/> No →Skip to Q12 <input type="checkbox"/> Unknown→Skip to Q12
11a. Before your most recent donation, had you ever received notification from blood center about your infection status (excluding any such notification after your most recent blood donation)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
11b. Had you sought further testing or health care according to the instruction of the notification (excluding any such notification after your most recent blood donation)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
11c. Are you planning to seek further testing or health care according to the instruction of the notification?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
12. Before your most recent donation, had you ever been permanently deferred as a blood donor?	<input type="checkbox"/> Yes→ANSWER QUESTION 12a <input type="checkbox"/> No→SKIP TO 13 <input type="checkbox"/> Unknown→SKIP TO 13
12a. For what reason were you permanently deferred?(Mark all that apply)	<input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C <input type="checkbox"/> Syphilis <input type="checkbox"/> HIV <input type="checkbox"/> Didn't pass Physical Exam, specify _____ <input type="checkbox"/> Didn't pass blood Test, specify _____ <input type="checkbox"/> Other, specify _____
13. Before your most recent donation, had you ever been temporarily deferred as a blood donor?	<input type="checkbox"/> Yes→ANSWER QUESTION 13a <input type="checkbox"/> No→SKIP to Q 14 <input type="checkbox"/> Unknown→SKIP to Q14
13a. For what ineligibility were you temporarily	<input type="checkbox"/> HBV rapid test

deferred?(Mark all that apply)	<input type="checkbox"/> ALT <input type="checkbox"/> Hemoglobin (Hb) level <input type="checkbox"/> Blood pressure <input type="checkbox"/> Heart rate <input type="checkbox"/> Body Weight <input type="checkbox"/> Fasting <input type="checkbox"/> Other, specify _____
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C. Health Condition History

<p>14. Have you ever received acupuncture treatment?</p> <p>14a. In the past 6 months, did you have acupuncture?</p>	<input type="checkbox"/> Yes → ANSWER QUESTION 14a <input type="checkbox"/> No → SKIP TO 15 <input type="checkbox"/> Unknown → SKIP TO 15 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<p>15. In the past 6 months, did you have any injection (including intravenous [IV] and intramuscular [IM] injections)?</p> <p>15a. How many times did you have injection(s)?</p>	<input type="checkbox"/> Yes → ANSWER QUESTION 15a <input type="checkbox"/> No → SKIP TO 16 <input type="checkbox"/> Unknown → SKIP TO 16 <p>___ times</p>
<p>16. Have you had any finger sticks (excluding the one prior to making a donation)?</p> <p>16a. In the past 6 months, did you have finger sticks (other than the one prior to making a donation)?</p>	<input type="checkbox"/> Yes → ANSWER QUESTION 16a <input type="checkbox"/> No → SKIP TO 17 <input type="checkbox"/> Unknown → SKIP TO 17 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

17. When you had acupuncture, finger sticks, or injections, were needles and syringes used disposable?

Were needles and syringes used disposable?	Seldom	Sometimes	Often	Always	Unknown
a. Acupuncture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Finger sticks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Injections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<p>18. In the past 6 months, have you ever visited the following medical facilities?(Mark all that apply)</p> <p style="margin-top: 20px;">18a. What kind of treatment did you receive from the above medical facilities?(Mark all that apply)</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Yes, county hospital→ANSWER QUESTION 18a <input type="checkbox"/> Yes, town hospital→ANSWER QUESTION 18a <input type="checkbox"/> Yes, community hospital→ANSWER QUESTION 18a <input type="checkbox"/> Yes, village clinic→ANSWER QUESTION 18a <input type="checkbox"/> Yes, private outpatient clinic→ANSWER QUESTION 18a <input type="checkbox"/> Yes, other, please specify→ANSWER QUESTION 18a <input type="checkbox"/> No →SKIP TO 19 <input type="checkbox"/> Unknown→SKIP TO 19 <ul style="list-style-type: none"> <input type="checkbox"/> Intravenous (IV) or intramuscular (IM)injection <input type="checkbox"/> Therapeutic transfusion <input type="checkbox"/> Outpatient surgeries (including anesthesia, removal of sebaceous cyst, wound suture etc.) <input type="checkbox"/> Dental care <input type="checkbox"/> Pediatrician visit or accompany for someone else <input type="checkbox"/> Other, please specify _____
<p>19. Have you ever had in-patient medical surgery?</p> <p style="margin-top: 20px;">19a. In the past 6 months, did you have in-patient medical surgery?</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Yes→ANSWER QUESTION 19a <input type="checkbox"/> No→SKIP TO 20 <input type="checkbox"/> Unknown→SKIP TO 20 <ul style="list-style-type: none"> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

<p>20. Have you ever had out-patient medical surgery?</p> <p>20a. In the past 6 months, did you have out-patient medical surgery?</p>	<p><input type="checkbox"/> Yes → ANSWER QUESTION 20a <input type="checkbox"/> No → SKIP TO 21 <input type="checkbox"/> Unknown → SKIP TO 21</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>
<p>21. Have you ever had cosmetic surgery (e.g. laser, eye/lip surgery, collagen injection, dermal abrasion)?</p> <p>21a. In the past 6 months, did you have cosmetic surgery?</p>	<p><input type="checkbox"/> Yes → ANSWER QUESTION 21a <input type="checkbox"/> No → SKIP TO 22 <input type="checkbox"/> Unknown → SKIP TO 22</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>
<p>22. Have you ever received a blood transfusion?</p> <p>22a. How many times did you have blood transfusions?</p> <p>22b. Year of your first time of blood transfusion?</p> <p>22c. Year of your last time of blood transfusion?</p>	<p><input type="checkbox"/> Yes → ANSWER 22a-22c <input type="checkbox"/> No → SKIP TO 23 <input type="checkbox"/> Unknown → SKIP TO 23</p> <p>__ __ times</p> <p>__ __ __ __ (year)</p> <p>__ __ __ __ (year)</p>
<p>23. Have you ever had any dental cleaning?</p> <p>23a. In the past 6 months, did you have dental cleaning?</p>	<p><input type="checkbox"/> Yes → ANSWER QUESTION 23a <input type="checkbox"/> No → SKIP TO 24 <input type="checkbox"/> Unknown → SKIP TO 24</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>

<p>24. Have you ever had any dental surgery, such as root canal treatment or tooth extraction?</p> <p>24a. In the past 6 months, did you have dental surgeries?</p>	<p><input type="checkbox"/> Yes→ANSWER QUESTION 24a <input type="checkbox"/> No→SKIP TO 25 <input type="checkbox"/> Unknown→SKIP TO 25</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>
<p>25. Have you ever had any endoscopy (such as gastroscopy and colonoscopy)?</p> <p>25a. In the past 6 months, did you have endoscopies?</p>	<p><input type="checkbox"/> Yes→ANSWER QUESTION 25a <input type="checkbox"/> No→SKIP TO 26 <input type="checkbox"/> Unknown→SKIP TO 26</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>
<p>26. Have you ever been previously diagnosed with hepatitis?</p> <p>26a. What type(s) of hepatitis did you have (please choose all that apply)?</p>	<p><input type="checkbox"/> Yes→ANSWER QUESTION 26a <input type="checkbox"/> No→SKIP TO 27 <input type="checkbox"/> Unknown→SKIP TO 27</p> <p><input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C <input type="checkbox"/> Other, specify _____ <input type="checkbox"/> Unknown</p>
<p>27. Have you ever been previously diagnosed with syphilis, gonorrhoea, or any other sexually transmitted disease?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>
<p>28. Have any of your family members had hepatitis?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown?</p>
<p>29. Have any of your family members had HIV/AIDS?</p>	<p><input type="checkbox"/> Yes</p>

	<input type="checkbox"/> No <input type="checkbox"/> Unknown
<p>30. Have you ever had household contact with someone with HIV/AIDS?</p> <p>30a. In the past 6 months, did you have household contact with someone with HIV/AIDS?</p>	<input type="checkbox"/> Yes → ANSWER QUESTION 30a <input type="checkbox"/> No → SKIP TO 31 <input type="checkbox"/> Unknown → SKIP TO 31 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

D. Drug Use History

<p>31. Have you ever used needles to shoot (or take) street drugs?</p> <p>31a. How long have you shot (or taken) street drugs?</p> <p>31b. How many times per month did you shoot (or take) street drugs?</p> <p>31c. Have you ever shared needles or syringes with others to inject street drugs?</p> <p>31d. In the past 6 months, did you ever use needles to shoot (or take) street drugs?</p>	<input type="checkbox"/> Yes → ANSWER QUESTIONS 31a-31d <input type="checkbox"/> No → SKIP TO 32 <input type="checkbox"/> Unknown → SKIP TO 32 ___ __ years ___ __ times/month <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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<p>32. Have you ever used illegal oral or intranasal drugs without doctor's prescription?</p> <p>32a. In the past 6 months, did you use illegal oral or intranasal drugs without doctor's prescription</p>	<p><input type="checkbox"/> Yes→ANSWER QUESTION 32a</p> <p><input type="checkbox"/> No→SKIP TO 33</p> <p><input type="checkbox"/> Unknown→SKIP TO 33</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Unknown</p>
<p>33. Have you ever lived with a person who was an intravenous drug user?</p> <p>3a. In the past 6 months, did you live with a person who was an intravenous drug user?</p>	<p><input type="checkbox"/> Yes→ANSWER QUESTION 33a</p> <p><input type="checkbox"/> No→SKIP TO 34</p> <p><input type="checkbox"/> Unknown→SKIP TO 34</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Unknown</p>
<p>34. Are any of your close friends or family member's intravenous drug users?</p>	<p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Unknown</p>

E. Sexual History

The next section of questions will ask you about your sexual experiences. In these questions, include only those people you have had oral, vaginal, or anal sex with. *Do not include people that you have just kissed.* Please note that for the next few questions the term "sex" refers to any of the following activities, whether or not a condom or other protection was used: Vaginal sex (contact between penis and vagina), Oral sex (mouth or tongue on someone's vagina, penis, or anus), Anal sex (contact between penis and anus).

<p>35. Have you had more than 2 concurrent sexual partners of the opposite sex?</p>	<p><input type="checkbox"/> Yes→ANSWER QUESTIONS35a1-35b2</p> <p><input type="checkbox"/> No→SKIP TO 36</p> <p><input type="checkbox"/> Unknown→SKIP TO 36</p>
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<p>35a1. In your lifetime, how many heterosexual partners did you have?</p> <p>35a2. In the past 6 months, how many heterosexual partners did you have?</p> <p>35b1. How often do you or your sex partner use a condom when you have sex with your heterosexual partner?</p> <p>35b2. In the past 6 months, how often do you or your sex partner use a condom when you have sex with your heterosexual partner?</p>	<p><input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5-7 <input type="checkbox"/> 8-10 <input type="checkbox"/> >10</p> <p><input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5-7 <input type="checkbox"/> 8-10 <input type="checkbox"/> >10</p> <p><input type="checkbox"/> Never <input type="checkbox"/> Sometimes <input type="checkbox"/> Half of time <input type="checkbox"/> Most of time <input type="checkbox"/> Always</p> <p><input type="checkbox"/> Never <input type="checkbox"/> Sometimes <input type="checkbox"/> Half of time <input type="checkbox"/> Most of time <input type="checkbox"/> Always</p>
<p>36. (FOR MALE RESPONDENTS ONLY) In your lifetime, have you ever had sex with another male?</p> <p>36a1. In your lifetime, how many times did you have sex with males?</p>	<p><input type="checkbox"/> Yes→ANSWERQUESTIONS 36a1-36b3 <input type="checkbox"/> No→SKIP TO 37 <input type="checkbox"/> Unknown→SKIP TO 37</p> <p><input type="checkbox"/> 1-2 <input type="checkbox"/> 3-5 <input type="checkbox"/> 6-10 <input type="checkbox"/> >10</p>

<p>36a2. In your lifetime, how many male partners have you had sex with?</p> <p>36a3. In your lifetime, how often do you or your sex partner use a condom when you have sex with male partner?</p> <p>36b1. In the past 6 months, how many times did you have sex with males?</p> <p>36b2. In the past 6 months, how many male partners have you had sex with?</p> <p>36b3. In the past 6 months, how often do you or your sex partner use a condom when you have sex with male partner?</p>	<p><input type="checkbox"/> 1-2 <input type="checkbox"/> 3-5 <input type="checkbox"/> 6-10 <input type="checkbox"/> >10</p> <p><input type="checkbox"/> Never <input type="checkbox"/> Sometimes <input type="checkbox"/> Half of time <input type="checkbox"/> Most of time <input type="checkbox"/> Always</p> <p><input type="checkbox"/> 1-2 <input type="checkbox"/> 3-5 <input type="checkbox"/> 6-10 <input type="checkbox"/> >10</p> <p><input type="checkbox"/> 1-2 <input type="checkbox"/> 3-5 <input type="checkbox"/> 6-10 <input type="checkbox"/> >10</p> <p><input type="checkbox"/> Never <input type="checkbox"/> Sometimes <input type="checkbox"/> Half of time <input type="checkbox"/> Most of time <input type="checkbox"/> Always</p>
<p>37. Have you ever paid or received money or other forms of remuneration for having sex?</p> <p>37a. In the past 6 months, have you paid or received</p>	<p><input type="checkbox"/> Yes → ANSWER QUESTIONS 37a <input type="checkbox"/> No → SKIP TO 38 <input type="checkbox"/> Unknown → SKIP TO 38</p> <p><input type="checkbox"/> Yes</p>

<p>money or other forms of remuneration for having sex?</p>	<p><input type="checkbox"/> No <input type="checkbox"/> Unknown</p>
<p>38. Have you ever had a sex partner who was an intravenous drug user?</p> <p>38a. In the past 6 months, did you have a sex partner who was an intravenous drug user?</p>	<p><input type="checkbox"/> Yes→ANSWER QUESTION 38a <input type="checkbox"/> No→SKIP TO 39 <input type="checkbox"/> Unknown→SKIP TO 39</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>
<p>39. In your lifetime, have you ever had a sex partner who had a positive test for syphilis, gonorrhea, or any other sexually transmitted disease?</p> <p>39a. In the past 6 months, did you have a sex partner who had a positive test for syphilis, gonorrhea, or any other sexually transmitted disease?</p>	<p><input type="checkbox"/> Yes→ANSWER QUESTION 39a <input type="checkbox"/> No→SKIP TO 40 <input type="checkbox"/> Unknown→SKIP TO 40</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>
<p>40. In your lifetime, have you ever had a sex partner who had been diagnosed with HIV/AIDS?</p> <p>40a. In the past 6 months, did you have a sex partner who had been diagnosed with HIV/AIDS?</p>	<p><input type="checkbox"/> Yes→ANSWER QUESTION 40a <input type="checkbox"/> No→SKIP TO 41 <input type="checkbox"/> Unknown→SKIP TO 41</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>
<p>41. In your lifetime, have you had sexual contact with anyone who received blood transfusion?</p> <p>41a. In the past 6 months, did you have sexual contact with anyone who received blood transfusion?</p>	<p><input type="checkbox"/> Yes→ANSWER QUESTION 41a <input type="checkbox"/> No→SKIP TO 42 <input type="checkbox"/> Unknown→SKIP TO 42</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>

F. Other Risk Factors

<p>42. Have you ever had contact with human blood and other human body fluids in your workplace?</p> <p>42a. In the past 6 months did you ever have contact with human blood and other human body fluids in your workplace?</p>	<p><input type="checkbox"/> Yes → ANSWER QUESTION 42a <input type="checkbox"/> No → SKIP TO 43 <input type="checkbox"/> Unknown → SKIP TO 43</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>
<p>43. Have you ever had a tattoo?</p> <p>43a. In the past 6 months, did you have a tattoo?</p>	<p><input type="checkbox"/> Yes → ANSWER QUESTION 43a <input type="checkbox"/> No → SKIP TO 44 <input type="checkbox"/> Unknown → SKIP TO 44</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>
<p>44. Have you ever had your ears or other body parts pierced?</p> <p>44a. In the past 6 months, did you have your ears or other body parts pierced?</p>	<p><input type="checkbox"/> Yes → ANSWER QUESTION 44a <input type="checkbox"/> No → END <input type="checkbox"/> Unknown → END</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>

Thank you very much for your participation!
Thank you for your contribution to our blood safety research!

