ALLERGY SURVEY

Bleed Label (DIN) _____

First: _____ Last: _____ MI: ____ Suffix: ____ Birthdate: ___/___/____

Address: _____ Phone: _____ Gender: M ___ F ____

Ethnic Background: __Caucasian __African American __Hispanic __ Asian __Other: _____

GENERAL	N/A	Yes	No	Symptoms/Reactions
What is your Occupation?				
Number of years in Occupation:				
Please list all states and or countries that you have lived in:				
When did your allergic condition begin?				
Do you receive allergy shots?	☐	☐	☐	
When were you on allergy shots?	☐			
How long were you on allergy shots?	☐			
What allergens were contained in the vaccine?	☐			
Do you carry an EpiPen?	☐	☐	☐	
Have you had a severe reaction to penicillin?	☐	☐	☐	
Are you allergic to any other drugs? Please describe:	☐	☐	☐	
Do you have Eczema?	☐	☐	☐	
Do you have Hives? Please Describe: (optional)	☐	☐	☐	
Do you have trouble with your eyes? Please Describe: (optional)	☐	☐	☐	
Do you have trouble with your nose? Please Describe: (optional)	☐	☐	☐	
Do you have trouble with your chest (wheezing)? Please Describe: (optional)	☐	☐	☐	
Do you have problems when you come in contact with latex?	☐	☐	☐	
Do you work around animals?	☐	☐	☐	
Any other general allergic conditions?				
Any other comments?				
List any medications you are currently taking:				

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CANNABIS AND RELATED PRODUCTS	Yes	No	Symptoms/Reactions/Comments
Any reaction or symptoms when exposed to cannabis?	☐	☐	
What were you doing when reaction occurred?	Describe Reaction/Symptoms:		
What Kind of Cannabis material do you have reaction to? Mark all that applies and explain as needed.	☐ Leaves/Buds ☐Seeds ☐Pollen ☐Oil ☐Smoke ☐Other (describe): _____		
Reaction to **Fresh** Leaves/buds?	☐	☐	
Reaction to **Dry** Leaves/buds?	☐	☐	
Reaction to pollen?	☐	☐	
Reaction to Smoke?	☐	☐	
Reaction to Other products?	☐	☐	
Any other Comments?			
Date of Last Exposure with reaction:			

ANY SYMPTOMS WITHEXPOSURE TO:	Yes	No	Describe Symptoms/Reactions
Hay, Circus	☐	☐	
Mowing Lawn	☐	☐	
Dusty Environment	☐	☐	
High Air Pollution	☐	☐	
Animals	☐	☐	
Cooking Odors	☐	☐	
Insecticides	☐	☐	
Paint Fumes	☐	☐	
Wool	☐	☐	
Road Dust	☐	☐	
Any Other Environmental Symptoms?	☐	☐	
Any Other Comments?	☐	☐	

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ANIMALS	Yes	No	Symptoms/Reactions
Cat	☐	☐	
Dog	☐	☐	
Horse	☐	☐	
Cow	☐	☐	
Guinea Pig	☐	☐	
Hamster	☐	☐	
Rabbit	☐	☐	
Duck	☐	☐	
Chicken	☐	☐	
Pigeon	☐	☐	
Parrot	☐	☐	
Any Other Animal Allergies?	☐	☐	
Any Other Comments?	☐	☐	

FOODS	Yes	No	Symptoms/Reactions
Cheese	☐	☐	
Mushrooms	☐	☐	
Coffee and/or Tea	☐	☐	
Fruit	☐	☐	
Vegetables	☐	☐	
Spices	☐	☐	
Milk and/or Milk Products	☐	☐	
Eggs	☐	☐	
Wheat Products	☐	☐	
Seeds	☐	☐	
Chocolate	☐	☐	
Alcoholic Beverages/Wine/Beer	☐	☐	
Any Other Food Allergies?	☐	☐	
Any Other Comments	☐	☐	
Tree Nuts (Almonds, Walnuts, etc.)	☐	☐	
Peanut	☐	☐	
Soybeans, Beans, Peas, Other Legumes	☐	☐	

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INSECTS	Yes	No	Symptoms/Reactions
Fire Ants	☐	☐	
Mosquito	☐	☐	
Cockroach	☐	☐	
Honeybee	☐	☐	
Yellow Jacket	☐	☐	
Paper Wasp	☐	☐	
Yellow Hornet	☐	☐	
Any Other Insect Allergies?	☐	☐	
Any other Comments?			
Date of Last Sting:			

CONSENT FOR BLOOD DRAW (VENIPUNCTURE) AND TESTING: Blood is generally obtained from a vein in the arm (near the crease where the elbow bends). The skin over the vein is cleaned with alcohol. A sterile needle is inserted into the vein and few tubes of blood is withdrawn. The needle is withdrawn, and light pressure will be applied with cotton over the puncture site for a few minutes until any bleeding or oozing ceases. There is usually some minimal pain associated with having a blood sample taken. Although rare, bleeding, bruising, vasovagal reaction, and infection can occur. These potential problems can be minimized by proper preparation for blood draw and appropriate after care. In the unlikely event that I experience an adverse event (medical problem) related or unrelated to the blood draw, I give permission to the collection staff and to administer necessary treatment for my benefit, as determined by their best judgment.

I certify that I have read and understand this consent and that all my questions have been answered to my satisfaction. I acknowledge that the information and answers to questions I provided are true to the best of my knowledge. I understand and give consent to Plasmalab International to test and use my laboratory results and demographic data for research and development purposes and possible publication. I understand the full extent of research is not always known. My personal identification information will remain confidential and never be used for publication.

I give consent to test my blood/plasma samples as necessary to determine if I qualify for any specialty plasma donation programs and to test, use or dispose of remaining samples as needed by Plasmalab and its affiliated lab partner(s). I understand that the allergy tests performed are for screening purposes only, not diagnostic testing. I consent to appropriate communications (call, email, or text) from Plasmalab regarding my test results and follow up as needed.

NOTE: Your allergy testing results will be available in approximately 5-6 weeks. To obtain your test results, you must sign consent for release of test results that is available at the time of collection or by contacting Plasmalab at 425-258-3653.

Potential Donor Signature of Acknowledgment: _____
Date: _____

STAFF USE ONLY

Arm Used: L R

I confirm that the same unique Bleed Label has been applied to collected samples from the donor and this form!
_____Date_____
Technician Signature/date
