



**COAGULOPATHY WORK-UP  
PATIENT QUESTIONNAIRE**  
FAX Completed Forms to: (918) 744-3236



Patient Name: _____	
Date of Birth: _____	Sex: _____ Soc. Security#: _____
Diagnosis: _____	
Ordering Physician: _____	Physician Phone#: _____

**PATIENT HISTORY**

YES   NO

     **Are you Fasting?**

YES   NO   **Have you ever had any of the following:**

     Have you ever had a Blood Clot?

     If yes, have you had more than one episode?

Please Describe all Episodes (eg. Date, Location, age):

     Onset before age 45?

     Occur following surgery?

     Occur following pregnancy?

     Occur after prolonged immobilization?

     A Heart Attack (MI)?

     A Stroke?

     Neurological disease (disorder of the brain)?

If yes, please describe:

     Autoimmune disease (eg. Lupus, rheumatoid arthritis)?

If yes, please describe:

     Family history of a blood clot at a young age (younger than 45)?

     Family history of a heart attack or stroke at a young age?

     Personal history of cancer?

If yes, Please provide details (eg. Date, age, location, type ets...):

     Diabetes?

     Heart failure?

     Recurrent miscarriages?

YES   NO   **Are you now taking:**

     Estrogen replacement or oral contraceptives?

     Coumadin?

     Heparin?

     Other anticoagulant (Blood Thinner)?

     If so, please list: