



**COAGULOPATHY WORK-UP
PATIENT QUESTIONNAIRE**
FAX Completed Forms to: (918) 744-2885



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: