COAGULOPATHY WORK-UP
PATIENT QUESTIONNAIRE

FAX Completed Forms to: (918) 744-2885

Patient Name: _____

Date of Birth: _____ **Sex:** ____ **MRN#:** _____

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: