


Medical History for Examinations of the Coagulation of the Blood in the Case of Disposition to Bleeding

Dear patient,

we are pleased to welcome you in our practice. We are happy to give you advice in all questions about blood coagulation and to help you to stay healthy or to recover health.

To determine the best diagnostics, recommendations or therapy for you we need your help. Please take the time to answer the following questions. If a question isn't clear, please leave it unanswered. One of our doctors will help you later on to answer it.

Of course all data will be handled strictly confidential and won't be passed to anyone without your consent.

<p>Personal data:</p> <p>Family name, forename:</p> <p>Street, location:</p> <p>Date of birth: Body weight: kg Body height: cm</p> <p>Phone No. (voluntary statement):</p> <p>I agree that the referring doctor as well as all doctors involved in my treatment will receive a report:</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>	
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Family History:

1. Does any family member have bleeding tendencies? (parents, grandparents, siblings)

- No
- Yes

If so, which one.....

Patient's History:

2. Do you suffer from bleeding (without any reason)?

- No
- Yes

Please turn over →

3. Do you suffer from one of the following diseases?

- Bleeding disorder

If so, which one.....

- | | |
|---|---|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Migraine without aura |
| <input type="checkbox"/> Dislipidemia | <input type="checkbox"/> Dysfunction of the liver |
| <input type="checkbox"/> Migraine with aura
(e.g. impaired vision) | <input type="checkbox"/> Dysfunction of the kidneys |

4. Do you take any medicine?

- No
- Yes

If so, which ones

- | | |
|---|--|
| <input type="checkbox"/> Hormonal contraception
(contraceptive pill) | <input type="checkbox"/> Xarelto® (Rivaroxaban) |
| <input type="checkbox"/> Low-molecular weight heparin
(LMWH) | <input type="checkbox"/> Eliquis® (Apixaban) |
| <input type="checkbox"/> Orgaran® (Danaparoid) | <input type="checkbox"/> Pradaxa® (Dabigatran) |
| <input type="checkbox"/> Argatra® (Argatroban) | <input type="checkbox"/> ASA (Acetyl salicylic acid) |
| <input type="checkbox"/> Arixtra® (Fondaparinux) | <input type="checkbox"/> Plavix® (Clopidogrel) |
| <input type="checkbox"/> Marcumar®/Coumadin®/Warfarin® | <input type="checkbox"/> Brilique® (Ticagrelor) |
| | <input type="checkbox"/> Efient® (Prasugrel) |
| | <input type="checkbox"/> Other medication: |

Dosage:.....

5. Do you smoke?

- No
- Yes

If so, how many cigarettes a day:.....

Thank you for your cooperation!

.....
Date

.....
Signature
(Parent, legal guardian or custodian)