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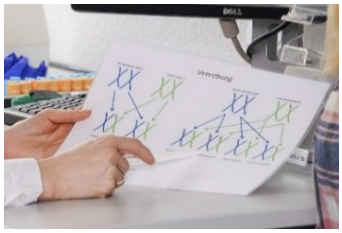
Medical History for Examinations of the Coagulation of the Blood in the Case of Disposition to Thrombosis

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.

Personal data:



Family name, forename: .....

Street, location: .....

Date of birth: ..... Body weight: ..... kg Body height: .....cm

Phone No. (voluntary statement): .....

I agree that the referring doctor as well as all doctors involved in my treatment will receive a report:

Yes ☐ **No** ☐

Family History:

1. Did family members (parents, grandparents, siblings) suffer from one of the following diseases (especially before they were 50 years old)?

☐ Thrombosis ☐ Stroke ☐ Abortion
☐ Pulmonary embolism ☐ Heart attack

2. Does any family member (parents, grandparents, siblings) suffer from a bleeding disorder?

☐ No
☐ Yes
If so, which one……

Patient's history:

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

☐ Varicosis
☐ Vein inflammation
If so, please tell us the time of the event and the location

.....

☐ Vein thrombosis
If so, please tell us the time of the event and the location

.....

Please turn over ➔

☐ Pulmonary embolism
If so, please tell us the time of the event and the location

.....

☐ Heart attack
If so, please tell us the time of the event and p.r.n. interventions (i.e. bypass, stents)

.....

☐ TIA, PRIND or stroke

☐ PAD or other artery occlusive diseases

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

☐ Hypertension
☐ Dislipidemia
☐ Migraine with aura (e.g. impaired vision)
☐ Migraine without aura
☐ Dysfunction of the liver
☐ Dysfunction of the kidneys

5. Do you take any medicine?

☐ No
☐ Yes
If so, which ones:

☐ Hormonal contraception (contraceptive pill)
☐ Low-molecular-weight-heparin (LMWH)
☐ Arixtra® (Fondaparinux)
☐ Orgaran® (Danaparoid)
☐ Argatra® (Argatroban)
☐ Marcumar®/Coumadin®/Warfarin®
☐ Eliquis® (Apixaban)
☐ Xarelto® (Rivaroxaban)
☐ Pradaxa® (Dabigatran)
☐ ASA (Acetyl salicylic acid)
☐ Plavix® (Clopidogrel)
☐ Brilique® (Ticagrelor)
☐ Efient® (Prasugrel)
☐ Other medications: .....

Dosage: .....

6. Do you smoke?

☐ No
☐ Yes
If so, how many cigarettes a day:……

If you are a woman:

☐ Abortions
If so, please tell us the time of the events and the week of gestation
.....
Are you pregnant at the moment?
☐ No
☐ Yes
If so, which week of gestation: .....

Thank you for your cooperation!

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