

Questionnaire tendency to thromboembolism[®] see also back page

Date.....

Last name First name..... Date of birth:

Heightcm Weight.....kg Blood group..... Phone:

Have you ever had a **venous thrombosis**? Yes No Month/Year.....
Have you ever had a **pulmonary embolism**? Yes No Month/Year.....
Have you ever had **phlebitis**? Yes No Month/Year.....

Venous thrombosis, phlebitis, where?

Lower leg	<input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both sides	Eye	<input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both sides
Thigh	<input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both sides	Arm	<input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both sides
Knee	<input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both sides	Brain	<input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both sides
Pelvis	<input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both sides	Other	<input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both sides

Prior to the pulmonary embolism or the thrombosis, did you have? (Please check):

Long distance journey or flight Injuries, completely or partially immobile
 Cold, other infections Bedridden
 Operation Came right out of the blue

Women: pregnant pill, hormone treatment

Have you ever had an **embolism in other organs except lungs e.g. brain, legs**? Yes No
Month/Year.....

Have you ever had **heart attacks**? Yes No
Have you ever had **strokes** or transient ischemic attacks? Yes No
Have you ever had **circulatory disorders in the legs**? Yes No
Month/Year.....

Current or previous smoker? No Yes, cigarettes/day.....

Have you ever had **malignant diseases, a tumor**?

No Yes when? year..... type of the disease

Do you suffer (if correct, please check)

High blood pressure arrhythmia varicose veins fluid retention in the legs
 diabetes mellitus high lipid levels

History of thrombosis or pulmonary embolism in

Father	<input type="checkbox"/> No <input type="checkbox"/> Yes, at the age ofYears
Mother	<input type="checkbox"/> No <input type="checkbox"/> Yes, at the age ofYears
Children	<input type="checkbox"/> No <input type="checkbox"/> Yes, at the age ofYears
Sisters and brothers	<input type="checkbox"/> No <input type="checkbox"/> Yes, at the age ofYears
Grandparents	<input type="checkbox"/> No <input type="checkbox"/> Yes, at the age ofYears
Cousins, aunts, grandchildren	<input type="checkbox"/> No <input type="checkbox"/> Yes, at the age ofYears

Please turn the page and fill in the back!

History of heart attack, stroke, other circulatory disorders in

- Father No Yes, at the age ofYears
- Mother No Yes, at the age ofYears
- Children No Yes, at the age ofYears
- Siblings No Yes, at the age ofYears
- Grandparents No Yes, at the age ofYears
- Cousins, aunts, grandchildren No Yes, at the age ofYears

Who? What? When? e.g. father heart attack at the age of 40

.....
.....

Are you taking any medication or dietary supplements (please indicate)?

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.....
.....

Have you ever had: tendency to easy bruising, prolonged bleeding from cuts or minor injuries, postoperative bleeding, bleeding after injuries or tooth extraction, poor wound healing? yes No

Do you have children? No Yes daughters/sons?.....

Only for women:

Have you had any spontaneous miscarriages? yes no

If yes, how many? in which week of pregnancy?

Did you experience any other complications during pregnancy, such as bleeding, gestosis (pre-eclampsia), high blood pressure, growth retardation of the child, premature birth premature detachment of the placenta?..... yes no

Are you trying to get pregnant? yes no

Have any artificial insemination procedures been done, such as IVF, ICSI? yes no

Are you currently pregnant? If yes, in which week? yes no

Do you have or have you had abundant or prolonged menstruation? yes no

Do you take a hormonal contraceptive (contraceptive pill)? yes no

If yes, which one?

Do you have to take hormones for other reasons, e.g. hormone substitution therapy? yes no

If yes, which hormone preparation do you take?

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Zürich, 25.02.2025

Prof. Dr. med. Peter Hellstern