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HISTORY OF ABNORMAL CLOTTING POSSIBLY ASSOCIATED WITH INHERITED DISORDERS OR ACQUIRED DISORDERS

NAME: _____ **DATE:** _____
Last First Middle Initial

1. Are you adopted? ☐ Yes ☐ No
   If Yes, do you know anything about your biological family? ☐ Yes ☐ No
2. Have you had any history of problems with any of the following and if so when and at what age?

History of:	When	Age
Blood Clots?		
Arteries?		
Veins?		
Thrombophlebitis?		
Pulmonary Emboli? (Blood clots to lungs or to heart)		
Strokes?		

3. Have any members of your family (parents, grandparents, brothers, sisters) had any of the following:
   (Please indicate by using the legend below * which family members, when and at what age.)

* **Legend**: Father (F) Mother (M) Brother (B) Sister (S) Paternal Grandfather (PGF) Paternal Grandmother (PGM) Maternal Grandfather (MGF) Maternal Grandmother (MGM) Uncles (U) Aunts (A) Cousins (C)

History of:	Family Member	When	Age
Blood Clots?			
Arteries Blocked?			
Veins with Clots?			
Thrombophlebitis?			
Pulmonary Emboli? (Blood clots to lungs or to heart)			
Strokes?			

4. Have any family members died in the first hours to weeks after surgery from any of the following?

History of:	Family Member	When	Age
Blood Clots?			
Arteries Blocked?			
Veins with Clots?			
Thrombophlebitis?			
Pulmonary Emboli? (Blood clots to lungs or to heart)			
Strokes?			

5. Have any of your children (C) or grandchildren (GC) had problems with any of the following?

History of:	Family Member	When	Age
Blood Clots?			
Arteries Blocked?			
Veins with Clots?			
Thrombophlebitis?			
Pulmonary Emboli? (Blood clots to lungs or to heart)			
Strokes?			

6. Have any of your family members had varicose veins? ☐ Yes ☐ No If Yes, which members?

   _____

7. Have any members of your family had to have a filter placed in their inferior vena cava so they did not get blood clots in their heart or lungs? ☐ Yes ☐ No

   If Yes, please complete the following indicating which family members according to previous legend *****.

Family Member	When

For patients who have had family members who have had clotting problems in their history, there are many things that we can test for in this day and age that may help clarify this. There are still others who have a family history that none of the current tests we have available are abnormal, but there may be some test available to identify these inherited disorders.

The following may be associated with acquired hypercoagulable (increased clotting) states. Have you had or do you have any of the following?

1.	1+ unexplained fetal demise at 10+ weeks?	☐ Yes ☐ No
2.	Recurrent pregnancy loss?	☐ Yes ☐ No
3.	Intrauterine growth retardation?	☐ Yes ☐ No
4.	Preeclampsia at less than 34 weeks of gestation?	☐ Yes ☐ No
5.	1+ premature birth at 34 weeks or less?	☐ Yes ☐ No
6.	3+ consecutive spontaneous abortions at less than 10 weeks?	☐ Yes ☐ No
7.	1+ episode of arterial, venous or small vessel thrombosis?	☐ Yes ☐ No
8.	Lupus or other autoimmune diseases or rheumatoid arthritis or scleroderma or fibromyalgia **(Must not be associated with malignancy)**	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
9.	Medications such as phenytoin (which is Dilantin), quinidine, hydralazine, procainamide?	☐ Yes ☐ No
10.	Have you required in vitro fertilization or is it being considered?	☐ Yes ☐ No
11.	Venous or arterial thrombosis that could not be explained by another condition such as trauma to your legs?	☐ Yes ☐ No
12.	Unexplained thrombocytopenia (decreased platelet count) or elevated PTT?	☐ Yes ☐ No
13.	Abnormal heart valves?	☐ Yes ☐ No
14.	Livedo reticularis? (unusual patchy or mottled discoloration of your skin)	☐ Yes ☐ No
15.	Amaurosis fugax? (episodes of transient blindness in one eye)	☐ Yes ☐ No
16.	Transient ischemic attacks? (little strokes)	☐ Yes ☐ No
17.	Migraine headaches?	☐ Yes ☐ No

Other things associated with increased clotting states:

1. Do you have a malignancy? ☐ Yes ☐ No
2. Do you have recent or unexplained weight loss? ☐ Yes ☐ No
3. Have you coughed up any blood in your sputum? ☐ Yes ☐ No
4. Do you have a high homocysteine? ☐ Yes ☐ No
5. Do you have Behçet disease? ☐ Yes ☐ No
6. Do you have Raynaud disease or cold intolerance in your fingers and toes? ☐ Yes ☐ No
7. Do you have hepatitis? ☐ Yes ☐ No

Do you have or do you have a family history of the following inherited disorders?

	You Have	Family History	No	Don't Know
1. Mutant factor V Leiden?	☐	☐	☐	☐
2. Protein C?	☐	☐	☐	☐
3. Protein S?	☐	☐	☐	☐
4. Antithrombin III?	☐	☐	☐	☐
5. Prothrombin gene mutation 20210A?	☐	☐	☐	☐
6. MTHFR gene mutation (with a high homocysteine)?	☐	☐	☐	☐