Bleeding (Coagulation / VWD) Disorder Questionnaire – complete for all requests

Collect ONLY what is requested on the request form.

Surname: …… First Name: ……..
DOB: ……. Doctor: ……..
Date: ……

Questions- circle answers		
1. Have you or your close family member ever needed medical attention for a bleeding problem or been told you had a bleeding problem?	YES	NO
2. Are you currently taking or have you recently taken any anticoagulation If yes, please give details of medication: …….. ……	YES	NO
3. Please give details of family relationship, diagnosis and type of bleeding Problem:……		
4. How would you describe the bleeding from minor cuts? Normal Free Flowing Oozing Do they bleed for greater than 10 minutes?	YES	NO
5. Do minor cuts rebleed spontaneously during the 7 days after the injury	YES	NO
6. Have you ever had any unexpected bleeding problems: a) After dental: Extractions / Post Operations / Post Childbirth / None b) If answer YES to one of the above: i) How long did the bleeding last?..... . ii) What were the details of the bleeding problems? E.g. prolonged, recurrent …….. iii) Did you need any treatment for this?.....	YES	NO
7. Do you have spontaneous nose bleeds lasting >10 minutes or required medical attention? If yes, is it one or both Nostrils?..... How often does it occur?.....	YES	NO
8. Do you have **life long** (Not recent history) heavy or prolonged periods, characterized by:		
a) Changing a pad or tampon more than hourly	YES	NO
b) Blood loss heavy for more than 5 days	YES	NO
c) Blood loss heavy for more than 7 days or resulting in anaemia or low iron	YES	NO
9. Current Medication (including self-prescribed e.g. aspirin, herbal tablets, pain killers etc.) ……		

Please take specimens as directed by Test Index

If unsure specimen requires contact Snr staff member.