SYNLAB

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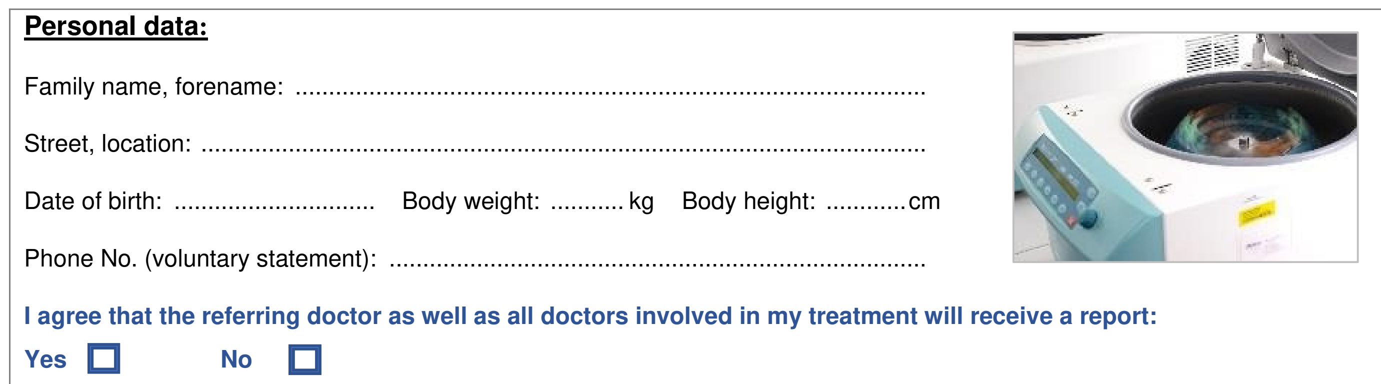
Medical History for Examinations of the Coagulation of the Blood in the Case of Disposition to Bleeding

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.



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. 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 ➔

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

- ☐ Bleeding disorder

  If so, which one……………………………………………………………………………………

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

4. Do you take any medicine?

- ☐ No
- ☐ Yes

  If so, which ones

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

  Dosage:……………..……………

5. Do you smoke?

- ☐ No
- ☐ Yes

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

I hereby confirm that I have read the data protection declaration on display in the waiting room and that my personal data (name, first name, date of birth, address, telephone number, if applicable) is permitted to be stored and processed by SYNLAB MVZ Stuttgart for the purpose of processing my examination.

Thank you for your cooperation!

....

Date

Signature
(Parent, legal guardian or custodian)

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