

**BLEEDING & CLOTTING DISORDERS INSTITUTE**  
**6811 N. KNOXVILLE AVE., SUITE A**  
**PEORIA, IL 61614**  
**Phone: (309) 692-5337**

**Name:** \_\_\_\_\_ **Birth date:** \_\_\_\_\_

**Your next Comprehensive Hemophilia Clinic visit is on** \_\_\_\_\_

Please complete this health questionnaire and bring it, your infusion logs, and any other forms sent to you, to the clinic with you. **REMEMBER TO BRING A PAIR OF SHORTS TO WEAR DURING THE MUSCLE AND JOINT EXAMINATION.**

**Health Questionnaire**

**Directions:** Please answer all questions. Answer most questions by drawing a circle around the appropriate answer or filling in the blanks. When a choice of several answers is offered, circle all answers that apply. If you are in doubt about an answer, place a question mark (?) next to the answer. Feel free to add notes about your answers on the margin of the page.

1. Circle any of the following problems you have:

- |                             |                             |                           |           |
|-----------------------------|-----------------------------|---------------------------|-----------|
| asthma, hayfever, allergies | diabetes (high blood sugar) | anemia                    | arthritis |
| high blood pressure         | heart disease               | kidney or bladder disease |           |
| thyroid trouble or goiter   | ulcers                      | gall stones               |           |
| epilepsy or seizures        | headaches                   | cancer                    |           |

2. Are any of these problems new since your last visit?.....No Yes

3. List all medicines you take (including those taken only occasionally and over-the counter drugs such as cold tablets, laxatives, herbal supplements, etc.), the dose and how often each medicine is taken.

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| 4. Do you have good strength and energy?.....                          | Yes | No  |
| 5. Do you tend to be constantly tired or to tire out easily?.....      | No  | Yes |
| 6. Do you have trouble falling asleep or staying asleep?.....          | No  | Yes |
| 7. Have you been losing or gaining weight? .....                       | No  | Yes |
| 8. Is your appetite good?.....   | Yes | No  |
| 9. Are you bothered by itching, skin rashes, infections or boils?..... | No  | Yes |
| 10. Have you had any bruises or bleeding in your muscles?.....         | No  | Yes |
| 11. Have you had trouble with bleeding from cuts?.....                 | No  | Yes |
| 12. Have you had trouble with frequent or lasting colds?.....          | No  | Yes |
| 13. Have you had any severe or long-lasting nosebleeds?.....           | No  | Yes |
| 14. Have you had any sores or soreness of your mouth or tongue?.....   | No  | Yes |
| 15. Have you had any trouble with bleeding gums?.....                  | No  | Yes |
| 16. Have you had frequent sore throats?.....                           | No  | Yes |
| 17. Have you had any trouble swallowing?.....                          | No  | Yes |

18. Have you had any lumps or swollen lymph nodes?..... No Yes  
 If yes, where? \_\_\_\_\_
19. Are you troubled by coughing or difficulty in breathing?.....No Yes
20. Have you had trouble with stiff, swollen, or painful joints?.....No Yes  
 If yes, which joints? \_\_\_\_\_
21. Have you had any pain in your back?.....No Yes
22. Have you had cramps or pain in your stomach or abdomen?.....No Yes
23. Have you had problems with heartburn, indigestion, bloating or gas?...No Yes
24. Have you had problems with nausea or vomiting?.....No Yes
25. Have you vomited any blood?.....No Yes
26. Have you noted your bowel movements to be (circle any that apply):  
 loose, watery, diarrhea                      hard, constipated                      bloody  
 white or clay-colored                      black, tar-like or coffee grounds
27. Have you been jaundiced (yellow eyes or skin)?.....No Yes
28. Do you have frequent headaches?.....No Yes
29. Have you had any spells of dizziness or fainting?.....No Yes
30. Have you had any trouble keeping your balance, stumbling or falling, or  
 bumping into things?.....No Yes
31. Have you had any trouble with blurred vision or seeing double?.....No Yes
32. Have you had any numbness, tingling or loss of sensation in any part  
 of your body?..... No Yes
33. Is any part of your body paralyzed or weak?.....No Yes
34. Have you had any pain or burning when passing urine?..... No Yes
35. Have you passed any blood in your urine?.....No Yes
36. Have you had trouble with heavy menstrual periods?..... No Yes  
 If yes, how many days does a period last? \_\_\_\_\_  
 How many pads do you use per day? \_\_\_\_\_ per period? \_\_\_\_\_
37. Have you had any infusions since your last visit?.....No Yes  
 If yes, how many? \_\_\_\_\_ (Be sure to bring infusion logs showing  
 dates, products received, amount, etc.)

**Additional comments/concerns:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Date completed:** \_\_\_\_\_

**Is it ok if we contact you by e-mail?    Yes    No**

**e-mail address:** \_\_\_\_\_