THROMBUS
HYPERCOAGULABLE CLOTTING DISORDER

CLIENT NAME: _____

Submit the Client Information Questionnaire with this form

1. Date of diagnosis: _____

2. Note the type of treatment:
   __ Coumadin
   __ Aspirin
   __ Heparin
   __ Hospitalization/date(s) _____

3. Was there a Thromboembolic event?
   __ MI
   __ DVT
   __ CVA
   __ PE
   __ Other _____
   __ None

4. Has there been any evidence of recurrence?
   ___ No
   ___ Yes; give details _____

5. Is client on any medications? (accurate name, dosage, and reason)