ANTIPHOSPHOLIPID SYNDROME (APS) NEW PATIENT QUESTIONNAIRE DR. SCHOFIELD

Date:_____

Patient Name:_____ **Date of Birth:**_____

University of Colorado Medical records **Yes** **or** **No** **IMMUNOe records** **Yes** **or** **No**

GENERAL

Who referred you for today's consultation?

What are your goals for today's consultation?

When/How did your illness/ symptoms begin?

What symptoms bother you the most?

1)

2)

3)

4)

Has APS affected your performance and/or ability to work or attend school? ☐ No ☐ Yes Please explain

SPECIALIST HISTORY

Have you seen a Hematologist for this illness?	☐ No	☐ Yes	Name:
Have you seen a Neurologist for this illness?	☐ No	☐ Yes	Name:
Have you seen a Rheumatologist for this illness?	☐ No	☐ Yes	Name:
Have you seen any other specialist for this illness?	☐ No	☐ Yes	Name:

MEDICATIONS TRIED

Have you been prescribed/ tried any of the following:			**Did it help with your symptoms?**
Aspirin	☐ No	☐ Yes	
Plavix (clopidogrel)	☐ No	☐ Yes	
Heparin (ex: Lovenox (enoxaparin), Fragmin (dalteparin))	☐ No	☐ Yes	
Arixtra (fondaparinux)	☐ No	☐ Yes	
Eliquis (apixaban)	☐ No	☐ Yes	
Xarelto (rivaroxaban)	☐ No	☐ Yes	
Pradaxa (dabigatran)	☐ No	☐ Yes	
Plaquenil (hydroxychloroquine)	☐ No	☐ Yes	

Other (please list):

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CURRENT MEDICATIONS

Please complete the *current medication form*.

DIAGNOSTIC TESTING HISTORY

Have you had any of the following performed?			
Leg or arm Doppler ultrasound?	☐ No	☐ Yes	Date:
Chest CT or V/Q scan?	☐ No	☐ Yes	Date:
Echocardiogram	☐ No	☐ Yes	Date:
Brain MRI	☐ No	☐ Yes	Date:
Spine MRI	☐ No	☐ Yes	Date:

PERTINENT LABS

SOCIAL HISTORY

What city/ state do you live in?			
What is your occupation?			
Marital Status	☐ S	☐ M	☐ D
Do you have children?	☐ No	☐ Yes	Age(s):
Do you or have you ever smoked cigarettes?	☐ No	☐ Yes	
Do you consume alcohol?	☐ No	☐ Yes	Consumption: ☐ Social ☐ Daily ☐ Rarely
Do you or have you used marijuana?	☐ No	☐ Yes	Details:
Do you or have you used other drugs?	☐ No	☐ Yes	

PAST MEDICAL HISTORY

Please list any important medical problems *(current or past)*:

PAST SURGICAL HISTORY

Please list any important previous surgical history *(including approx. date)*:

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FAMILY HISTORY			
Does anyone in your family have a history of any of the following?			
Autoimmune disease (e.g. lupus, multiple sclerosis, rheumatoid arthritis, Crohn's disease, celiac disease juvenile diabetes, etc)?	☐ No	☐ Yes	
Blood clot at age <50 years	☐ No	☐ Yes	
Stroke at age <50 years	☐ No	☐ Yes	
Heart attack at age <50 years	☐ No	☐ Yes	
Multiple miscarriages or stillbirth	☐ No	☐ Yes	
Please note any other family history you feel may be important to your current issue or if your family history is unobtainable:			
THROMBOSIS HISTORY			
Do you have a history of venous blood clots (ex: DVT, PE)?	☐ No	☐ Yes	Location:
			Date:
Do you have a history of arterial blood clots (ex: stroke, heart attack)?	☐ No	☐ Yes	What:
			Date:
PREGNANCY HISTORY			
Have you ever been pregnant?	☐ No	☐ Yes	# of pregnancies:
			# of live births:
			Wks/ gestation:
			# of miscarriages:
			Wks/ miscarriage:
Were any of your pregnancies complicated by pre-eclampsia/eclampsia?	☐ No	☐ Yes	
Were any of your pregnancies complicated by low birth weight/ growth?	☐ No	☐ Yes	
Were any of your pregnancies complicated by low platelet counts?	☐ No	☐ Yes	
Were any of your pregnancies complicated by HELLP syndrome?	☐ No	☐ Yes	
Do you desire any future pregnancies?	☐ No	☐ Yes	
GENERAL SYMPTOMS			
Fatigue?	☐ No	☐ Yes	Severity: ☐ Mild ☐ Mod ☐ Severe
DERMATOLOGIC SYMPTOMS			
Raynaud's phenomenon (fingers/ toes turn white/ blue in cold)?	☐ No	☐ Yes	
Livedo reticularis?	☐ No	☐ Yes	
Skin ulcers?	☐ No	☐ Yes	
VISUAL SYMPTOMS			
Visual disturbance?	☐ No	☐ Yes	If yes please explain:
NEUROLOGICAL SYMPTOMS			
Memory Loss?	☐ No	☐ Yes	
Headache?	☐ No	☐ Yes	
Seizures?	☐ No	☐ Yes	

Tinnitus (ringing in the ears)?	☐ No	☐ Yes	
Other	☐ No	☐ Yes	If yes please explain:
AUTONOMIC SYMPTOMS			
Do you ever feel light-headed when you stand up?	☐ No	☐ Yes	How often?
Have you ever passed out?	☐ No	☐ Yes	How often?
Tachycardia and/or palpitations?	☐ No	☐ Yes	How often?
Muscle cramps and/or twitching?	☐ No	☐ Yes	
Temperature and/or sweating dysregulation?	☐ No	☐ Yes	
CARDIOVASCULAR / PULMONARY SYMPTOMS			
Chest pain?	☐ No	☐ Yes	
Shortness of breath?	☐ No	☐ Yes	
GASTROINTESTINAL SYMPTOMS			
Do you ever have abdominal pain after you eat?	☐ No	☐ Yes	How often?
Weight loss?	☐ No	☐ Yes	Details:
Other GI symptoms?	☐ No	☐ Yes	
SKELETAL / BONE SYMPTOMS			
Non-traumatic or minimally traumatic fracture(s)?	☐ No	☐ Yes	
Avascular necrosis?	☐ No	☐ Yes	
AUTOIMMUNITY SYMPTOMS			
Have you ever lost your hair in patches?	☐ No	☐ Yes	
Do you have Raynaud's (fingers/toes change color in response to the cold)?	☐ No	☐ Yes	
Do you get a rash on your cheeks that lasts for a few days at a time?	☐ No	☐ Yes	
Have you ever had pericarditis or pleurisy?	☐ No	☐ Yes	
Do you ever have joint pain?	☐ No	☐ Yes	
Do you ever have joint swelling?	☐ No	☐ Yes	
Do you have dry eyes, dry mouth or trouble wearing contacts?	☐ No	☐ Yes	
DEPRESSION?	☐ No	☐ Yes	
ANXIETY?	☐ No	☐ Yes	
PAIN?	☐ No	☐ Yes	
SLEEP DISTURBANCE?	☐ No	☐ Yes	

OTHER SYMPTOMS

Please list any other symptoms which you are concerned about: