NAME:_____

DVT Risk Assessment/Patient Questionnaire

Date:_____ **Age**:_____ **SEX:** Male / Female **Your home ZIP code** _____

Height: Feet_____ Inches_____ **Weight in pounds:**_____

Race: Caucasian / African-American / Asian / Hispanic / Native American / Other

What specialty is your personal doctor or primary care physician? (Circle one)

Internist / Family practitioner / Cardiologist / Clinic doctor / HMO doctor

Osteopath / Other / I don't have a doctor

Do you have? Diabetes Y/N High blood Pressure Y/N Heart failure Y/N Smoker? Never / Now / Quit

Do you take blood thinner? None / Coumadin / Aspirin / Plavix / Ticlid / Pletal / Aggrenox

Why are you here today? (circle most appropriate):

Do you have leg pain? (None) (Occasional) (Daily) (Limit activities)

Do you have swelling? (None) (Evenings/ankle only) (Afternoon/leg) (Morning/leg)

Do you use compression stockings? (Not used) (Intermittent use) (Most days) (Continually)

Medical History

(Circle appropriate answers)

				Points for "yes" answer
1.	Have you ever had a blood clot in your legs or lungs?	Yes	No	(3)
2.	Do you have a family history of blood clots in the veins?	Yes	No	(3)
3.	Do you have leg swelling every day?	Yes	No	(1)
4.	Do you have visible varicose veins or spider veins?	Yes	No	(1)
5.	Do you have inflammatory bowel disease?	Yes	No	(1)
6.	Do you have emphysema or COPD?	Yes	No	(1)
7.	Have you had more than three days of continuous bed rest due to injury or illness in past month?	Yes	No	(1)
8.	Have you had a pelvic fracture or a plaster leg cast in the last month?	Yes	No	(1)
9.	Have you had a heart attack or heart failure?	Yes	No	(1)
10.	Have you had major surgery lasting over an hour in the last month?	Yes	No	(1)
11.	Do you have or have you had a malignant disease (cancer)?	Yes	No	(1)
12.	Do you weigh over 250 pounds?	Yes	No	(1)
13.	AGE (Circle) Under 40 40-59 (1) 60-69 (2) Over 70 (3)	(0)	(1) (2)	(3)

The following questions are for WOMEN only

14.	Do you use birth control pills or estrogen replacement therapy?	Yes	No	(1)
15.	Are you pregnant or had a baby within the last month?	Yes	No	(1)

Total: _____

(Add all points for "Yes" answer and "Age" group.)

adapted from Caprini risk assessment

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