Anticoagulation Clinic
Initial Patient Screening

Thank you for completing this history. It will help us to better manage your Coumadin.®

Patient Name: _____ Date: _____

Sex: ☐M ☐F Age: _____ Doctor: _____

Address: _____
street city zip

Phone: _____ Emergency Phone: _____

Current Coumadin® dose: _____

Why did your doctor prescribe Coumadin® for you? _____

How long have you been taking Coumadin®? _____

Please list all of your current medications, herbs, & vitamins, including occasional use of over-the-counter drugs for headache, colds, etc.

_____

_____

Please list your other medical problems, if any: _____

_____

_____

Do you have allergies? ☐ No ☐ Yes – please list: _____

Do you smoke? ☐No ☐Yes: How many packs per day? _____

If you are a former smoker, when did you quit? _____

Please indicate your level of alcohol consumption:
☐ *None* ☐ *1 or fewer drinks per week* ☐ *1 or fewer drinks daily* ☐ *2 or more drinks daily*

Have you ever had problems with uncontrolled bleeding in or from your (check all that apply):
☐ *Gums* ☐ *Nose* ☐ *Stomach* ☐ *Rectum* ☐ *Urine* ☐ *Vagina (women)*
☐ *A skin tear or cut* ☐ *Other location:* _____

If yes to any of the above, please describe treatment, if any, that was given:

_____