Utah Center for Bleeding & Clotting Disorders
at Huntsman Cancer Institute

Patient Name:

Birth date:

Please fill out this questionnaire as completely as you can. This information helps us give you the best medical care.

1. What is your diagnosis? Please mark all that apply.

   ☐ Hemophilia A ☐ Hemophilia B ☐ Von Willebrand ☐ Carrier

   Other (please specify) ________________

2. What is your main concern today? ________________

Medicines

3. Do you take medicines for your bleeding disorder? ☐ Yes ☐ No
4. How do you use clotting factor? Please mark all that apply.

   ☐ a. I infuse following a routine schedule to prevent bleeding. How many units? ____ How often? ________

   ☐ b. I infuse as a treatment after a bleed has occurred. How many units? ____ How often? ________

   ☐ c. I infuse so I can do activities I like, such as sports or travel.

   ☐ d. Other (please specify) ________________

5. What brand of clotting factor do you use? ________________
6. What home care pharmacy supplies your clotting factor? ________________

   Who is your pharmacy contact? ________________ Phone number ________________

7. Do you need refills on any prescriptions related to your bleeding disorder? ☐ Yes ☐ No
8. How satisfied are you with your current prescription? [1 = Unsatisfied; 5 = Completely satisfied]

   1 2 3 4 5

9. Do you take your prescription as directed? ☐ Yes ☐ No

   a. If No, how are you taking it? ☐ Less often than directed ☐ Different dosage than directed

   b. If No, why are you not following the directions?

   ☐ Hard to infuse ☐ Can't afford the medicine ☐ I accidentally skip doses ☐ All of these

   ☐ Other (please specify) ________________

10. Can you start an IV and infuse your clotting factor? ☐ Yes ☐ No
11. Do you have any problems or concerns with infusing yourself? ☐ Yes ☐ No

    If Yes, please specify. ________________

12. Do you need more information about your condition? ☐ Yes ☐ No
13. Do you need more information about the medicines you take? ☐ Yes ☐ No

Continued on other side

Bleed History

14. How do you keep track of your bleeds? ______________________________

15. What are your target joints? ______________________________

16. When was your last bleed? ____________ Where was it on your body? ____________

    What caused it? ____________ Could it have been prevented? ☐ Yes ☐ No

17. How was your last bleed treated?

    How many units? __________ How many infusions per day? __________ How many days? __________

18. How many bleeds have you had in the past 12 months? _____ Please write the number of bleeds in each month below.

Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec

    a. How sure are you about the accuracy of the bleed info you recorded above? ☐ Very sure ☐ Not sure

Bleed Knowledge

19. Circle the number that shows your level of knowledge about each of the topics below.
    (0 = no knowledge, or I do not know how to do this; 5 = high knowledge, or I know how to do this)

Topic	Level of Knowledge					
a. I can tell when a bleed is happening.	0	1	2	3	4	5
b. I can tell whether a bleed is in a joint or a muscle.	0	1	2	3	4	5
c. I can treat a bleed.	0	1	2	3	4	5
d. I know how to prevent bleeds.	0	1	2	3	4	5
e. I know what time of day to infuse.	0	1	2	3	4	5
f. I know how to prevent joint damage such as arthritis.	0	1	2	3	4	5
g. I know how to navigate my insurance and health care needs.	0	1	2	3	4	5

Other

20. Do you have a Medic Alert tag? ☐ Yes ☐ No

21. Do you have a primary care doctor for your other health concerns? ☐ Yes ☐ No

22. Are you planning on any medical (for example, surgery or colonoscopy) or dental procedures in the next 12 months?
    ☐ Yes ☐ No
    a. If yes, what is the procedure? ______________________________

23. Do you want to learn more about the genetics of your bleeding condition and how it is passed on through the family?
    ☐ Yes ☐ No

24. (For patients 18 years of age or older) I understand that the Utah Center for Bleeding & Clotting Disorders cannot give information about my health care, including health status updates and medication refills, to anyone else unless I give permission in writing. ☐ Yes ☐ No

The Patient Health Questionnaire (PHQ-9)

Patient Name ______________________________ Date of Visit ______________

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Column Totals _____ + _____ + _____

Add Totals Together ____________________

10. If you checked off any problems, how difficult have those problems made it for you to Do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

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Generalized Anxiety Disorder Screener (GAD-7)

Over the *last 2 weeks*, how often have you been bothered by the following problems?	Not at all	Several Days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritated	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
	Add columns			
	Total Score			
8. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

When did the symptoms begin? ____

Boston University AM-PAC™
Basic Mobility Outpatient Routine Short Form
Please check the box that reflects your best answer to each question.

How much difficulty do you currently have... (If you have not done an activity recently, how much difficulty do you think you would have if you tried?)	**Unable**	**A Lot**	**A Little**	**None**
1. Bending over from a standing position to pick up a piece of clothing from the floor, without holding onto anything?	☐1	☐2	☐3	☐4
2. Standing up from a low, soft couch?	☐1	☐2	☐3	☐4
3. Taking a 1-mile brisk walk, without stopping to rest?	☐1	☐2	☐3	☐4
4. Running for 5 minutes on even surfaces?	☐1	☐2	☐3	☐4
5. Walking several blocks?	☐1	☐2	☐3	☐4
6. Walking up and down steep unpaved inclines (e.g., steep gravel driveway)?	☐1	☐2	☐3	☐4
7. Running a short distance, such as to catch a bus?	☐1	☐2	☐3	☐4
8. Carrying something in both arms while climbing a flight of stairs (e.g., laundry)?	☐1	☐2	☐3	☐4
9. Going up and down a flight of stairs outside, without using a handrail?	☐1	☐2	☐3	☐4
10. Making sharp turns when running fast?	☐1	☐2	☐3	☐4
11. Taking part in strenuous activities (e.g., running 3 miles, swimming half mile, etc.)?	☐1	☐2	☐3	☐4
12. Standing up from an armless straight chair (e.g., dining room chair)?	☐1	☐2	☐3	☐4
13. Walking on an uneven surface (e.g., grass, dirt road or sidewalk, brick walkways, sidewalks with curb and driveways cuts)?	☐1	☐2	☐3	☐4
14. Walking around one floor of their home, taking into consideration thresholds, doors, furniture, and a variety of floor coverings?	☐1	☐2	☐3	☐4
15. Doing light housework (e.g., dusting, minor sweeping)?	☐1	☐2	☐3	☐4
16. Moving up in bed (e.g., reposition self)?	☐1	☐2	☐3	☐4
17. Getting into and out of a car/taxi (sedan)?	☐1	☐2	☐3	☐4
18. Cleaning up spills on the floor with a mop?	☐1	☐2	☐3	☐4

Raw Score: ____________________ CMS 0-100% Score: ____________________

Standardized (t-scale) score: __________ CMS Modifier: ____________________

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ACCOUNT NO.

MED. REC. NO.

NAME

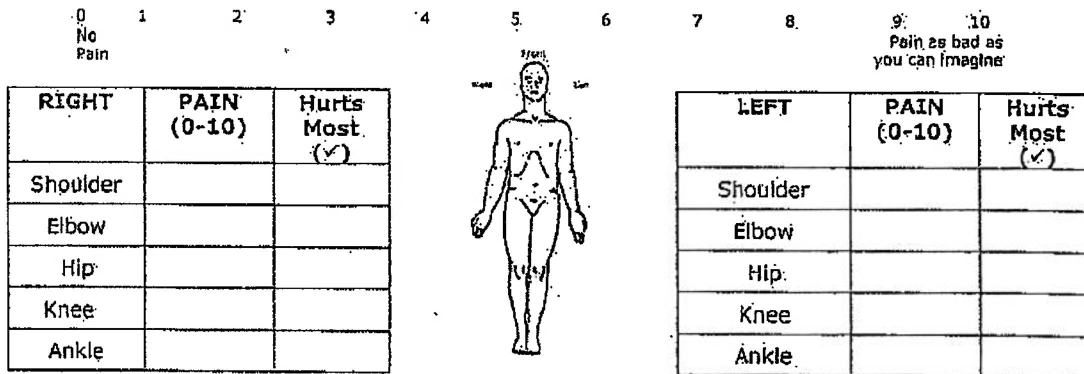
BIRTHDATE

Pain Questionnaire

1. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain **during the last week**?

☐ Yes ☐ No

2. Please mark the 10 major joints listed below and indicate the pain level in each joint using the scale below. Please also put a check mark in the box corresponding to the one joint with the most pain.



0 No Pain 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

RIGHT	PAIN (0-10)	Hurts Most (✓)
Shoulder		
Elbow		
Hip		
Knee		
Ankle		

LEFT	PAIN (0-10)	Hurts Most (✓)
Shoulder		
Elbow		
Hip		
Knee		
Ankle		

3. Please rate your pain by circling the one number that best describes your pain at its ***worst*** in the **last week**.

0 *No Pain* 1 2 3 4 5 6 7 8 9 10 *Pain as bad as you can imagine*

4. Please rate your pain by circling the one number that best describes your pain at its ***least*** in the **last week**.

0 No Pain 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

5. Please rate your pain by circling the one number that best describes your pain on the ***average***.

0 *No Pain* 1 2 3 4 5 6 7 8 9 10 *Pain as bad as you can imagine*

6. Please rate your pain by circling the one number that tells how much pain you have ***right now***.

0 *No Pain* 1 2 3 4 5 6 7 8 9 10 *Pain as bad as you can imagine*

7. In the last 12 months, have you experienced chronic pain related to your bleeding disorder?

☐ Yes No ☐ Unknown

If yes, about how often in the last 12 months did the last 12 months did you experience chronic pain related to your bleeding disorder.

☐ Everyday ☐ Most Days ☐ Some Days ☐ Unknown

Pain Questionnaire

ACCOUNT NO.

MED. REC. NO.

NAME

BIRTHDATE

8. In the **last week**, how much relief have pain treatments or medications provided? Please circle the one percentage that most shows how much ***relief*** you have received.

0% No relief	10%	20%	30%	40%	50%	60%	70%	80%	90%	100% Complete relief

9. Circle the one number that describes how much, **during the past week**, pain has ***interfered*** with your:

A. General Activity

0 *Does not interfere*	1	2	3	4	5	6	7	8	9	10 *Completely Interferes*

B. Mood

0 *Does not Interfere*	1	2	3	4	5	6	7	8	9	10 *Completely interferes*

C. Walking Ability

0 *Does not Interfere*	1	2	3	4	5	6	7	8	9	10 *Completely Interferes*

D. Normal Work (includes both work outside the home and housework)

0 *Does not interfere*	1	2	3	4	5	6	7	8	9	10 *Completely Interferes*

E. Relations with other people

0 *Does not interfere*	1	2	3	4	5	6	7	8	9	10 *Completely Interferes*

F. Sleep

0 *Does not Interfere*	1	2	3	4	5	6	7	8	9	10 *Completely Interferes*

G. Enjoyment of life

0 *Does not Interfere*	1	2	3	4	5	6	7	8	9	10 *Completely Interferes*

10. In the last 12 months, have you been prescribed or used opioids for the treatment of chronic pain related to your bleeding disorder in the outpatient setting?

☐ Yes ☐ No ☐ Unknown

If yes, about how often in the last 12 months did you use opioids for chronic pain related to your bleeding disorder?

☐ Everyday ☐ Most Days ☐ Some Days ☐ Unknown