UW Medicine
NEIGHBORHOOD
CLINICS

ANTICOAGULATION VISIT QUESTIONNAIRE

Your answers to the following questions will help us to understand the concerns you'd like to discuss with your doctor. Please fill out as much of this questionnaire as possible. If you cannot answer some of the questions or feel uncomfortable answering them, leave them blank. Thank you for your help.

PATIENT NAME: ____

PATIENT DATE OF BIRTH: ____________ **TODAY'S DATE:** ________________________

Target INR Range: ______________________________________

Day	Number of pills	mg size of pills	Total mg days dose
Sunday	pills	mg	mg
Monday	pills	mg	mg
Tuesday	pills	mg	mg
Wednesday	pills	mg	mg
Thursday	pills	mg	mg
Friday	pills	mg	mg
Saturday	pills	mg	mg
Total weekly dose			**mg**

Have you made any changes to your diet, or have you started taking any supplements, since your last visit?

☐ Yes
☐ No

If yes, please explain: ____

____

Have you missed any of your anticoagulation medication doses, or taken any extra doses, since your last visit?

☐ Yes
☐ No

If yes, please explain: ____

____

Have you had any bleeding or bruising since your last visit?

☐ Yes
☐ No

If yes, please explain: ____

____

Have you had any symptoms of stroke, such as numbness, tingling, weakness or change in vision, since your last visit?

☐ Yes
☐ No

If yes, please explain: ____

____

Have you made any changes to your medications since your last visit?

☐ Yes
☐ No

If yes, please explain: ____

____

Do you smoke or use any tobacco products?........................ ☐ Yes ☐ No ☐ Quit
Do you drink alcohol?.. ☐ Yes ☐ No ☐ Quit

Are there other issues you would like to discuss with your doctor today?

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