

_____ - _____ - _____

Shaded items represent questions from regular UDC annual form.

Date of Visit
____/____/____

Date Form Completed
____/____/____

Form Completed By

Data entered by

DEMOGRAPHIC INFORMATION

(1) Zip code (first 3 digits):

(2) Weight

_____ . ____ kg

(3) Height

_____ cm

(4) Education: Check the highest education level completed by patient

Primary/Secondary school

Enter grade 1-12 _____

Technical school

College degree

Advanced degree

Other _____

(4a) Current student: Yes No

(5) Employment status (check one):

Employed full-time

Employed part-time

Not employed

(5a) If not employed, check **one** of the following:

Child or student

Homemaker

Able, but not currently working

Permanently disabled

Retired

Other _____

(6) HTC utilization (check one):

Frequent (visits HTC once per year)

Infrequent (visits HTC every 2 – 3 years)

Rare (visits HTC every 4 or more years)

First visit

(7) Health Insurance (check all that apply):

Straight (traditional) commercial insurance

Commercial insurance HMO

Commercial insurance PPO

- Straight Medicare
- Medicare HMO
- Straight Medicaid
- Medicaid HMO
- TRICARE
- State high-risk insurance plan
- Uninsured
- Other _____

(8) Has the patient had an analysis of her genetic mutation since birth or the last visit?
 Yes No Unknown

TREATMENT INFORMATION

(9) Treatment type (check one): Episodic care Immune tolerance Prophylaxis
 If prophylaxis, then:
 Intermittent
 Continuous

(10) Highest inhibitor titer since and including the last annual visit:
 Bethesda Units Date: not done
 _____ ____/____/____

(11) Immune tolerance therapy since the last annual visit: Yes No Unknown
 (11a) If yes, Successful Unsuccessful

(12) Bleeding episodes in the last 6 months (if none enter zero):
 Based on infusion logs OR Estimated by patient recall
 Number of joint bleeds _____
 Number of muscle bleeds _____
 Number of other bleeds _____

(13) Intracranial hemorrhage (ICH) since last annual visit? Yes No
 If yes, date: ____/____/____
 Associated with: Trauma Thrombocytopenia Other _____

(14) Home infusion? Yes No
 If yes, infused by (check all that apply):
 Patient Family member Medical care provider

INFECTIOUS DISEASE

(15) Risk factors for liver disease:
 (15a) Past/present hepatitis infection
 Positive HBsAg and/or anti-HBC and/or anti-HBS in absence of vaccination
 Yes No Unknown/untested

 Positive anti-HCV and/or RIBA and/or PCR
 Yes No Unknown/untested

(15b) Other risk factors (check all that apply)
 History of alcohol abuse
 Other _____
 None

(16) Signs or symptoms of liver disease since the last annual visit: (check all that apply)
 Jaundice Ascites Varices Other _____ None

(17) Does the patient have chronically elevated ALT/AST levels? Yes No Not measured

(18) Has the patient had an elevated prothrombin time (PT) since the last annual visit?
 Yes No Not measured

(19) Has the patient received any therapy for chronic viral hepatitis? Yes No

(19a) If yes, agent used (see reverse for brands): Pegylated Interferon Interferon Ribavirin
 Lamivudine Other _____

(19b) If yes, sustained response? Yes No Unknown

(19c) Hepatitis C genotype: 1a or 1b other than 1a or 1b Unknown

(20) Has the patient used a CVAD since the last annual visit? Yes No

(20a) If yes, type of CVAD (check all that apply) Port Catheter PICC

(20b) If yes, any infection in CVAD since last visit? Yes No

RISK REDUCTION

(21) What is the HIV status of the patient?
 Positive **if positive and age ≥ 16 , go to item #22**
 Negative **if negative, skip to item #26**
 Untested **if untested, skip to item #26**

(22) Does the patient have a regular partner? Yes No

(22a) If yes, has this patient's regular partner ever been tested for HIV?
 Yes No Unknown

(22b) If yes, was the result positive? Yes No Unknown

(23) How often is a condom used when having sex?

- Does not have sex (practices abstinence)
- Never
- Less than 50% of occasions
- Usually (50 – 89% of occasions)
- Nearly always (90 – 99% of occasions)
- Always

(24) How many sex partners of this patient were tested for HIV since the last annual visit? _____

(25) How many sex partners of this patient have tested newly positive for HIV since the last annual visit? _____

JOINT DISEASE

(26) How often since the last annual visit has the patient used a cane, crutches, or walker for ambulation or mobility?
 Never Intermittently Always

(27) How often since the last annual visit has the patient used a wheelchair for mobility?
 Never Intermittently Always

(28) How many days since the last annual visit has the patient missed work or school because of lower extremity joint problems?
 _____ days N/A

(29) How many days since the last annual visit has the patient missed work or school because of upper extremity joint problems?
 _____ days N/A

(30) Has the patient experienced a joint infection since the last annual visit? Yes No

- (31) Check the statement which best describes the patient's current overall activity level:
- Unrestricted school/work and recreational activities
 - Full school/work with limited recreational activity levels due to pain, loss of motion, weakness
 - Limited school/work and recreational activity levels due to pain, loss of motion, weakness
 - Limited school/work, recreational activity levels, and self-care activity levels due to pain, loss of motion, weakness
 - Requires assistance from another person for school/work/self-care, and unable to participate in recreation due to pain, loss of motion, weakness

BLEEDING SYMPTOMS

(32) Has the patient experienced any of the following symptoms since the last visit? If so, please indicate the number of times symptoms were experienced and whether or not a health care provider intervention (i.e. consultation, procedure, hospitalization) was required as a result. *(Please check all that apply)* N/A- First Visit

Bleeding Symptoms	Experienced symptom since the last visit?		If yes, how many times since last visit?	If yes, Provider Intervention Required?	
	Yes	No		Yes	No
1. More than one nosebleed per year lasting 10 min or longer	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
2. Oral mucosal bleeding lasting 10 min or longer	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
3. Bleeding during or after dental procedures of concern to health care provider	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
4. Bleeding from minor cuts lasting 5 min or longer	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
5. Bruises larger than a quarter size occurring at least once a month without trauma	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
6. Bleeding after surgery of concern to health care provider	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
7. Menstrual bleeding that required protection change at least every 2 hours on heaviest day	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
8. Bleeding with pregnancy/post-partum of concern to health care provider	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
9. Joint bleeding	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
10. Muscle bleeding	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
11. CNS bleeding	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
12. GI bleeding	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

(33) Has patient been diagnosed with anemia since the last visit?
 Yes No

(34) Does the patient have any of the following health impairments? *(Check all that apply.)*

	Yes	No	Unknown		Yes	No	Unknown
Anxiety/Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angina/Myocardial Infarction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Replacement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Venous Thrombosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

TREATMENTS

(35) Please check whether or not the patient has used any of the following medications, treatments, or surgeries to treat any bleeding problems since the last visit. Also, check if the patient used any of the treatments specifically to treat menorrhagia. Please indicate if the response to treatment was excellent, good, fair, or poor.

If this is first visit, check here and skip to #36

	Usage for any bleeding problems?	Usage for menorrhagia?	Response to treatment for menorrhagia					
	(Check if Yes)	(Check if Yes)	Excellent	Good	Fair	Poor	Intolerant	
Medications/Devices								
Antifibrinolytics (Amicar, Tranexamic Acid)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Side effect(s)?:	
Desmopressin (DDAVP, Stimate)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Side effect(s)?:	
Oral contraceptives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Side effect(s)?:	
Levonorgestrel IUD (Mirena)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Side effect(s)?:	
Other hormonal contraceptives (i.e. patch, ring, implants, etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Side effect(s)?:	
Surgeries								
Dilation and curettage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Endometrial ablation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Uterine artery embolization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Other gynecological surgery:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Nasal cauterization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Blood/Factor Products								
Clotting factor products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Blood (packed RBC or whole blood) or plasma products (ex. Blood/plasma transfusion, cryoprecipitate)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Platelet transfusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Other								
Other medication, treatment, or surgery Please specify:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

(36) Treatment product(s) used since the last annual visit: (check all that apply)

- NONE USED UNKNOWN

Factor VIII, VWF, or Non-plasma Products

Recombinant FVIII

- Advate
- Helixate FS
- Kogenate FS
- Recombinate
- ReFacto
- Other, specify _____

Monoclonal FVIII

- Hemofil M
- Monarc-M
- Monoclate P
- Other, specify _____

Human FVIII containing VWF

- Alphanate
- Humate P
- Koate DVI
- Other, specify _____

Porcine factor VIII

- Other, specify _____

Blood bank products

- Cryoprecipitate
- Fresh-frozen plasma
- Platelets
- Packed RBCs or whole blood

Non-plasma and topical products

- Intravenous desmopressin (DDAVP)
- Nasal desmopressin (Stimate)
- Amicar
- Fibrin glue
- Other, specify _____

Factor IX, PCC, and Other Factor Products

Recombinant FIX

- BeneFIX
- Other, specify _____

Human FIX

- AlphaNine S-D
- Mononine
- Other, specify _____

Prothrombin complex

- Bebulin VH
- Profilnine SD
- Proplex T
- Other, specify _____

Activated prothrombin complex

- Autoplex T
- FEIBA VH
- Other, specify _____

Concentrates of other factors

- NovoSeven (FVIIa)
- Fibrogammin P (FXIII)
- Other, specify _____

MENSTRUAL SYMPTOMS

(37) Has patient had first menstrual period since the last visit?

- Yes No- has not had first period; skip to #61 N/A

(37a) If yes, what was age at first menstrual period? ___ ___ years old

(38) Does the patient have menstrual periods?

- Yes No **(if no, skip to #58)**

(39) Are periods regular, so that patient could predict when next period would begin?

- Yes No

(40) What is the average length of patient's menstrual cycle (i.e. from the first day of one period to the first day of the next period)?

- ___ ___ days
- Unknown

(41) How many days does menstrual period last?

___ ___ days

(42) Are periods presently perceived as heavy by the patient?

- Yes
- No

(43) How frequently does patient change protection on heaviest day?

Once every ___ ___ min hour

(44) Are clots larger than a quarter?

- Yes
- No

(45) Has patient lost time from school, work, or recreational activities since the last visit because of periods?

- Yes
- No

(45a) If yes, what is average number of days lost since the last visit?

___ ___ days lost

(46) Does pain/cramping during menstrual period impair quality of life?

- Yes
- No

REPRODUCTIVE/GYN HISTORY

(47) Has the patient tried to get pregnant since the last visit?

- Yes
- No
- First Visit

(48) Has the patient become pregnant since the last visit?

- Yes
- No
- First Visit **(if no or first visit, skip to #58)**

(49) How many times has the patient been pregnant since the last visit? ___ ___ **(if none, skip to #58)**

- First Visit

(50) How many times has patient experienced each of the following pregnancy and/or delivery outcomes since the last visit? *(Please write in appropriate numbers)*

- ___ Currently pregnant
- ___ Live birth
- ___ Elective termination of pregnancy
- ___ Ectopic, tubal, or molar pregnancy
- ___ 1st trimester miscarriage
- ___ 2nd trimester miscarriage
- ___ Pre-term delivery
- ___ Stillbirth

(51) If patient has experienced a miscarriage since the last visit, did she have a problem with bleeding during miscarriage?

- Yes
- No
- N/A

(51a) During how many miscarriages did patient have a problem with bleeding?

Number: _____

(52) Has patient had any problems with bleeding during pregnancy since the last visit?
 Yes No

(52a) During how many pregnancies did patient have a problem with bleeding?

Number: _____

(53) Has patient had post-partum hemorrhage of concern to healthcare provider since the last visit?
 Yes No Unknown First Visit **(if no, unknown, or first visit, skip to #57)**

(54) Has patient had post-partum hemorrhage of concern to healthcare provider within the first 24 hours following delivery of a baby since the last visit?
 Yes No N/A

(54a) If yes, how many deliveries did patient have post-partum hemorrhage within the first 24 hours?

Number: _____

(54b) Which mode of delivery was associated with post-partum hemorrhage?
 Vaginal birth
 Cesarean section (C-section) birth
 Both

(55) Has patient had post-partum hemorrhage of concern to healthcare provider after the first 24 hours following delivery of a baby since the last visit?
 Yes No N/A

(55a) If yes, after how many deliveries did patient have a problem with bleeding after the first 24 hours?

Number: _____

(55b) How many days after delivery did post-partum hemorrhage start?

<u>First occurrence</u>	<u>Second occurrence</u>	<u>Third occurrence</u>
<input type="checkbox"/> 1 – 7 days	<input type="checkbox"/> 1 – 7 days	<input type="checkbox"/> 1 – 7 days
<input type="checkbox"/> 8 – 14 days	<input type="checkbox"/> 8 – 14 days	<input type="checkbox"/> 8 – 14 days
<input type="checkbox"/> 15 days – 6 weeks	<input type="checkbox"/> 15 days – 6 weeks	<input type="checkbox"/> 15 days – 6 weeks
<input type="checkbox"/> More than 6 weeks	<input type="checkbox"/> More than 6 weeks	<input type="checkbox"/> More than 6 weeks
<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown

(55c) How many days did the post-partum hemorrhage last?

<u>First occurrence</u>	<u>Second occurrence</u>	<u>Third occurrence</u>
____ days	____ days	____ days

(55d) Which mode of delivery was associated with post-partum hemorrhage?
 Vaginal birth
 Cesarean section (C-section) birth
 Both

(56) Were any of the following treatments given for up to 4 weeks post-partum due to excessive vaginal bleeding of concern to healthcare provider? Also, indicate if treatment was given prophylactically.

	Yes	No	Unk	Prophy?		Yes	No	Unk	Prophy?
Red cell transfusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cryoprecipitate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Desmopressin (DDAVP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Platelet transfusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FVIII or vWf concentrate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fresh frozen plasma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other- specify:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(57) Before patient became pregnant with most recent pregnancy, did she see a health care provider to plan for a healthy pregnancy?

- Yes No

(57a) If yes, what was the main reason the patient visited a health care provider to plan for a healthy pregnancy? *Please check one response.*

- a. Wanted to check on overall health before trying to get pregnant _____
- b. Patient wanted counseling on the potential impact of her bleeding disorder on her pregnancy _____
- c. Presence of another/other ongoing health condition(s) (e.g., high blood pressure, diabetes, epilepsy) _____
- d. Problems with a prior pregnancy or previous miscarriage or infant death. _____
- e. Wanted information about smoking, drinking or substance use before pregnancy _____
- f. Wanted to get weight under control before pregnancy _____
- g. Concerned about genetic disease _____
- h. Concerned about patient/patient's partner exposure to chemicals or other harmful substances _____
- i. other _____

MENOPAUSE

(58) Has patient experienced any signs or symptoms of menopause or perimenopause since the last visit?

- Yes No Unknown First Visit *(if no, unknown, or first visit, skip to #61)*

(58a) If yes, what was patient's age at last menstrual period?

(59) Have the following bleeding symptoms increased, decreased, or remained unchanged since patient entered perimenopause/menopause?

	Increased	Decreased	Unchanged
Vaginal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epistaxis > 10 min	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bruises larger than a quarter size occurring at least once a month without trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding from minor cuts > 5 min	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CNS bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GI bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(60) Please check whether or not the patient has ever used any of the following medications, treatments, or surgeries to treat menopause related bleeding since the last visit. Also, check if the response to treatment was excellent, good, fair, or poor.

	Usage for menopause related bleeding? (Check if Yes)	Response to treatment					
		Excellent	Good	Fair	Poor	Intolerant	
Medications/Devices							
Antifibrinolytics (eg. Amicar, Tranexamic Acid)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Side effect(s)?:	
Desmopressin (DDAVP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Side effect(s)?:	
Oral contraceptives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Side effect(s)?:	
Levonorgestrel IUD (Mirena)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Side effect(s)?:	
Surgeries							
Dilation and curettage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Endometrial ablation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Uterine artery embolization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Other gynecological surgery:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Blood/Factor Products							
Clotting factor products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Blood (packed RBC or whole blood) or plasma products (ex. Blood/plasma transfusion, cryoprecipitate)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Platelet transfusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Other							
Other medication, treatment, or surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Please specify:							

Only completed for severe patients with factor levels < 10% (e.g. Type 3 VWD, severe factor deficiency, etc)

(61) Ranges of motion

Date ROM measurements performed

___/___/___

CODES*		
<u>Not measured</u>	<u>Orthopedic appliance</u>	<u>Invasive procedure</u>
A = Acute bleed	D = Cast	H = Arthrodesis
B = Post-op restrictions	E = Splint	I = Joint replacement
C = Other medical reason	F = Orthosis	J = Arthroscopic synovectomy
G = Brace		K = Open synovectomy
		L = Radioisotopic synovectomy
		M = Other invasive procedure

*See reverse for definitions

Record ROM Endpoint

Check

Circle all codes that apply from list above

Left	Joint and Measuring Position	Right	Target Joint	Not measured	Orthopedic Appliance	Invasive Procedure
	<u>Hip</u>		<u>Hip</u>	<u>Hip</u>		
___	Extension (sidelying)	___	L: ___	L: A B C	L: D E F G	L: H I J K L M
___	Flexion (supine)	___	R: ___	R: A B C	R: D E F G	R: H I J K L M
	<u>Knee</u>		<u>Knee</u>	<u>Knee</u>		
___	Flexion (supine)	___	L: ___	L: A B C	L: D E F G	L: H I J K L M
___	Extension (supine)	___	R: ___	R: A B C	R: D E F G	R: H I J K L M
___	Hyperextension (supine)	___				
	<u>Shoulder</u>		<u>Shoulder</u>	<u>Shoulder</u>		
___	Flexion (supine)	___	L: ___	L: A B C	L: D E F G	L: H I J K L M
			R: ___	R: A B C	R: D E F G	R: H I J K L M
	<u>Elbow</u>		<u>Elbow</u>	<u>Elbow</u>		
___	Flexion (supine)	___	L: ___	L: A B C	L: D E F G	L: H I J K L M
___	Extension (supine)	___	R: ___	R: A B C	R: D E F G	R: H I J K L M
___	Hyperextension (supine)	___				
___	Pronation (sitting)	___				
___	Supination (sitting)	___				
	<u>Ankle</u>		<u>Ankle</u>	<u>Ankle</u>		
___	Dorsiflexion (sitting)	___	L: ___	L: A B C	L: D E F G	L: H I J K L M
___	Plantarflexion (sitting)	___	R: ___	R: A B C	R: D E F G	R: H I J K L M

Ranges of motion measured by (check one): Physical therapist Other