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von Willebrand's Disease Patient Information Form

1. General Information

Name of Patient <i>First</i> _____ <i>Last</i> _____	Ethnic origin: Asian <input type="checkbox"/> Black or African <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Other <input type="checkbox"/>
Date of Birth: __ month __ date ____ year	ABO Blood Group: A <input type="checkbox"/> B <input type="checkbox"/> AB <input type="checkbox"/> O <input type="checkbox"/>
Patient Identifier or Social Security No.	Male <input type="checkbox"/> Female <input type="checkbox"/> Pregnancy: No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, Due date __ month __ date ____ year

2. Clinical Symptoms (please check all that apply)

- Epistaxis
- Excessive Bruising
- Menorrhagia
- Post-extraction bleeding
- Hematomas
- Bleeding from minor wounds
- Gum bleeding
- Post-surgical bleeding
- Post-partum bleeding
- Gastrointestinal bleeding
- Joints or muscle bleeding
- Hematuria
- Cerebral bleeding

3. Clinical Diagnosis and Lab tests

Clinical Diagnosis	FVIII, %	vWF: Ag, % (antigen)	vWF: RCo, % (Ristocetin cofactor)	Multimeric analysis	vWF: CB, % (Collegen binding)	vWF: FVIII, % (FVIII binding)	Bleeding Times
Type 1 VWD							
Type 2A VWD							
Type 2B VWD							
Type 2M VWD							
Type 2N VWD							
Type 3 VWD							
Acquired VWD							
Pseudo VWD							
Other: _____							

4. Please Attach Pedigree.