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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 Black or African Caucasian Hispanic Other
Date of Birth: __ month __ date __ __ __ year	ABO Blood Group: A B AB O
Patient Identifier or Social Security No.	Male Female Pregnancy: No Yes 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.