National Blood Clot Alliance
Stop The Clot®

Women and Blood Clots Risk Assessment Tool

Use this questionnaire at your general check up exams, when considering birth control options that contain the hormone estrogen, when considering starting a family or undergoing IVF, before childbirth or after pregnancy, when considering hormone replacement therapy, and as you get older. Share the results of this questionnaire with your healthcare provider before or after any of these life events. Your healthcare provider will use your answers to the questions below to help assess your risk for blood clots.

Name:______________________________ Healthcare provider:_______________________________ Date: ______________________
DOB:__________ Age: _______ Weight: ________ BMI (weight/height): __________ Date of last women's health clinical visit: _____________
Any allergies to medications? Circle one: Yes / No If yes, list them here: ____

General Questions

1. Have you or any member in your family ever had a blood clot? YES NO
2. Have you ever been told by a medical professional that you are at a high risk of developing a blood clot? YES NO
3. What was the first date of your last menstrual period? (month/day/year) (___/___/____)
4. Are you currently breastfeeding an infant who is less than 1 month of age? YES NO
5. Do you think you might be pregnant now? YES NO
6. Have you been told that you are overweight or obese? (Overweight: BMI >25, Obese: BMI >30) YES NO
7. Do you smoke cigarettes? YES NO
8. Do you have diabetes? YES NO
9. Do you get migraine headaches, or headaches so bad that you feel sick to your stomach, you lose the ability to see, it makes it hard to be in light, or it involves numbness? YES NO
10. Do you have high blood pressure, hypertension, or high cholesterol? YES NO
11. Have you ever had a heart attack or stroke, atrial fibrillation, or been told you had any heart disease? YES NO
12. Have you had bariatric surgery or stomach reduction surgery? YES NO
13. Have you had recent major surgery or are you planning to have surgery in the next 4 weeks? YES NO
14. Do you have or have you ever had breast cancer? YES NO
15. Do you have lupus, rheumatoid arthritis, or any blood disorders? YES NO
16. Do you take medication for seizures, tuberculosis (TB) fungal infections, or human immunodeficiency virus (HIV)? If yes, list them here: ____ YES NO
17. Do you have any other medical problems or take regular medication? Please list: ____ YES NO

Family Planning (Birth Control, IVF, Pregnancy, Childbirth, and Postpartum)

18. Have you ever taken birth control pills, or used a birth control patch, ring, or shot/injection? If no, go to question 19. If yes, please indicate dates here: ____ YES NO
    a. Did you ever experience a bad reaction to using hormonal birth control? YES NO
    b. Are you currently using birth control pills, or a birth control patch, ring, or shot/injection? YES NO
19. Have you ever been told by a medical professional not to take hormones? YES NO
20. Have you ever had a miscarriage? YES NO
21. Are you using or have you tried other fertility treatments? If yes, explain:____ YES NO
22. Have you given birth within the past 6 weeks? YES NO
23. Did you deliver by C-section? YES NO
24. Did you have any complications after your pregnancy? If yes, please explain: ____ YES NO
25. Have you experienced prolonged immobility due to your pregnancy? (Decreased activity, bed rest, travel, recovery after travel) YES NO
26. Are you currently breastfeeding an infant who is less than 1 month of age? YES NO
27. Are you 35 years or older and pregnant or looking to get pregnant? YES NO
28. Have you experienced prolonged immobility due to your pregnancy? (Decreased activity, bed rest, travel, recovery after travel) YES NO

Treatment of Menopause Symptoms

29. Are you taking hormone replacement therapy (HRT)? If yes, what type are you taking? _______________________________________ YES NO
30. Why are you taking hormone replacement therapy? **Circle one**: Menopause / Menopausal symptoms / Other:__________________
31. How old were you when you started taking HRT? ___________

Feminizing Hormone Therapy

32. Are you taking hormone replacement therapy (HRT)? If yes, what type are you taking? _______________________________________ YES NO