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XARELTO QUESTIONNAIRE

Name (please state if client is deceased, if so please state who is acting on their behalf):

____

Address: ____

City: ______________________ State:______ Zip: ______________

Home Phone:______________________ Work Phone:______________________

Cell Phone: ______________________ Email: ______________________

Occupation: ______________________ Spouse: ______________________

Date of Birth: ______________ Height: __________ Weight: ____________

Reason you were prescribed XARELTO:______________________________

Doctor who prescribed you XARELTO: ______________________________

Pharmacy where XARELTO prescription was filled: ______________________

Date you began taking XARELTO: ______________________________

Date you discontinued use of XARELTO: ______________________________

Do you have the XARELTO packaging or prescription bottle in your possession: Yes __ No___

Dosage: __________

Please list other illness present at the time of XARELTO use: (Diabetes, cancer, etc.)

____

Injuries Caused by XARELTO:

_____ Gastrointestinal bleeding

_____ Abdominal bleeding

_____ Rectal bleeding

_____ Stroke

_____ Brain Hemorrhage

_____ Death

_____ Uncontrollable Bleeding

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Hospitalization from XARELTO use? Yes ____ No ____
If yes, please answer the following:

Name of the Hospital: ____

Hospital Address: ____

Length of Hospitalization: ____

Diagnosis: ____

Permanent Injuries: ____

Pharmacy used to fill XARELTO prescription:

Name: ____

Address: ____

____

Name: ____

Address: ____

____

Cardiologist:

Name: ____

Address: ____

____

Any other doctors you saw regarding XARELTO use:

Name: ____

Address: ____

____

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***Please state ALL problems you have experienced from taking XARELTO:**

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