Questionnaire

Study ID number
Age
Contact numbers (to facilitate follow up)

General Medical History

What medical problems do you have?
Have you been admitted into hospital before? If so for what?
Are there any diseases that are common in your family?
What drugs you are currently taking?
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Blood Clotting History

Previous clots Yes/No?
If yes a) were you off treatment or on treatment, which treatment?
b) were there any other complications Yes/No, if so what were these?

Heart History

What date was your mechanical heart valve was inserted?
What was the disease that led to your heart valve developing a problem to begin with?
Did you have a scan of the heart (echocardiogram) done Yes/No?
Have you had any problems with your mechanical heart valve so far?
If yes what were they?

Birth History

How many children have you delivered?
How did you deliver your babies?
If it was a normal vaginal delivery was it assisted or not?
How many of those were delivered with your mechanical heart valve in place?
If any, a) what treatment were you put on for your pregnancy
b) Did you have any problems during your pregnancy?
c) If yes what were they?