

1. About you

Thank you for participating in the Blood Brotherhood program. The following is demographic information for our program development use. It will not be shared with anyone outside of the management team of the Hemophilia Federation of America.

1. Name

2. Address

Street

City

State

Zip

3. Contact information

Phone

E-mail

Other

4. Employer

5. Date of Birth

6. Insurance

Employer Provided Private (Blue Cross, Aetna, etc.)

State High Risk Pool

Medicaid, Medicare

None

Other (please specify)

2. About your bleeding disorder

1. If you go to a Hemophilia Treatment Center, which one?

2. Where do you get your factor?

3. What is your bleeding disorder?

Hemophilia A

Hemophilia B

vWD

Other (please specify)

4. How Severe?

Mild

Moderate

Severe

Don't Know

5. How would you rate each of the following?

	poor				great
your health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
your support systems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
your physical activity level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
your overall wellbeing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>