

1. Personal details

Insurance number:.....

Name:.....

Date of questioning:

Date of follow-up examination: 1 month / 1 year

Country:

City:

Hospital:

Doctor:

Blood sample code:

Date of blood sampling:

2. Change in anamnestic details

Alcohol consumption: yes / no / no detail

If yes: frequency: no data / occasionally / monthly / weekly / daily

Amount (g/day):.....

Since when?.....

Alcohol consumption in the past 2 weeks (g):

If not: **Have you consumed alcohol before?** yes / no / no data

If yes: frequency: no data / occasionally / monthly / weekly / daily

Amount (g/day):.....

For how long?.....

When did you quit drinking alcohol?.....

Guide for estimation of the amount:

1 dl beer (4.5 vol. %) = ~3.5 g alcohol

1 dl wine (12.5 vol. %) = ~10 g alcohol

1 dl hard drink (50 vol. %) = ~40 g alcohol

Smoking: yes / no / no data

If yes: Amount (cigarettes/day):.....

Since when?:.....

If not: **Have you smoked before?** yes/no

If yes: amount (cigarettes/day):.....

For how long?.....

When did you quit smoking?

Drug abuse: yes / no / no data

Prescribed medication should not be included here.

If yes: Type of drug:.....

Amount:.....

For how long?.....

Diet: yes / no

If yes: type: diabetic / gluten free / vegetarian / paleolit / lactose free / other:.....

Autoimmun disease: yes / no

If yes: **has it been recorded before?** yes / no

If not: specify:.....

Diabetes mellitus: yes / no

If yes: **has it been recorded before?** yes / no

If not: type: type I / type II / type III / MODY

Since when? (years).....

Lipid metabolism disorder: yes / no

If yes: **has it been recorded before?** yes / no

If not: Since when? (years).....

High blood pressure: yes / no

If yes: **has it been recorded before?** yes / no

If not: Since when? (years):.....

Thyroid disease: yes / no

If yes: **has it been recorded before?** yes / no

If not: type: hypothyroidism / hyperthyroidism / other:.....

Since when? (years).....

Other diseases: yes / no

If yes: **has it been recorded before?** yes / no

If not: specify:.....

Medications taken regulary: yes / no

If yes:

Name of medication:.....active substance:.....
 dose: unit: g / mg / IU, if fluid, concentration: (e.g. 10%,
 1g/2ml)..... how many times per day (e.g. 3)method of
 administration:.....other notes:.....

Name of medication:.....active substance:.....
 dose: unit: g / mg / IU, if fluid, concentration: (e.g. 10%,
 1g/2ml)..... how many times per day (e.g. 3)method of
 administration:.....other notes:.....

Name of medication:.....active substance:.....
 dose: unit: g / mg / IU, if fluid, concentration: (e.g. 10%,
 1g/2ml)..... how many times per day (e.g. 3)method of
 administration:.....other notes:.....

Name of medication:.....active substance:.....
 dose: unit: g / mg / IU, if fluid, concentration: (e.g. 10%,
 1g/2ml)..... how many times per day (e.g. 3)method of
 administration:.....other notes:.....

Malignant disease in family history: yes / no / no data

If yes: Has it been recorded before? yes / no

If not: relationship: father / mother / sibling / child / paternal grandfather / paternal grandmother / maternal grandmother / maternal grandfather / paternal cousin / maternal cousin / father sibling (uncle, aunt) / mother sibling (uncle, aunt) / siblings child (nephew, niece) / grandchild / paternal grandfathers sibling / paternal grandmothers sibling / maternal grandfathers sibling / maternal grandmothers sibling / other blood relation / spouse (husband, wife, other not blood relation)

Other anamnestic detail:

.....
.....

3. Current problems and symptoms yes/no

Difficulty with swallowing: yes / no

If yes: Since when? (*prior to this examination, how much time has passed since the occurring of the symptom?*) week/s / month/s / year/s

Food consistency: solid/pulpy/liquid

Frequency: every meal / daily / occasionally

Chest tightness: yes/no

If yes: frequency: every meal / daily / occasionally

Regurgitation: yes/no

If yes: frequency: every meal / daily / occasionally

Vomiting: yes/no

If yes: frequency: every meal / daily / occasionally

Appetite: good / retained (varying) / bad

Change in body weight: yes / no

If yes: direction of change: weight loss / weight gain

How much?:.....(kg)

How long did it take? (week/s):.....

Coughing: yes/no

Follow-up Eckard score:

4. Status

Weight (kg):.....

Height (m):.....
BMI....

Blood pressure (Hgmm):...../.....
Pulse (/min):.....

Abdominal tenderness: yes / no / no data

5. Examinations

5.1 Laboratory: yes/no

erythrocyte sedimentation rate (mm/h)	
CRP (mg/l)	
Blood	
WBC count (G/l)	
RBC count (T/l)	
Hemoglobin (g/l)	
Hematokrit (%)	
MCV	
Platelet count (G/l)	
Ions	
Sodium (mmol/l)	
Potassium (mmol/l)	
Calcium (mmol/l)	
Magnesium (mmol/l)	
Phosphate (mmol/l)	
Chloride (mmol/l)	
Iron (umol/l)	
Pancreas	
Glucose (mmol/l)	
Amylase (U/l)	
Lipase (U/l)	
Renal functions	
Urea nitrogen (Karbamid) (mmol/l)	
Kreatinin (umol/l)	
eGFR	
Liver functions	
Total bilirubin (umol/l)	
Direct/conjugated bilirubin (umol/l)	
Indirect bilirubin (umol/l)	
ASAT/GOT (U/l)	
ALAT/GPT (U/l)	
Gamma GT (U/l)	
Alkaline phosphatase (U/l)	

Laktate dehydrogenase LDH (U/l)	
Protrombin (%)	
Protrombin INR	
Metabolism	
Cholesterol (mmol/l)	
Triglicerides (mmol/l)	
Uric acid (umol/l)	
TSH (mU/l)	
HgbA1C (%)	
Proteins	
Total protein (g/l)	
Albumin (g/l)	
Globulin alfa1 (g/l)	
Globulin alfa2 (g/l)	
Globulin beta (g/l)	
Globulin gamma (g/l)	
Fibrinogen (g/l)	
Blood gases	
PaO2 (Hgmm)	
HCO3 (mmol/l)	
sO2 (%)	
Other	

5.2 Barium swallow X-ray: yes / no

if yes:

date of examination:.....

Width of esophagus:..... (cm)

Rate of retention:.....(cm)

Width of cardia:(mm)

5.3 Esophagus manometry: yes/no

Type of manometry: fluid-perfusion / high-resolution, fluid-perfusion catheter / high-resolution, solid pressure sensor

Date of examination:

LES position: between-..... cms

LES base pressure:..... (Hgmm)

LES relaxation:..... (%).....(Hgmm)

Tubular esophageal motility: aperistaltic / simultaneous contractions below 30 Hgmm / simultaneous contractions above 30 Hgmm / incoordinate movements /

other:.....

UES position: between-..... cms

UES base pressure:.....(Hgmm)

UES relaxation:.....(%)

Chicago classification in case of HR manometry: I. classic/II. classic achalasia with esophagus compressions/III. spastic

6. Changes in therapy

Medication: yes /no

If yes:

Type of medication: calcium channel blockers / nitrate / nitric oxid donor /

Other.....

Dose..... (mg)

How many times / day:.....

Botulinum toxin therapy: yes /no

If yes:

Dose:

Number of theatments:

Ballon dilation: yes /no

If yes:

Ballon type:.....

Dilatation length:.....(min)

Dilatation rate:.....

Repeated dilation: yes /no if yes: how many times:.....

Complication: yes /no

Type of complication: mucous membrane injury / perforation / fever / other.....

POEM: yes /no

If yes: Complications: yes / no

If yes: Type of complication:

Repeated intervention: yes / no

Heller myotomy: yes /no

If yes:

Fundoplication type:.....

Complication: yes /no

Type of complication: perforation / fever / other.....

Reoperation: yes / no

8. Epicrisis, complications

Complications: yes / no

If yes: mucous membrane injury / perforation / fever / bleeding /other.....

Mortality: yes / no

If yes, date:.....

Description:

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