

The physical examination has to be done ON ADMISSION!
The blood for laboratory parameters has to be drawn ON ADMISSION!
This form has to be filled ON ADMISSION!

Questionnaire

1. Patient personal details

Insurance number:.....
 First name:.....
 Last name:,.....
 Date of birth:.....
 Gender: female male
 Ethnicity/Race: White / Black / Asian-Indian Not known
 Telefonszám:
 Hozzá tartozó neve, telefonszáma:
 Cím:
 E-mail cím:

2. Details from the medical history

Alcohol consumption: yes / no
 if yes: frequency: occasionally/monthly/weekly/daily
 amount (g/day):.....
 since when? (years):.....
 Alcohol consumption in the last 2 weeks:

if not:
 Did you drink alcohol earlier? yes/no
 if yes: frequency: occasionally/monthly/weekly/daily
 amount (g/occasion):.....
 For how many years?.....
 How long ago did you stop 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
 if yes: amount (cigarettes/day):.....
 For how many years?,.....
 if not:
 Did you smoke earlier? yes/no
 if yes: amount (pcs/occasion):.....
 For how many years?.....
 How long ago did you stop smoking?,.....

Drug abuse: yes / no *Prescribed medication should not be included here.*
 if yes: type of drug:..... amount:.....
 since when (year):.....
 (if there are more drugs, please describe them in the NOTES section at the end)

Country:
Town:
Hospital:
Doctor:
Patient No:

Acute pancreatitis

Diabetes mellitus: yes / no
 if yes: type: Type I. / Type II./Type III. c / MODY
 since when (year):.....

Lipid metabolism disorder: yes / no
 if yes: type: since when (year):.....

Any disease of the pancreas: yes / no *Not counting the current episode.*
 if yes: acute pancreatitis/ chronic pancreatitis/ autoimmune pancreatitis/ tumor/ other
 if other: please describe:.....

If the patient had ACUTE PANCREATITIS in the history:
 How many times did the patient have acute episodes before this episode:.....
 When did the patient have the first acute episode (year):.....

If the patient has CHRONIC/AUTOIMMUNE PANCREATITIS:
 When was it diagnosed?.....
 How many times did the patient have acute episodes before this episode:.....
 When did the patient have the first acute episode (year):.....

If the patient has PANCREATIC CANCER::
 When was it diagnosed?.....
 Was the patient diagnosed with chronic pancreatitis? yes / no
 If yes, when was it diagnosed?.....
 How many times did the patient have acute episodes before this episode?:.....
 When did the patient have the first acute episode (year):.....

Other information:

Pancreas disorders in family history:
 acute pancreatitis: yes / no if yes: relationship to patient:.....
 chronic pancreatitis yes / no if yes: relationship to patient:.....
 autoimmune pancreatitis: yes / no if yes: relationship to patient:.....
 pancreas tumor: yes / no if yes: relationship to patient:.....
 other (please describe):.....relationship to patient:.....

Congenital Anatomical Malformation of the pancreas: yes / no / no data
 if yes: please describe:.....

Other illnesses: yes / no
 if yes: please list/describe them:.....

Medications taken regularly: yes / no *Please specify the name of the active substance (e.g. "acetylsalicylic acid"). Please specify the amount using the International System of Units –SI (e.g. milligram, gram)*

if yes:
 name:..... how many times per day:.....dose.....
 type of administration:.....other notes:

Acute pancreatitis

name:..... how many times per day:.....dose.....
 type of administration:.....other notes:

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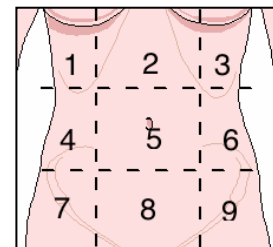
3. Etiology *The answer is “yes” if the etiological factor is proved, the answer is “no” if the etiological factor can be ruled out, the answer is “no data” if the etiological factor was not examined. Please answer “yes” to “Idiopathic” if etiological factor was not identified.*

Biliary	yes	no	no data
Alcohol	yes	no	no data
Virus infection	yes	no	no data
Trauma	yes	no	no data
Drug-induced	yes	no	no data
Congenital anatomical malformation	yes	no	no data
Cystic fibrosis	yes	no	no data
Gluten-sensitive enteropathy	yes	no	no data
Hypertriglyceridaemia	yes	no	no data
Genetic	yes	no	has not been tested yet
Idiopathic	yes	no	
Other	yes	no	

if yes: please describe:.....

4. Complains, symptoms

Abdominal pain: yes / no
 if yes: since when (hours):.....
 type: cramping / dull / sharp
 intensity (1-10):.....
 location: diffuse / localized
 Please mark the location!
 radiation:.....



Nausea: yes / no

Vomiting: yes / no
 if yes: how many times:.....
 contents of cast:.....

Acute pancreatitis

Subfebrility/fever: yes / no

if yes: since when:.....
 degree (°C):.....

Appetite: good / retained / bad

Weight loss: yes / no

if yes: how much (kg):.....
 How long did it take? (weeks):.....

Jaundice: yes / no

if yes: for how long:.....

Stool: normal / diarrhea / constipation / fatty / putrid / undigested food/bloody/mucus

Please refer to the period just before your symptoms has started.

5. Admission details and state

Blood pressure (Hgmm):.....

Heart rate (/minute):.....

Body weight (kg):.....

Body height (cm):.....

Respiratory rate (/minute):.....

Body temperature (°C):
 axillary/rectal

Oxygen saturation (%):

Previous O2 therapy: yes/no

Abdominal tenderness : yes / no

Abdominal guarding: yes / no

Glasgow Coma Scale (GCS):.....

Glasgow Coma Scale:

Eye response

- 4 points: Spontaneous eye opening
- 3 points: Eye opening in response any speech
- 2 points: Opening to response to pain
- 1 point: No eye opening

Verbal Response

- 5 points: Orientated
- 4 points: Confused conversation
- 3 points: Inappropriate speech
- 2 points: Incomprehensible speech
- 1 point: No verbal response.

Motor Response

- 6 points: Obeying command
- 5 points: Localizing response to pain
- 4 points: Withdraws to pain
- 3 points: Decorticate posture
- 2 points: Decerebrate posture
- 1 point: No response to pain

Virus serology: yes / no

6. Imaging examinations on admission

Does the patient have pleural fluid?	yes	no	N/A
Does the patient have lung infiltrate?	yes	no	N/A
Does the patient have abnormal pancreatic structure?	yes	no	N/A
If yes: hypoechoic/hyperechoic/peripancreatic fluid/irregular and blurred contours/Wirsung dilatation (above 1mm)/ascites/calcification/cyst/inhomogeneous structure/ fatty tissue infiltration/edematous pancreas/enlarged pancreas			

Abdominal Computed Tomography: yes no
Description:

.....
Abdominal X-ray: yes no
Description:

.....
Chest X-ray: yes no
Description:

.....
Chest Computed Tomography: yes no
Description:

7. Genetic testing

Has it been performed earlier? yes no
if yes: please describe:

8.a Intravenous fluid in the early period

Intravenous fluid in the early period.....ml

8.b Immediate therapy on admission

Intravenous fluid	yes	no
if yes:	type of fluid.....	
	amount (ml).....	

Acute pancreatitis

Pain management: **yes** **no**
 if yes:
 name:..... how many times per day:.....dose.....
 type of administration:.....other notes:

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name:..... how many times per day:.....dose.....
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Insulin: **yes** **no**
 if yes: name of the medication:.....
 total dose of medication:.....

Intensive care: **yes** **no**
 if yes: namely (ventilation, vasopressor therapy):.....

Other:
 if yes: please describe:.....

.....

.....

.....

9. Interventions, endoscopic treatment: yes no

if yes: ERCP-EST/endobiliary stent/Wirsung stent/cysta drainage

Stent: 1 plastic stent/more plastic stents/uncovered metal stent/covered metal stent

Early complications: none/bleeding/perforation

ERCP: yes no
 if yes:

Successful biliary cannulation:	yes	no	if yes: notes:
Precut:	yes	no	if yes: needleknife/precut papillotomy
EST:	yes	no	if yes: biliary/pancreatic
Stone extraction:	yes	no	
Stent:	yes	no	if yes: metal/plastic
How many pcs?	diameter(Fr)?		length(cm)?
Pancreatic duct filling:	yes	no	if yes: notes:

10. Complications *Please register pancreatic complication of fluid collection/pseudocyst/necrosis only if you had imaging proof on the day of admission, otherwise, please mark "no data".*

Pancreatic: yes no no data
 if yes: fluid collections /pseudocyst / necrosis / diabetes

Organ failure: yes no
 if yes:, lung /heart / kidney /other

Death: yes no
 If yes: the exact time of death: e.g. 10.25 or 22.45

NOTES

.....

DATE:

YEAR: MONTH: DAY: HOUR MIN:

Finish Date:

YEAR: MONTH: DAY: HOUR MIN:

THE TOTAL TIME SPENT THE PATIENT ON ADMISSION: HOUR MIN:

TOWN WHERE THE PATIENT WAS TRANSFERRED FROM:.....

NAME OF THE DOCTOR WHO MADE EXAMINATION:**SIGNATURE:**

Please NOTE! The doctor made the randomization MUST NOT be involved in the treatment of patients any longer. She/He has to keep the information secretly from the patients and medical team involved in the treatment.

NAME OF THE DOCTOR MADE THE RANDOMIZATION:**SIGNATURE:**