**1. Patient personal details**

Institute:

Doctor code

Blood sample code:

Date of blood sampling:

**Insurance number:**

**Name:**

**Date of birth:**

**Age:**

**Gender:** female / male

**Race:** Asian-Indian / White / Black / N/A

**Date of diabetes diagnosis:**

**Inclusion date:**

**2. Inclusion criteria**

|  |  |  |
| --- | --- | --- |
| Patients older than 60 years | **YES** | **NO** |
| Newly diagnosed diabetes mellitus (in the last 6 months) | **YES** | **NO** |
| Written informed consent signed | **YES** | **NO** |
| One „NO” is present = DO NOT INCLUDE! | | |

**3. Exclusion criteria**

|  |  |  |
| --- | --- | --- |
| Continuous alcohol abuse | **YES** | **NO** |
| Chronic pancreatitis | **YES** | **NO** |
| Previous pancreas operation/pancreatectomy | **YES** | **NO** |
| Pregnancy | **YES** | **NO** |
| Present malignant disease | **YES** | **NO** |
| One „YES” is present = EXCLUDE! | | |

**4. Details from the medical history**

**Alcohol consumption**: yes / no

If yes: frequency: N/A / occasionally/monthly/weekly/daily

**Smoking**: yes / no

if yes: amount (cigarettes/day):…………………

for how many years? …………………………

if not: Did you smoke earlier? yes/no/ N/A

if yes: amount (cigarettes/day):…………………………………

for how many years?………………………………………

How long ago did you stop smoking? ……………………………….

**Antidiabetic treatment**

Name of medication:………..……..

active substance:………………

dose: ………….

dose without unit (number only!)

unit: g / mg / IU

how many times per day (e.g. 3): ………….

Method of administration: oral / subcutan

Name of medication:………..……..

active substance:………………

dose: ………….

dose without unit (number only!)

unit: g / mg / IU

how many times per day (e.g. 3): ………….

Method of administration: oral / subcutan

Name of medication:………..……..

active substance:………………

dose: ………….

dose without unit (number only!)

unit: g / mg / IU

how many times per day (e.g. 3): ………….

Method of administration: oral / subcutanv

Name of medication:………..……..

active substance:………………

dose: ………….

dose without unit (number only!)

unit: g / mg / IU

how many times per day (e.g. 3): ………….

Method of administration: oral / subcutan

Name of medication:………..……..

active substance:………………

dose: ………….

dose without unit (number only!)

unit: g / mg / IU

how many times per day (e.g. 3): ………….

Method of administration: oral / subcutan

**Insulin:** yes / no

**dosage**

Name of the medication:..……………………………

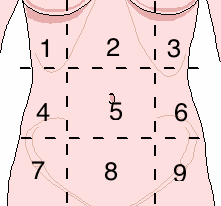
Dosage (00:00 – 23:00)

**5. Status on admission**

**Body weight:**……………………………… kg **Body height:** ………………………………… cm

**Calculated BMI:**

**6. Complains, symptoms**



**Abdominal pain:** yes / no

If yes: since when (hours):….………………………………………..

type: N/A / cramping / dull / sharp

intensity (1-10):……………………………………..

location: diffuse / localised

Please mark the location!

radiation:………………………………………………..

**Appetite:** good / retained / bad

**Weight loss:** yes / no

If yes: How long did it take? (weeks):…………………………

How much (kg):…………………………………………….

**7. Laboratory parameters on admission**

|  |  |
| --- | --- |
| White blood cell (WBC) count (G/l) |  |
| Hemoglobin (g/l) |  |
| Hematocrit (%) |  |
| Thrombocyte (G/l) |  |
| ASAT/GOT (U/l) |  |
| ALAT/GPT (U/l) |  |
| Gamma GT (U/l) |  |
| Total bilirubin (umol/l) |  |
| Direct/Conjugated bilirubin (umol/l) |  |
| Alkaline phosphatase (U/l) |  |
| Cholesterol (mmol/l) |  |
| Triglyceride (mmol/l) |  |
| Glucose (mmol/l) |  |
| Blood urea nitrogen (mmol/l) |  |
| Creatinine (umol/l) |  |
| HbA1c (%) |  |
| CA 19-9 (U/ml) |  |
| Fe (µmol/l |  |
| Sedimentation rate (mm/h) |  |
| Na (mmol/l) |  |
| K (mmol/l) |  |

**8. Imaging examinations needed**  yes / no

|  |  |  |
| --- | --- | --- |
| Weight loss | **YES** | **NO** |
| Abdominal pain/discomfort | **YES** | **NO** |
| Abnormal laboratory data | **YES** | **NO** |
| Unstable glucose metabolism\* | **YES** | **NO** |
| One “YES” is present = worrisome features -> EUS/MRCP! | | |

\* despite the adequate diet and medical treatment and without intercurrent infection

**EUS:** yes / no

If yes: Description:

………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

**MRCP:** yes / no

If yes: Description:

………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

**Other examinations happened :**

**Abdominal ultrasonography:**  yes / no

If yes: Description: ………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

**Abdominal Computed Tomography:** yes / no

If yes: Description:

………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

**9. Date of next visit:**