# Questionnaire

| |
|---|
| **Country:** |
| **Town:** |
| **Hospital:** |
| **Doctor's Name/Initials:** |
| **Patient No:** |

## *1. Patient personal details*

**First name:**……
**Last name:** ……
**Date of birth:**…… ……
**Insurance number:**……
**Gender:** male female
**Ethnicity/Race:** White / Black / Asian-Indian Not known

## *2. Details from the medical history*

What kind of pancreatic diseases had/has the patient?

| | |
|---|---|
| Acute Pancreatitis | (AP) |
| Acute Recurrent Pancreaitis | (ARP) |
| Chronic Pancreatitis | (CP) |
| Autoimmune Pancreatitis | (AIP) |
| Pancreatic Cancer | (PC) |

Other: ……..

If the patient had ACUTE (RECURRENT) PANCREATITIS:
How many times did the patient have acute episodes:……
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:……..
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?:……..
When did the patient have the first acute episode (year):……

**Diabetes mellitus**: yes / no
if yes: type: Type I. / Type II. / Type IIIc / MODY
since when (year):……

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

**Gluten-sensitive enteropathy:** yes / no if yes: since when (year):……



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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:……

pancreatic cancer: 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

if yes:

name:…… amount:…… since when:……

name :…… amount:…… since when:……

name :…… amount:…… since when:……

name :…… amount:…… since when:……

name :…… amount:…… since when:……

name :…… amount:…… since when:……

name :…… amount:…… since when:……

*(if there are more medications, please describe them in the NOTES section at the end)*

**Diet:** yes / no

if yes: please describe:……



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***3. Etiology***

| | | | |
|---|---|---|---|
| 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 |
| Hypertrigliceridaemia | yes | no | no data |
| Gluten-sensitive enteropathy | yes | no | no data |
| Genetic | yes | no | has not been tested yet |
| Idiopathic | yes | no | no data |
| Other | yes | no | |

if yes: please describe:……

***4. Genetic testing***

Has it been performed earlier? yes no

if yes: please describe:

……

……

……

**DATE:**

YEAR: …… MONTH: …….. DAY: …… HOUR …… MIN: ……

**NAME OF THE DOCTOR:** ……**SIGNATURE:** ……



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