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

a) Family medical history:

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:………………………………………

Other diseases in family history:……

……….

b) Medical history of the child:

Known diseases: yes / no
if yes: please list/describe them:

………

………

………

………

HPSG chair and IAP scientific committee member:
Péter Hegyi Tel: +36 70 375 1031 e-mail: hegyi2009@gmail.com
Principal Investigator:
Dóra Mosztbacher Tel: +36 20 984 0776
e-mail: dora.mosztbacher@gmail.com

Abdominal surgery: yes / no

If yes, please describe …….

New medications taken in the last 2 weeks: yes / no

If yes, please list them ……….

……

Medications taken regularly: yes / no

If yes:

name:…………………………… amount:………………………..

name :…………………………… amount:………………………..

name :…………………………… amount:………………………..

name :…………………………… amount:………………………..

name :…………………………… amount:………………………..

New symptoms, diagnosed disease in the last two weeks (e.g. respiratory inflammation, fever, etc.): yes / no

If yes, please describe:……….

…….

New diet, change in diet in the last 2 weeks: yes / no

If yes, please describe: ………..

Any event strongly affecting the child emotionally in the last 2 weeks: yes / no

If yes, please describe:………..

Change in the environment of the child in the last 2 weeks: yes / no

If yes, please describe:………..

Any other event in the last two weeks: yes / no

If yes, please describe:………..

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Was there any examination concerning abdominal pain? yes / no

If yes, what kind of examination? What was the result?

…….

……

Length of brest milk feeding:…….

3.Complains, symptoms

a) Abdominal pain:

How many hours have passed since the pain started? ………………………………………………………………………………

How long did it last? …………………………………………………………

Continuity: continuous / intermitting / changing

Intensity on a 1-10 scale: ……………………….., decreasing /intensifying / stagnating

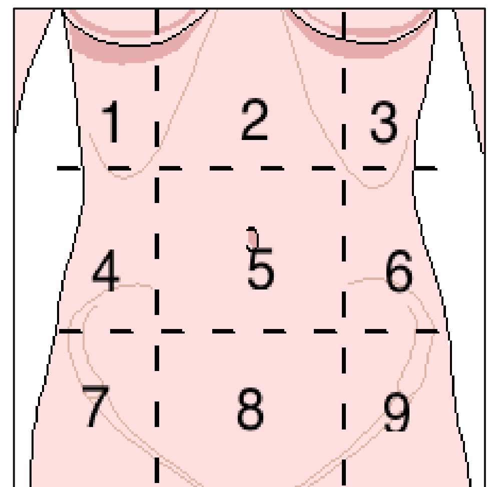
Forced posture: yes /no

Nature: dull / sharp / cramping

Location: diffuse / localized

In case of localized pain please mark it on the illustration!

(You may mark more areas)



Illustration

b) In case of abdominal pain longer than 48 hours:

Was the everyday activity influenced? yes / no

Did the child wake up at night because of the pain? yes / no

Which part of the day the pain appeared mostly?

after waking up / in the morning / in the afternoon / in the evening / at night

Was it connected to eating? yes / no

If yes: before eating / while eating / after eating

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c) Other complains:

Nausea: yes / no

Vomiting: yes / no If yes: How many times?:…………………Content of cast:…………………………………..

Subfebrility, fever: yes / no If yes: Since when?…………………………Temperature:……………………………………

Appetite: good / retained / bad

Weight loss: yes / no If yes: How much? (kg):…………………How long didi t take? (weeks):………………

Jaundice: yes / no If yes: Since when?…………………………………………………………

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

4. Admission details, status

Blood pressure (Hgmm):…………………………….. **Heart rate (/minute):**…………………………….

Body weight (kg):………………………………………. **Body height (cm):**…………………………………….

Respiratory rate (/minute):……………………….. **Body temperature (°C):**………………………….

Abdominal guarding: yes / no

Abdominal tenderness : yes / no

Location of abdominal tenderness …………………………………………………………….

Jaundice: yes / no

Bowel sounds: No/Hypoactive/Normal/ Hyperactive

5. Laboratory parameters

Amylase (U/l): ……………………………………….

Lipase(U/l): ……………………………………….

6. Imaging examinations at admission

Pancreas deviation suggesting acute pancreatitis? yes / no

Pancreas deviation suggesting chronic pancreatitis yes / no

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Abdominal ultrasonography: yes / no

Description:

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....
....
....

Abdominal CT: yes / no

Description:

....
....
....
....

7. Diagnosis: ....

8. Diagnosis - Main Group: ....

(Unknown, Cardiology, Dentistry, Dermatology, Endocrinology, Gastroenterology Gynecology, Haematology, Immunology, Infectology, Nephrology, Neurology, Oncology, Ophtalmology, Orthopaedy, Oto-Laryngology, Psychiatry, Pulmonology, Surgery, Traumatology, Urology, Other)

9. What happened with the patient? admission to an inpatient department / went home / other

Notes:

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....
....
....

Date:

Day: .... Month: .... Year:................ hour: .... minute: ....

Name of the doctor: ....**Signature:** ....

HPSG
www.pancreas.hu

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