Hospital Questionnaire (Version 4.0)
Regional Myocardial Infarction Registry Saxony-Anhalt

Hospital-Code ☐

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Inclusion criteria
Confirmed diagnosis myocardial infarct (STEMI and NSTEMI)

A1 **consent is given**

1. Personal data

Name _____

First name _____

Birthdate |__||__|.|__||__|.|__||__||__||__| ☐ Man ☐ Woman
Day Month Year

Weight _____ kg Height _____ cm

_____
Postcode, place of residence

_____ _____
Name of family physician health insurance

_____
Assignment number from emergency protocol

2. First care

Symptom-onset |__||__|.|__||__|.|__||__| |__||__|.|__||__| ☐ n. k.
Day Month Year Hour Min.

Hospital admission|__||__|.|__||__|.|__||__| |__||__|.|__||__| ☐ n. k.
Day Month Year Hour Min.

Intrahospital ☐ yes ☐ no ☐ n.k.

First treatment ☐ NEF ☐ RTW ☐ RTH/ITH
☐ KTW ☐ KV-Dienst ☐ alone ☐ n.k.

First aid (lay) ☐ yes ☐ no ☐ n.k.

Assignment ☐ ja ☐ nein ☐ n.k.

If yes, from which: _____

3. Risk factors and comorbidities

Smoker	☐ yes	☐ formerly	☐ no	☐ n.k.
Diabetes mellitus	☐ yes	☐ new	☐ no	☐ n.k.
Hypertension	☐ yes		☐ no	☐ n.k.
Hypercholesterolemia	☐ yes		☐ no	☐ n.k.
Post-myocardial infarction status	☐ yes		☐ no	☐ n.k.
Post-PCI status	☐ yes		☐ no	☐ n.k.
Post-Bypass-OP status	☐ yes		☐ no	☐ n.k.
Post-Apoplexy status	☐ yes		☐ no	☐ n.k.
Atrial fibrillation/flutter	☐ yes		☐ no	☐ n.k.
Heart failure	☐ yes		☐ no	☐ n.k.
Renal failure	☐ yes		☐ no	☐ n.k.
pAVK	☐ yes		☐ no	☐ n.k.

4. Acute diagnostic investigations

On admission HF |__||__||__|/Min.

RR |__||__||__|/|__||__||__| mmHg

Cardiogenic shock on admission:
☐ yes ☐ no ☐ n.k.

First EKG ☐ STEMI ☐ NSTEMI ☐ new LSB

☐ Troponin I ☐ Troponin T Value |_____| Threshold value___|

☐ Type 1 ☐ Type 2 ☐ Type3 ☐ Type4a ☐ Type4b ☐ Type5 ☐ n.k.

First attending station:
☐ ITS ☐ IMC/CPU
☐ Station with monitoring system ☐ Normalstation

5. First therapy (PCI see 5a)

☐ ASS ☐ Clopidogrel/Prasugrel/Ticagrelor ☐ Heparin
☐ GP IIb/IIIa-Antagonist

Thrombolytic therapy ☐ ja |__||__|.|__||__|.|__||__| |__||__|.|__||__|
Day Month Year Hour Min.
☐ no ☐ n. k.

If yes, which substance: _____ ☐ n. k.

Bypass-OP ☐ yes ☐ no ☐ n. k.
If yes, ☐ elective or
☐ Emergency-OP: |__||__|.|__||__|.|__||__|
Day Month Year

Why neither thrombolytic therapy nor PCI nor CABG:
_____

5a. PCI

PCI	☐ yes	☐ no
If yes, access:	☐ transradial	☐ transfemoral
Stent	☐ yes	☐ no
If yes,	☐ BMS	☐ DES

Date PCI: |__||__|.|__||__|.|__||__|
Day Month Year

Vessel puncture |__||__|.|__||__| First Ballon |__||__|.|__||__|
Hour Min. Hour Min.

TIMI (before) _____ TIMI (afterwards) _____

IABP ☐ yes ☐ no

6. Stationary complications

☐ none
☐ Shock (new) ☐ Intubation ☐ Resuscitation
☐ Re-infarct ☐ Stroke ☐ Re-intervention
☐ Severe bleeding
☐ Other: _____

7. Medications at discharge

☐ ASS ☐ Beta blocker ☐ ACE/ARB-Hemmer
☐ Clopidogrel/Prasugrel/Ticagrelor
☐ Diuretic ☐ Anticoagulant ☐ Aldosteronantagonist
☐ Statine ☐ other Cholesterol lowering drug
☐ Insulin ☐ oral Antidiabetic drug
☐ Other: _____

8. Discharge, Transfer, Death

☐ Patient discharged Date: |__||__|.|__||__|.|__||__|
Day Month Year

☐ Patient transferred Date: |__||__|.|__||__|.|__||__| |__||__|.|__||__|
Day Month Year Hour Min.

If Patient transferred, transfer to:
☐ Bad Bevensen ☐ Magdeburg ☐ Perleberg
☐ Stendal ☐ Uelzen ☐ Wittstock
☐ Other: _____

☐ Patient died Date: |__||__|.|__||__|.|__||__| |__||__|.|__||__|
Day Month Year Hour Min.

Questionnaire filled: |__||__|.|__||__|.|__||__|
Day Month Year

_____
Name oft he Physician (block capital)

_____
Signature oft he physician