

**Pregnancy in patients
with Philadelphia negative chronic myeloproliferative disorders**

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http://www.uni-ulm.de/onkologie/pages/studienzentrale.html - formulare

Data Entry Form

patient number <i>was given by the coordinator</i>	_ _ _ _	hospital number	_ _ _		
Patient's initials (first & last name)	_ _ _	date of birth	_ _ _ _ _		
Date of evaluation	_ _ _ _ _				
<u>Chronic myeloproliferative disorder</u>		date of diagnosis	_ _ _ _ _		
Laboratory values at diagnosis					
White blood count	_ _ _ _ _	G/l	Hemoglobin		
			_ _ _ , _ _ g/dl		
Platelet count	_ _ _ _ _	G/l	Hematocrit		
			_ _ _ %		
			LDH		
			_ _ _ _ _ U/l		
Bone marrow biopsy	<input type="checkbox"/> not done				
Diagnosis	_____				

Molecular genetics					
JAK2-mutation	<input type="checkbox"/> negative	<input type="checkbox"/> positive	<input type="checkbox"/> not done		
Spleen at diagnosis					
Splenomegaly	<input type="checkbox"/> no	<input type="checkbox"/> yes	size		
			_ _ _ cm under costal arch		
Sonography date	_ _ _ _ _	longitudinal diameter	_ _ _ , _ _ cm		
Clinical course and management					

<u>Patient history</u>					
Other illnesses					

Cardiovascular risk factors	no	yes	no	yes	
Smoking (>10 cig./day)	<input type="checkbox"/>	<input type="checkbox"/>	diabetes	<input type="checkbox"/>	<input type="checkbox"/>
hyperlipidemia	<input type="checkbox"/>	<input type="checkbox"/>	arterial hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Hereditary factors for thrombophilia	<input type="checkbox"/> no		<input type="checkbox"/> unknown		
Yes,	_____				

Thromboembolism within the family	<input type="checkbox"/> venous		<input type="checkbox"/> arterial	<input type="checkbox"/> none	

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Date

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Signature/Stamp