

**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