EWOG MDS 2006

cbl Follow-up N12 years

Examination interval: Every %& months

Patient Name |____|

Patient identification number |____|

Sex ☐ male ☐ female

Date of Birth (dd/mm/yy) |____________|

Medical history and physical examination

Height: _______cm

Weight: _______cm

Schooling: __________________________________

Grade: __________________________________

Education: __________________________________

	No	Yes	
Intellectual disability	☐	☐	
Dyslalia	☐	☐	
Dysmorphic features	☐	☐	if yes, please specify: ____________________________ ____
Xanthoma	☐	☐	if yes, give exact number: ____________
“Cafe au lait” spots	☐	☐	if yes: ☐ < 10 spots give exact number ___ ☐ ≥ 10
Received anaesthesia previously	☐	☐	
If yes: Complications during anaesthesia:	☐	☐	if yes, please enclose medical report.
Seizures	☐	☐	if yes, please enclose medical report.
Hepatitis/ Hepatopathy	☐	☐	if yes, please enclose medical report.
Known Bleeding disorder	☐	☐	if yes, please specify: ________________________
Bleeding complications:	☐	☐	if yes, please enclose medical report.

Spleen size below costal margin by palpation I______I cm

Liver size below costal margin by palpation I______I cm

Blood pressure: Right arm: _________ Right leg: _________ Left arm: _________ Left leg: _________

Other signs or symptoms ☐ ☐ if yes, specify: ________________________________

____

Therapy

I. Observation period (no therapy)

From (dd/mm/yy) |____________| until (dd/mm/yy) |____________|

II. Drug treatment:

Begin	ongoing: no	ongoing: yes	**end**	**drug**	**dosage**
|____________|	☐	☐	|____________|	I____________________I	I_____________I
|____________|	☐	☐	|____________|	I____________________I	I_____________I
|____________|	☐	☐	|____________|	I____________________I	I_____________I
|____________|	☐	☐	|____________|	I____________________I	I_____________I

Remission achieved ☐ ☐ date (dd/mm/yy) |____________|

No **Yes**

II. Splenectomy ☐ ☐ date (dd/mm/yy) |____________|

III. Stem cell transplantation:

☐ ☐ date (dd/mm/yy) |____________| (please fill in SCT form)

Laboratory data

Date (dd/mm/yy) |____________|

receives red cell transfusions regularly ☐ no ☐ yes

receives platelet transfusions regularly ☐ no ☐ yes

Peripheral blood

Hb _______ unit ______

MCV _______ unit ______

Platelets _______ unit ______

WBC _______ unit ______

Reti count _______

Bone marrow aspirate: ☐ not done

cell content ☐ decreased ☐ normal ☐ increased

megakaryocytes ☐ decreased ☐ normal ☐ increased ☐ none

auer rods ☐ no ☐ yes

Hb-Electrophoresis

HbA_1 I______I (%) ☐ not done HbA_2 I______I (%) ☐ not done

HbF I______I (%) ☐ not done

Differential count (%)	Peripheral blood	Bone marrow
Blast		
Promyelocyte		
Myelocyte		
Metamyelocyte		
Band		
Segmented		
Eosinophil		
Basophil		
Lymphocyte		
Monocyte		
Erythroblast		
	100	**100**

Name of reviewing center:

Clinical Chemistry:

GOT/ASAT ________ unit _______ g-GT ________ unit ______ CHE ________ unit ______
GPT/ALAT ________ unit _______ AP ________ unit _______ Bilirubin dir ______ unit ________

Additional Exams

	Yes	No	
Ophthalmologic exam: Opticus atrophy	☐	☐	if yes, please specify side: |____________________|
Audiometry: Hearing loss	☐	☐	if yes, please specify side: |________________________| degree: |________________________|

Abdominal ultrasound incl. Doppler ultrasound:

	No	Yes	
Pathological if yes, please specify:	☐	☐	
Splenomegaly	☐	☐	if yes: size below costal margin ____cm
Hepatomegaly	☐	☐	if yes: size below costal margin _____cm
Liver abnormality	☐	☐	if yes please specify: ___________________________
Signs of vasculopathy	☐	☐	if yes please specify: ___________________________
Other	☐	☐	if yes, please specify in detail or include report: ______

____

		No	Yes	
ECG:	Pathological	☐	☐	if yes please specify: ___________________________

____

Echocardiography:

	No	Yes	
Pathological	☐	☐	
Hypertrophy	☐	☐	if yes please specify: _________________________
Valvular pathologies	☐	☐	if yes please specify: _________________________
Other:	☐	☐	if yes, please specify in detail or include report: ___

____

Laboratory data:

GOT/ASAT _______ unit ______ g-GT _______ unit _____ CHE _______ unit _____
GPT/ALAT _______ unit ______ AP _______ unit ______ Bilirubin dir _____ unit _______

Additional exam every 2 years:

		No	Yes
Cranial MRI:	Pathological if yes, please specify:	☐	☐
	Leukencephalopathy	☐	☐
	Tumor	☐	☐
	Vasculitis	☐	☐

Other: ____

Date |____________| Signature ____________________________________