



# Yazd CABG Registration Form



## 1-Demographic data:

Questionnaire COD:

Name:	Date of birth:	Hospital ID:
Gender: male <input type="checkbox"/> female <input type="checkbox"/> Marriatal Status : married <input type="checkbox"/> single <input type="checkbox"/> Married : Divorced <input type="checkbox"/> Widow <input type="checkbox"/>		
Surgeon : Dr mirhosseini <input type="checkbox"/> Dr Hadad zadeh <input type="checkbox"/> Dr Mali <input type="checkbox"/>		National code:
Address:	Telephone1:	Telephone2:
Date of Admission:	Date of surgery:	Date of discharge:

## 2-Preoperative data:

Weight: .....	Height: .....	
<b>DM:</b> no <input type="checkbox"/> yes <input type="checkbox"/> Unknown <input type="checkbox"/> if yes: OHA <input type="checkbox"/> Insulin <input type="checkbox"/> both <input type="checkbox"/> none <input type="checkbox"/>		
<b>Hypertension:</b> no <input type="checkbox"/> yes <input type="checkbox"/> Unknown <input type="checkbox"/>	<b>Hyper Cholestrolemia:</b> no <input type="checkbox"/> , yes <input type="checkbox"/> Unknown <input type="checkbox"/>	
<b>Smoker:</b> no <input type="checkbox"/> yes <input type="checkbox"/> if yes <input type="checkbox"/> : current <input type="checkbox"/> , former <input type="checkbox"/>	<b>Addict:</b> no <input type="checkbox"/> , yes <input type="checkbox"/> if yes: opium <input type="checkbox"/> others <input type="checkbox"/>	
<b>COPD:</b> no <input type="checkbox"/> yes <input type="checkbox"/>	<b>Pervious CVA:</b> no <input type="checkbox"/> , yes <input type="checkbox"/>	<b>Pervious PVD:</b> no <input type="checkbox"/> , yes <input type="checkbox"/>
<b>Thyroid disease:</b> no <input type="checkbox"/> yes <input type="checkbox"/> Unknown <input type="checkbox"/> if yes: Hypo <input type="checkbox"/> Hyper <input type="checkbox"/> Other <input type="checkbox"/>		
<b>Previous Cardiac Surgery:</b> no <input type="checkbox"/> yes <input type="checkbox"/> if yes: Date: .....	Type: .....	
<b>Prior major non Cardiac Surgery:</b> no <input type="checkbox"/> yes <input type="checkbox"/> if yes: Cancer <input type="checkbox"/> Date: .....	Type: .....	
Lung <input type="checkbox"/> Date: ..... Type: .....	Vessels <input type="checkbox"/> Date: ..... Type: .....	Brain <input type="checkbox"/> Date: ..... Type: .....
<b>Prior PCI:</b> no <input type="checkbox"/> yes <input type="checkbox"/> if yes: which vessel: LAD <input type="checkbox"/> , CX <input type="checkbox"/> , RCA <input type="checkbox"/> , D <input type="checkbox"/> , OM <input type="checkbox"/> , PDA <input type="checkbox"/> when: .....	NA <input type="checkbox"/>	
<b>Current Symptom:</b> Angina: no <input type="checkbox"/> , yes <input type="checkbox"/> if yes: NYHA class: I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> Excertional Dyspnea: no <input type="checkbox"/> , yes <input type="checkbox"/>		
Renal failure : no <input type="checkbox"/> , yes <input type="checkbox"/>	<b>Family History:</b> (Mother or Sister <65 year & Father or Brother <55 y) yes <input type="checkbox"/> no <input type="checkbox"/>	

## 3-indication for CABG

<b>Emergent CABG:</b> no <input type="checkbox"/> yes <input type="checkbox"/> if yes: Post AMI <input type="checkbox"/> Post unstable angina <input type="checkbox"/> Post Procedural (PCI) complication <input type="checkbox"/> unknown <input type="checkbox"/>
which complication: .....
<b>Elective CABG:</b> no <input type="checkbox"/> yes <input type="checkbox"/> if yes: Refractory angina <input type="checkbox"/> increasing survival (LM Diseases 3VD) <input type="checkbox"/> unknown <input type="checkbox"/>

## 4-Current medications:

ASA <input type="checkbox"/>	β-Blocker <input type="checkbox"/>	Nitrates <input type="checkbox"/>	ACEI <input type="checkbox"/>	ARB <input type="checkbox"/>	Statin <input type="checkbox"/>	Steroid <input type="checkbox"/>	Ca Blocker <input type="checkbox"/>	Fibrate <input type="checkbox"/>
Anticoagulant <input type="checkbox"/>	Digoxin <input type="checkbox"/>	OHA <input type="checkbox"/>	insulin <input type="checkbox"/>	Clopidogrel <input type="checkbox"/>	Diuretic <input type="checkbox"/>	Other: <input type="text"/>		

## 5-Cath data before operation:

Vessels with significant stenosis: LAD <input type="checkbox"/> LCX <input type="checkbox"/> RCA <input type="checkbox"/> D <input type="checkbox"/> OM <input type="checkbox"/> PDA <input type="checkbox"/> PLV <input type="checkbox"/>
Left Main > %50: <input type="checkbox"/> EF: <input type="text"/> Valve involvement <input type="checkbox"/> LV aneurysm <input type="checkbox"/>

## 6-Lab data before operation:

WBC:	Hb:	PLT:	B Group:	BUN:	Cr:
Na :	K:	Ca:	ESR:	INR:	PTT:
FBS:	Cholesterol:	TG:	LDL:	HDL:	
HIV: Neg <input type="checkbox"/> pos <input type="checkbox"/>	HBS: Neg <input type="checkbox"/> pos <input type="checkbox"/>		HCV: Neg <input type="checkbox"/> pos <input type="checkbox"/>		

### 7- Echo data:

<b>Before operation:</b> LVEF: .....	Other valves: .....	SPAP: .....
MR severity: No <input type="checkbox"/> Mild <input type="checkbox"/> Mod <input type="checkbox"/> sever <input type="checkbox"/> LV aneurysm, no <input type="checkbox"/> yes <input type="checkbox"/>		
<b>Post operation echo:</b> LVEF: .....	Other valves: .....	SPAP: .....

### 8-Operation Information:

<b>CABG:</b> off Pump <input type="checkbox"/> On Pump <input type="checkbox"/> Conversion <input type="checkbox"/>
Lima: no <input type="checkbox"/> yes <input type="checkbox"/> if yes: Which vessels: ..... Radial: yes <input type="checkbox"/> no <input type="checkbox"/> Rima: yes <input type="checkbox"/> no <input type="checkbox"/>
SVG1: no <input type="checkbox"/> yes <input type="checkbox"/> if yes: Which vessels: ..... SVG2: ..... SVG3: ..... SVG4: .....
<b>Valve Surgery:</b> no <input type="checkbox"/> yes <input type="checkbox"/> if yes: Which valve: Mitral <input type="checkbox"/> Aortic <input type="checkbox"/> Tricuspid <input type="checkbox"/> Pulmonary <input type="checkbox"/> (Running <input type="checkbox"/> Interrupted <input type="checkbox"/> { Repair <input type="checkbox"/> type of repair: Ring anuloplasty <input type="checkbox"/> Neochordal <input type="checkbox"/> Resection <input type="checkbox"/> { Implant <input type="checkbox"/> type of implant: Prosethetic <input type="checkbox"/> Biologic <input type="checkbox"/> Size: .....
End Arterectomy: no <input type="checkbox"/> yes <input type="checkbox"/> if yes: Which vessels: .....
<b>Special finding or Iatrogenic injuries during surgery:</b> Estimated EF: ..... LVH: yes <input type="checkbox"/> no <input type="checkbox"/> Scar heart : yes <input type="checkbox"/> no <input type="checkbox"/> Fragile Heart: yes <input type="checkbox"/> no <input type="checkbox"/> Lung adhesion: yes <input type="checkbox"/> no <input type="checkbox"/> Other <input type="checkbox"/>
CPB time (min): ..... Cross Clamp time (min): .....

### 9- Post operation Information:

<b>Intubation duration</b> (hr): ..... <b>Recurrent intubation</b> no <input type="checkbox"/> yes <input type="checkbox"/> if yes duration (hr): .....
<b>Reoperation:</b> no <input type="checkbox"/> yes <input type="checkbox"/> if yes: tamponade <input type="checkbox"/> infection <input type="checkbox"/> excessive bleeding <input type="checkbox"/> other <input type="checkbox"/>
<b>Amount of Bleeding</b> (CC): ( ..... ), ( ..... ), ( ..... ), ( ..... )
<b>Blood Product used:</b> Pack Cell <input type="checkbox"/> Units: ..... FFP <input type="checkbox"/> Units: ..... PLT <input type="checkbox"/> Units: ..... <b>ICU Stay</b> (day): .....
<b>Drugs:</b> Trans amino <input type="checkbox"/> Fibrinogen <input type="checkbox"/>

### 10- Complications:

<b>Tamponade:</b> no <input type="checkbox"/> yes <input type="checkbox"/> <b>Surgical site Infection:</b> no <input type="checkbox"/> yes <input type="checkbox"/> , if yes: Leg <input type="checkbox"/> Sternum <input type="checkbox"/>
<b>Renal Failure:</b> no <input type="checkbox"/> yes <input type="checkbox"/> <b>Dialysis:</b> no <input type="checkbox"/> yes <input type="checkbox"/> <b>Max Cr</b> ..... <b>Cr at discharge</b> .....
<b>Endocrine complication</b> <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> , if yes: Diabetes <input type="checkbox"/> Hypotiroidism <input type="checkbox"/>
<b>Neurologic:</b> no <input type="checkbox"/> yes <input type="checkbox"/> if yes: TIA <input type="checkbox"/> CVA <input type="checkbox"/> Convulsion <input type="checkbox"/>
<b>Inotrope use:</b> no <input type="checkbox"/> yes <input type="checkbox"/> which ..... <b>IABP use:</b> no <input type="checkbox"/> yes <input type="checkbox"/> if yes: pre op <input type="checkbox"/> intra op <input type="checkbox"/> post op <input type="checkbox"/>
<b>Anti arrhythmia:</b> no <input type="checkbox"/> yes <input type="checkbox"/> which ..... <b>Pace use:</b> no <input type="checkbox"/> yes <input type="checkbox"/>
<b>Pulmonary complication:</b> no <input type="checkbox"/> yes <input type="checkbox"/> if yes: atelectasia <input type="checkbox"/> aspiration <input type="checkbox"/> pneumonia <input type="checkbox"/> lung injury <input type="checkbox"/>
<b>In-hospital mortality:</b> no <input type="checkbox"/> yes <input type="checkbox"/> , if yes: which day ..... <b>Cause of death:</b> .....