Baseline

Center Code:_____ Patient ID:___ Subject Initials Name/Surname:___/___

Demographics / Clinical Data

Enrollment Date: __/__/____ Age: ____ ys Height: ___ cm Weight: ___ kg
NYHA: □ I □ II □ III □ IV Sex: □ M □ F

Quality of Life :
□ NO
□ YES, SF-12 □ YES, EQ-5D
□ YES, ICDC-8 □ YES, HADS

Cardiomyopathy and Comorbidities

Cardiomyopathy:

□ YES:
□ Hypertrophic □ Arrhythmogenic right ventricular dysplasia
□ Dilated □ Valvular
□ Other:_____

□ NO
(Genetic syndrome / Arrhythmogenic / Other)
□ Idiopathic FV
□ Brugada Syndrome □ LQTS □ SQTS
□ CPVT
□ Other:_____

Waiting for Heart Transplantation: □ NO □ YES

Clinical History : additional information/notes:

_____

_____

Basal ECG

Conduction System Abnormalities:
□ NO
□ YES(Ventricular): □ LBBB □ RBBB □ LAH □ LPH □ IVCD □ Other
□ YES (AV): □ AVBI □ AVB II Mobitz I □ AVB II Mobitz II
□ Persistent AVB III □ Paroxysmal AVB III

Sick Sinus Disease: □ NO □ YES Chronotropic incompetence: □ NO □ YES
Other pacing indications: □ NO □ YES, Specify: _____
Rhythm at implant: □ Sinus rhythm □ Atrial Fibrillation/Flutter □ Paced rhythm
Heart rate: ___ bpm
PR duration: ___ ms
Intrinsic QRS duration: ___ ms Paced QRS duration (PM dependent): ___ ms

Drug treatment		
ACE-inhibitors: □ NO □ YES Betablocker: □ NO □ YES Statins: □ NO □ YES	Diuretics: □ NO □ SI Specify:_____ Ivabradine: □ NO □ YES	ARB : □ NO □ YES Dose: _____[mg/day]
Antiarrhythmics: □ NO □ YES, Specificy: _____		
Oral Anti Platelet:	None □ Single □ Double □	
Oral Anti Coagulants (OAC):	□ NO □ YES, Standard OAC □ YES, New OAC	Specify: _____ Specify: _____

Basal Ecocardiographic Assesment			
Left Ventricle LV	LVEF: ____ %	LVFS: ____ %	
	ESV: ____ ml	EDV: ____ ml	
	ESD: ____ mm	EDD: ____ mm	Z score:_____
Other information/additional notes:	_____		
Mitral Regurgitation (0, 1+, 2+, 3+, 4+): ___ degree		Tricuspid Regurgitation (0, 1+, 2+, 3+, 4+): ___ degree	

Arrhythmic History and Arrhythmic Risk Stratification		
Atrial Fibrillation History:	□ NO □ YES, Paroxysmal (spontaneous termination) □ YES, Persistent (>7 days, requiring intervention) □ YES, Permanent	
Atrial Cardioversion in the last 12 months?	□ NO □ YES, electrical cardioversion □ YES, pharmacological cardioversion	 Number: ___ Number: ___
History of ventricular arrhythmias:	□ NO □ YES, Ventricular Fibrillation □ YES, Ventricular Tachycardia: □ Monomorphic □ Polymorphic □ Both □ YES, Non Sustained Ventricular Tachycardia	
Arrhythmic tests (Electrophysiology study/Holter, etc): □ NO □ YES Description: _____		
Syncope: □ NO □ YES	Number: _____	last event date: __/__/____
Ablation procedures:	□ NO □ YES, AVRT/AVNRT □ YES, Atrial Flutter/Fibrillation □ YES, TV	 last procedure date: __/__/____ last procedure date: __/__/____ last procedure date: __/__/____

Additional information: _____
_____
_____
_____